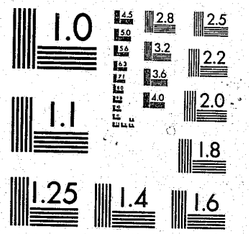
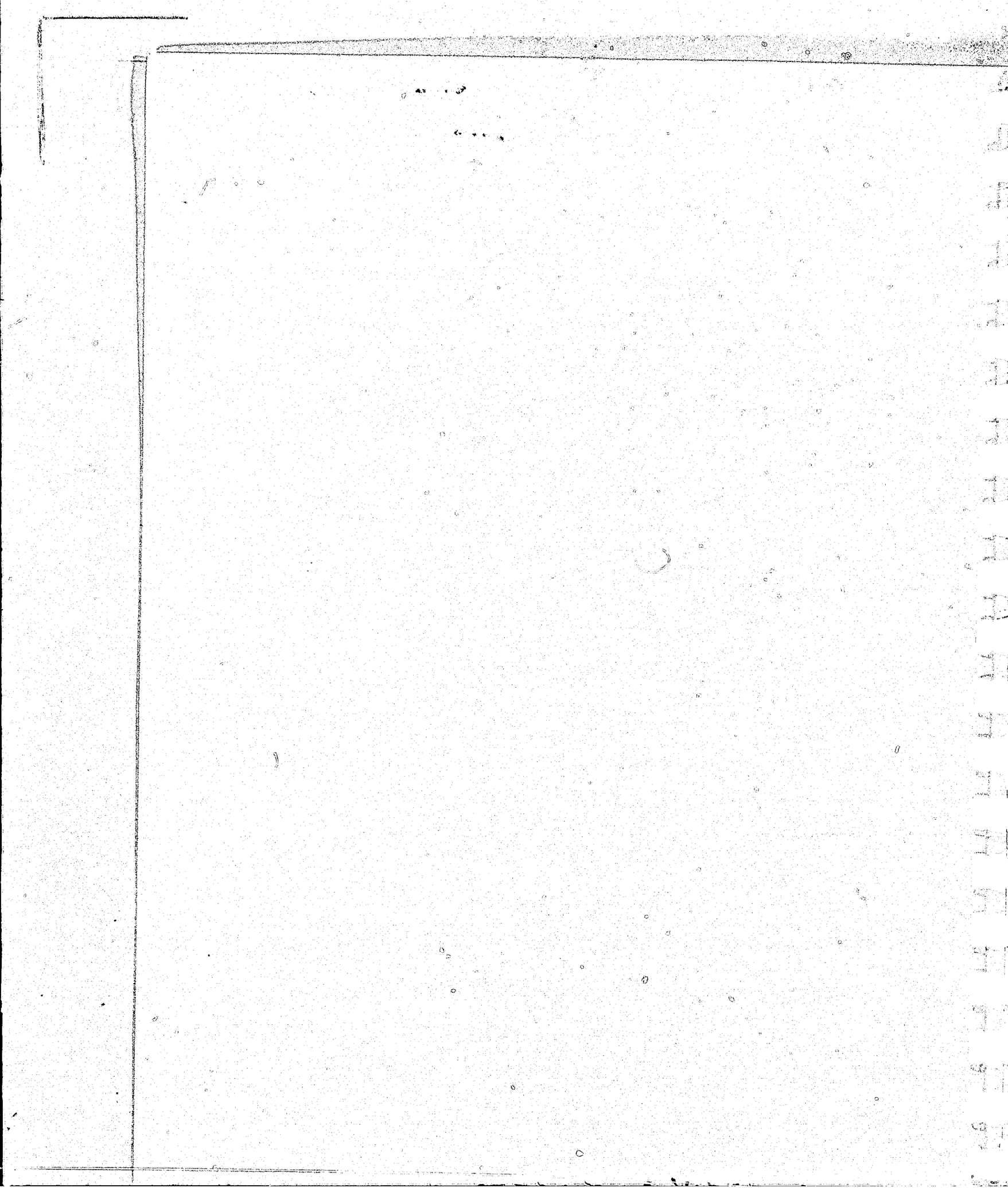


INVESTIGATION OF ALLEGATIONS OF THE USE OF UNREASONABLE FORCE AGAINST INMATES DURING THE SHAKEDOWN OF THE OAHU COMMUNITY CORRECTIONAL CENTER FROM DECEMBER 14 THROUGH DECEMBER 18, 1981

OFFICE OF THE OMBUDSMAN
STATE OF HAWAII

SEPTEMBER, 1983



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Office of the Ombudsman

State of Hawaii

September, 1983

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Chapter I

INTRODUCTION

This is a report of the investigation by the Office of the Ombudsman of allegations made by inmates and members of the public that inmates were brutalized, or systematically beaten by corrections officers, with the knowledge and consent of the administrators, during a major shakedown at the Oahu Community Correctional Center (formerly known as the Hawaii State Prison). The shakedown was conducted at that facility from Monday, December 14, 1981 through Friday, December 18, 1981.

Objectives of the Investigation

(1) To determine whether unreasonable force was used against inmates.

(2) To identify, if unreasonable force was used, the responsible officers and employees.

(3) To refer to the appropriate authorities for action those cases where the Ombudsman thinks there has been a breach of duty or misconduct by an officer or employee of the Department.

(4) To recommend appropriate means to correct noted deficiencies.

Scope of Investigation

The scope of the investigation was limited to respond to the complaints brought to the attention of the office.

To determine whether unreasonable force was used against inmates, and if so, by whom, every individual allegation and accusation concerning the use of force against an inmate was investigated, except for those of six inmates who filed suit against the State and its employees in the United States District Court for the District of Hawaii while the investigation was in progress. Those six cases were terminated, after notice to the inmates, in accordance with the office's policy which is subsequently explained.

To determine whether inmates were beaten by adult corrections officers with the knowledge and consent of, or in accordance with a plan orchestrated by, high-ranking administrators of the Corrections Division, a review and analysis was required of: (1) the cumulative effect of each allegation; and (2) information collected from inmates, adult corrections officers, administrators, police officers, National Guardsmen, and personnel of the Department of the Attorney General.

Thus, the scope of the investigation was limited to the use of force against specific inmates during the shakedown and to the other general allegations about the use of force made by inmates and members of the public. There was no attempt to critically evaluate the shakedown plan or the implementation of that plan.

Organization of the Report

The subject matter of this report is divided into six chapters:

. Chapter I consists of this introduction.

. Chapter II provides background information about the shakedown.

. Chapter III describes the investigation and the problems encountered.

. Chapter IV describes a standard to determine whether force used against an inmate was reasonable or unreasonable.

. Chapter V reports the investigative findings.

. Chapter VI reports the recommendations.

Guide to Abbreviations and Terms

Abbreviations and terms are used throughout this report. The following list of such abbreviations and terms is organized with reference to agencies, personnel, the Oahu Community Correctional Center physical structure, and other miscellaneous terms.

Terms and Abbreviations Referring to Agencies

AG	The Department of the Attorney General, State of Hawaii, which provides legal counsel to the DSSH, CD, and all correctional facilities. The Attorney General is Tany S. Hong.

CD	The Corrections Division of the DSSH, which administers and oversees the operation of all correctional facilities.
CTC	The Corrections Training Center of the CD, which trains correctional personnel.
DSSH	The Department of Social Services and Housing, State of Hawaii, which administers and oversees the operations of the CD. The Director is Franklin Y. K. Sunn.
HHSF	The Halawa High Security Facility, a correctional facility and branch under the administration of the CD.
HNG	The Hawaii National Guard of the Department of Defense, State of Hawaii, which was activated by the Governor to assist in the shakedown.
HPD	The Honolulu Police Department of the City and County of Honolulu, which assisted in the shakedown.
OCCC	The Oahu Community Correctional Center, a correctional facility and branch under the administration of the CD.
TOD	The Tactical Operations Division of the HPD, which trains and handles police dogs in the search for drugs, firearms, and explosives.

Terms and Abbreviations Referring to Personnel
(See Appendix A for a partial DSSH organizational chart)

ACO	Adult Corrections Officers, or guards, of all rank.
AG Investigators	AG personnel who handled and processed contraband recovered from inmates or discovered in the facility.
CDA	The Corrections Division Administrator, Michael Kakesako, the highest-ranking administrator of the CD.
CDAA	The Corrections Division Assistant Administrator, the second highest-ranking administrator of the CD. The position was occupied by Edith Wilhelm at the time of the shakedown.

HHSF Administrator	The highest-ranking administrator of the HHSF, William Oku, who supervises all HHSF employees.
HHSF Program Control Administrator	The second highest-ranking administrator of the HHSF, Lawrence Shohet.
OCCC Administrator	The highest-ranking administrator of the OCCC, Edwin T. Shimoda, who supervises all OCCC employees.
OCCC Chief of Security	The highest-ranking ACO of the OCCC, Fred Ragasa, who supervises all ACOs of the facility.
OCCC Program Control Administrator	The second highest-ranking administrator of the OCCC, Eric Penarosa, who supervises the Chief of Security.
TOD Officers	The sergeant and the five police officers who handled the dogs used in the search for contraband.

Terms Referring to the OCCC Physical Structure
(See Appendix B for diagrams of most locations)

Cellblock	An "X-shaped" structure, comprised of open dormitories and corridors with cells, in which inmates are housed.
Central Control Station	The control station located in Module 9 from where movement and activities within the OCCC can be monitored through a closed-circuit television system and other devices.
Control Station 4	A station from which inmate movement is monitored and controlled, located at a dogleg in a corridor between Modules 14 and 16.
Four-way or 4-way	A square "room" measuring 20 feet by 20 feet, with clear plastic walls and a door on each side leading to a corridor.
Holding Unit	A three-tiered structure in which inmates are housed for disciplinary reasons or other administrative purposes.
Holding Rooms	Rooms located in Module 5 which are used to temporarily detain inmates during their processing into or out of the facility.

Keehi Annex	A cluster of portable wooden structures, enclosed by a high fence at the Ewa end of the facility, in which inmates are housed.
Medical Unit	The OCCC dispensary, located in Module 5 and staffed by facility employees, where medical treatment is provided to inmates.
Modules	Relatively new self-contained residential units. Male inmates were housed in Modules 1, 2, 3, 4, 11, and 13; and female inmates were housed in Modules 7 and 8.
Recreation Field	An open field, enclosed by a high fence, located adjacent to the facility parking lot and main entrance.
The "T"	A point along the route taken by the inmates from the recreation field to the 4-way, near the facility kitchen, at which two corridors intersect and form an abstract capital "T".

Other Terms and Abbreviations

Accusation	A charge that a single ACO or police officer, identified by name or photograph, used unreasonable force against an identified inmate.
Allegation	An assertion that an incident occurred in which one or more identified or unidentified individuals used unreasonable force against an identified inmate on a particular day, at an approximate time, and at a designated location.
CCTV System	A closed-circuit television system employing cameras placed at various locations to monitor movement and activities within the OCCC.
Command Post	A post established in Module 9 during the shakedown, staffed by high-ranking officials, where significant information was to be channeled and from which major decisions were to emanate.
Command Post Log	A chronological notation of events reported to the Command Post during the shakedown.
Contraband	Any item not authorized to be in the possession of an inmate by the administrator of a facility. During the shakedown, the types of contraband especially sought were illicit drugs, alcohol, and weapons.

Strip Search Team	A small group of ACOs responsible for strip searching inmates who were sent individually to the team.

Chapter II

THE SHAKEDOWN: BACKGROUND INFORMATION

The December, 1981, shakedown of the OCCC was the most comprehensive shakedown of that facility within the past several years. Personnel of several agencies, including agencies outside the CD, participated in a variety of tasks over a span of five days. The shakedown tasks, activities, and the roles played by the participating agencies are described below.

Purpose of the Shakedown

Based on information from various sources, CD officials were concerned about the possibility that inmates were in possession of weapons and that a large-scale disturbance would occur. The former CDAA, Edith Wilhelm, stated that the need for a shakedown at the OCCC was recognized as early as September, 1981. Thus, according to CD officials, the objectives of the shakedown were to recover firearms, other weapons, drugs, and other prison contraband and to avert an inmate disturbance. Their goal was to insure the safety of the inmates and staff members.

The Shakedown--What It Entailed

The recovery of contraband from within the confines of the facility involved two primary tasks--the search of the facility and grounds and the body search of the entire inmate population.

Search of the facility and grounds. At the time of the shakedown, the OCCC inmates were housed in four separate residential units--the cellblock, an "X-shaped" structure dating back to 1917; the modules, eight smaller and much newer units; the Holding Unit, a three-tiered structure which was part of the old Hawaii State Prison; and the Keehi Annex, a complex of portable wooden structures located on the Ewa end of the facility grounds apart from the cluster of the other residential units.

Each of the inmate residential units, the inmates' personal property, and the facility grounds were searched during the shakedown. Other areas of the facility searched included the inmate training and school facilities, the kitchen and dining areas, program areas, staff lockers, and areas set aside for staff.

Inmate strip search. Each inmate was subjected to a body search, more commonly known as a strip search. Prior to the search of a residential unit, the inmates were usually evacuated. Upon leaving, each was strip searched to prevent contraband from being smuggled out. After the search of the residential unit was completed, the inmates were returned and strip searched to prevent contraband from being smuggled into the unit.

Differing versions of the strip search procedure were described by CD staff members, although ACO recruits of both the HHSF and the OCCC are initially trained to conduct strip searches by the CTC. At the time of the shakedown, the procedure used by the HHSF was generally conceded by OCCC administrators and ACOs to be more thorough than that practiced at the OCCC. According to HHSF administrators, the HHSF practice is similar to that employed by the HPD and was developed through experience in conducting strip searches.

A CTC trainer described the officially prescribed procedure for strip searches of male inmates as follows:

> The inmate is ordered to strip and, after having complied, is told to run his fingers through his hair while the ACO examines his hair for contraband. The inside of the inmate's ears are checked and the inmate is then told to bend his ears forward while the ACO checks behind them. He is then told to tilt his head back and the ACO inspects his nostrils. As the ACO checks the inmate's mouth, the inmate is instructed to open his mouth, stick out his tongue, and remove his dentures, if any.
>
> The search then moves to the inmate's lower body. The inmate is ordered to lift his penis and then his testicles so that the areas underneath can be visually inspected by the ACO. The inmate is then instructed to bend over and spread his "cheeks", or buttocks, so that his anus can be visually examined. The inmate then stands while the ACO checks behind his knees. The inmate is then ordered to lift his feet and the ACO examines the soles and the spaces between the toes. The ACO then inspects the inmate's clothes, returns them to him, and the inmate is allowed to dress.

A film entitled: "The Correctional Officer: Inmate Body Searches (Unclothed)", produced by the Aims Instructional Media, is used by the CTC for ACO recruit training. While the procedure depicted in the film is essentially the same as described by the CTC trainer, a notable addition is that the inmate is required to squat and cough during the search. That addition is intended to dislodge contraband from the inmate's anus. HHSF administrators reported that HHSF ACOs employ the squat and cough procedure in conducting strip searches.

The training film asserts that most ACOs do not touch an inmate in carrying out a strip search. The CTC trainer stated that it should not be necessary to touch an inmate during a strip search. He also stated that batons are not to be used for any purpose in carrying out a strip search. ACOs are also taught that the recovery of contraband from an inmate's anus, nostrils, or from inside an inmate's ears should be attempted only by medical personnel. The only body cavity from which an ACO may attempt to recover contraband, under certain circumstances, is an inmate's mouth.

The Shakedown Participants

The shakedown was a massive operation involving hundreds of inmates and employees. Personnel of the participating agencies performed a wide range of shakedown tasks.

The inmates. According to OCCC Administrator Shimoda, approximately 800 inmates were incarcerated at the facility at the time of the shakedown. About 260 inmates were housed in the cellblock, and the remaining 540 inmates were housed in the modules, the Holding Unit, and the Keehi Annex.

Normal program activities, such as vocational training, educational classes, and recreational activities, were suspended during the shakedown. Other than those periods during which inmates were evacuated from their residential units so that the units could be searched, the inmates were confined to their residential units.

DSSH and CD personnel. High-ranking officials of the DSSH and the CD were present at the OCCC at various times. The DSSH Director, Franklin Y. K. Sunn, observed the return of some of the inmates to the cellblock on the second day of the shakedown, as did Deputy Director Alfred Suga, who was periodically at the facility during the first three days.

The CDA, Michael Kakesako, and former CDAA, Edith Wilhelm, were present throughout the shakedown, except for Mr. Kakesako's

absence on the last day. The Department's Public Information Officer, Chapman Lam, was also present to respond to the news media.

These officials, along with representatives of the participating agencies, spent most of their time in the shakedown Command Post located in Module 9. According to plan, the Command Post was the central location to which information would be forwarded and from which decisions would emanate. Contact with personnel stationed in various sections of the facility was maintained via two-way radio.

OCCC staff members. According to the shakedown plan, OCCC staff members were to carry out the major tasks involved in the shakedown. The search of the physical structure and surrounding grounds, as well as the strip searches of the inmates, was to be conducted by OCCC employees. Although generally adhered to, major deviations from the plan occurred on Tuesday and Wednesday when HHSF ACOs conducted strip searches of inmates on their return to their residential units.

The OCCC staff members, including ACOs, counseling staff, office workers, and supervisors, performed a wide range of assignments relating to the actual search of the facility while maintaining essential institutional operations, such as the preparation and serving of meals and medical care of inmates. Therefore, work assignments at times exceeded the normal scope of duties of the employees, such as when counseling staff assisted in the preparation and serving of meals, or when ACOs hauled and dumped large amounts of trash. However, there were few complaints and it appears that the staff cooperation and effort were commendable.

The OCCC Administrator and Chief of Security remained within the Command Post in Module 9 most of the time. The OCCC Administrator stated that he needed to remain readily accessible for decision-making purposes because he retained final authority over all matters pertaining to the shakedown. As the primary adviser to the OCCC Administrator in security matters, the Chief of Security also spent most of his time in the Command Post.

With few exceptions, the OCCC staff members worked extremely long hours during each day of the shakedown. Many of the ACOs reportedly worked consecutive shifts and many remained overnight at the facility, especially during the first three days of the shakedown.

HHSF staff members. The HHSF Administrator and the HHSF Program Control Administrator were at the OCCC, either in the Command Post or in other parts of the facility, during nearly the entire duration of the shakedown. The HHSF assigned 31 ACOs to assist the OCCC in conducting the shakedown. The ACOs were divided into two teams and, with the exception of the second day,

only one of the teams was on duty at the OCCC at any given time. While one team assisted with the shakedown at the OCCC, the other worked a normal shift of duty at the HHSF. After working an 8-hour shift, the team at the HHSF relieved the team at the OCCC, and that team returned to the HHSF to work an 8-hour shift there. As a result, each of the HHSF ACOs who assisted in the shakedown worked two consecutive 8-hour shifts on each day of the shakedown.

According to the shakedown plan, the HHSF ACOs were to assist in providing security coverage along the perimeter of the OCCC grounds. Most of the HHSF ACOs were positioned around the recreation field and along the OCCC perimeter adjacent to Puuhale Road, while a few were at other posts within the facility.

A significant departure from the shakedown plan occurred on Tuesday, the second day of the shakedown, when the HHSF ACOs rather than the OCCC ACOs conducted all of the strip searches of the inmates as they returned to the cellblock. On Wednesday, the HHSF ACOs conducted some of the strip searches of inmates of the modules and the Holding Unit as the inmates were returned to those residential units, which was also not in accordance to the shakedown plan.

HPD officers. The HPD was represented in the shakedown Command Post and several officers assisted in providing perimeter security. However, the more significant involvement of the HPD was through the work of the six TOD officers, who handled five police dogs to assist in the search of the facility and grounds. The TOD officers train and handle police dogs which are able to detect narcotic drugs, firearms, and explosives by scent.

Although the planned involvement of the TOD officers and dogs was limited to the search for contraband, their role was expanded on the second day of the shakedown. As the inmates were moved in small groups from the recreation field back to the cellblock, the TOD officers and dogs were positioned at points along the route taken by the inmates. Their presence was intended to discourage the inmates from creating any disturbances or problems as they reentered the facility.

National Guardsmen. The HNG was activated and a total of 96 guardsmen, divided into three 32-man teams, assisted in the performance of a variety of tasks. These tasks included preparing meals, assisting the OCCC Medical Unit staff, operating metal detectors in a search of the facility and grounds, installing lights surrounding the recreation field, welding metal screens over the windows of the cellblock, and hauling trash out of the facility.

Armed guardsmen also served as a "backup" security force as inmates were moved to and from the recreation field from their residential units. With the exception of two National Guard

medics who observed strip searches of cellblock inmates, the HNG was positioned in the immediate vicinity of the strip searches only when inmates returned to Modules 11 and 13.

AG staff members. Five employees of the AG--the First Deputy AG, a Deputy AG, and three investigators--were present at the OCCC during the shakedown. Their duties were to process contraband recovered from inmates for possible criminal prosecution and to provide legal advice as required.

The AG investigators were responsible for maintaining a proper chain-of-evidence for possible criminal prosecution of inmates found to be in possession of contraband. Therefore, they were called to the scene when contraband was found, took possession of the contraband, and noted the pertinent facts. The AG investigators were present at the facility during most of the shakedown activities of the first four days.

The First Deputy indicated that he assisted in the recovery of contraband and that he was present at the facility during much of the first three days of the shakedown. The Deputy AG, who was assigned as legal counsel to the CD, was present through much of the first four days of the shakedown and observed some of the strip searches as the inmates returned to their residential units on both the second and third days.

Aside from the Deputy AG, only one investigator reported having observed many of the strip searches of inmates as they returned to their residential units. The First Deputy reported having witnessed the strip searches for a short period of time on the second day of the shakedown, while the other investigators indicated that their observations were even more limited.

Shakedown Activities

The activities pertinent to the investigation occurred during the first four days of the shakedown, Monday, December 14, 1981 through Thursday, December 17, 1981. With regard to the allegations of the use of unreasonable force against inmates, the activities are best understood when considered in three distinct phases: the shakedown of the cellblock; the shakedown of the Holding Unit and seven of the eight residential modules; and the shakedown of the final residential module and the Keehi Annex.

The shakedown of the cellblock--the first two days. In the pre-dawn hours of Monday, December 14, 1981, CD and OCCC officials arrived at the facility. Telephone calls were made to OCCC ACOs, who were ordered to report immediately to the facility without being told the nature of the impending operation.

The first entry in the Command Post log, a chronological listing of events that occurred during the shakedown, was the erection of a tent in the OCCC recreation field at 6:30 a.m. on Monday.

At about the same time that the tent was being erected, several OCCC ACOs were conducting routine head counts of inmates inside the cellblock. The ACOs said they were unaware of the impending shakedown and were caught by surprise when a television news program reported the shakedown while the ACOs were inside the inmate dormitories. An ACO testified that angry inmates considered taking the ACOs as hostages, until cooler heads prevailed, and the ACOs were allowed to leave the dormitory.

Both the OCCC Chief of Security and the Program Control Administrator indicated they believed that not informing the cellblock ACOs of the shakedown was a conscious decision to preserve the element of surprise. However, the OCCC Administrator termed it an oversight. In either case, it appears that the administration failed to take adequate precautions to insure the safety of the ACOs.

The cellblock was the first area to be searched. Beginning at about 8 a.m., all but 12 of the cellblock inmates were strip searched by the OCCC ACOs and moved to the facility's recreation field adjacent to the parking lot. Eleven inmates were identified as potentially troublesome leaders and were transferred to the HHSF, and one inmate was placed in the Holding Unit after attempting to stab an ACO with a pair of scissors.

By 10:05 a.m., the cellblock was cleared of inmates and the search of the open dormitories and the corridors with individual cells began. The search was carried out primarily by OCCC personnel, with the assistance of the TOD police officers with dogs and National Guardsmen with metal detecting devices. AG staff members were also present to assist in the processing of the contraband that was found.

The cellblock search progressed more slowly than anticipated. Over the years, the inmates had accumulated many unauthorized items which had to be searched and hauled out of the cellblock for dumping or storage. Also, the work of the police dogs was slowed because the inmates had sprinkled powdered cleanser to hinder the dogs' sense of smell and because the heat in the cellblock required more frequent rest periods for the dogs.

In the early afternoon, a decision was made to tear down wooden partitions that were previously constructed in the open dormitories of the cellblock. The partitions hindered the search and constituted a hazard to ACOs who worked in the cellblock because their line of sight in the dormitories was

obstructed. However, the decision to remove the partitions, while apparently justified for the safety of the ACOs and security of the facility, was a major factor in delaying the completion of the cellblock search until the following day.

The delay forced the inmates to remain in the recreation field overnight which, in turn, required that ACOs be posted around the field on guard duty throughout the night. Although the ACOs were rotated during the night, the disruption of their rest period contributed to the erosion of ACO stamina as the days passed. Similarly, the cold and uncomfortable conditions under which the inmates spent the night may have made them less tractable the following day.

Many persons observed and recalled the conduct of the cellblock inmates who were in the recreation field during the first two days of the shakedown. By most accounts, some of the inmates behaved in a verbally abusive manner toward persons in the vicinity of the field. Personal insults, obscenities, and threats were shouted at many of the ACOs positioned around the field, at personnel from the CD and the other participating agencies, and at other persons in the vicinity.

The verbally abusive conduct of the inmates was described as being "more personal" than usual by many staff members. Obscenities and threatening comments were made to staff members about their families, as well as about the personal characteristics of the staff members themselves.

Witnesses also indicated that a few of the inmates periodically threw rocks and other objects over the recreation field fence. A police officer and the parked cars of some of the staff members were reportedly struck by thrown objects.

Many witnesses testified that the inmates were in possession of contraband while in the recreation field. Staff members indicated that inmates openly smoked marijuana and taunted them about their inability to take corrective action. Because inmates in the recreation field possessed contraband, many observers concluded that the OCCC ACOs had not conducted thorough strip searches before the inmates were moved to the field.

The reactions of the staff members to the abusive conduct of the inmates varied. Many said that they were not bothered by the abuse they received because such abuse "comes with the job" and is to be expected. Others testified that a person could not help but become angry over some of the inmates' abusive comments or conduct.

The HHSF ACOs reportedly found it particularly difficult to cope with the abusive conduct of the inmates as many of them were continuously positioned on the perimeter of the recreation

field. In addition, several of the less-experienced HHSF ACOs testified that they were unaccustomed to the type of abuse that they received from the inmates since such abusive conduct does not routinely occur at the HHSF. At least two of the HHSF ACOs became very angry and were relieved from their posts on the recreation field perimeter because of the abuse they received.

Several OCCC staff members said that HHSF personnel attempted to identify some of the abusive inmates in the recreation field. They said they were asked for the names of certain inmates by HHSF personnel, a contention which was generally denied by HHSF staff members.

Other observers recalled that the police officers of the TOD were also verbally abused by the inmates. The officers themselves recalled having received various obscene or disrespectful comments from the inmates. A few OCCC staff members stated that they were asked to identify certain inmates by police officers, although not necessarily by the officers of the TOD.

The overall atmosphere at the OCCC during the period that the cellblock inmates remained in the recreation field was described as extremely tense and volatile. Staff members recalled rumors of the inmates' intent to rush the recreation field gate or to riot upon their return to the cellblock.

Specific occurrences, such as those described hereafter, added to, or resulted from the tenseness of the situation. On Monday evening, an inmate was struck with a metal object by another inmate and warning shots were fired by ACOs. A police officer recalled a rumor, which was subsequently found to be untrue, that an inmate had been killed and that staff members would have to enter the recreation field to retrieve the body. A warning shot was fired on another occasion in response to the abusive conduct of the inmates in the field. The tent was torn down, parts of it were set afire, and the Honolulu Fire Department was called and firefighters stood by temporarily as a precautionary measure.

In this environment, the search of the cellblock resumed on Tuesday morning. In the early afternoon, it became apparent that the search would soon be completed and that the cellblock would be ready for reoccupation by the inmates who were still in the recreation field.

Under the original shakedown plan, the OCCC ACOs were to conduct the strip searches of the inmates as they returned to the cellblock. However, early Tuesday afternoon, a decision was made that the HHSF ACOs would conduct the searches and the OCCC ACOs were assigned auxiliary functions.

Conflicting testimony was received from HHSF and OCCC supervisors, regarding the reasons for and circumstances under which it was decided that the HHSF ACOs would conduct the strip searches on Tuesday. According to the HHSF testimony, the HHSF Administrator and the HHSF Program Control Administrator were absent from the meeting in which the decision was made and were not consulted regarding the change in plans. Both learned of the decision only after it was made. An HHSF captain testified that he volunteered the HHSF forces to perform the strip searches because the OCCC ACOs had not conducted thorough strip searches of the inmates as they left the cellblock. The captain explained that if inmates were subjected to the same type of strip search upon their return, contraband would reenter the cellblock and the search of the cellblock would have been futile.

In contrast, the OCCC Chief of Security testified that he was approached by the same HHSF captain, who asked that the HHSF be allowed to conduct the strip searches so that they could identify, pull aside, and transfer to the HHSF those inmates who behaved abusively while in the recreation field. The OCCC Program Control Administrator, who testified that he was present, verified that the HHSF captain approached the OCCC Chief of Security and asked that the HHSF be permitted to conduct the strip searches so that they could identify and transfer to the HHSF those inmates who were abusive. The OCCC Chief of Security also testified that he was subsequently approached by the HHSF Administrator, who asked that the HHSF be permitted to conduct the strip searches for the same reason.

The OCCC Administrator testified that although he retained "final authority" in all matters pertaining to the shakedown, he was not involved in the decision to permit the HHSF ACOs to conduct the strip searches. He did not learn that the HHSF was conducting the strip searches until after the searches began. He further stated that he was informed by his Chief of Security that the HHSF was conducting the searches so that they could identify inmates who behaved abusively and transfer them to the HHSF.

The return of the inmates from the recreation field to the cellblock commenced at about 2:30 p.m. Inmates residing in the same dormitories or corridors of the cellblock were brought to the 4-way, usually in groups of six. Only a single group was returned at a time and, according to HHSF testimony, it was not until a group entered the cellblock that the next group of inmates was brought to the 4-way. This procedure continued until all inmates of a particular dormitory or corridor were returned to the cellblock, whereupon the return of inmates from the next dormitory or corridor began.

The strip searches were conducted in the 4-way, a square "room" measuring 20 feet by 20 feet with clear plastic walls and a door on each of the four sides. Each of the doors leads to a

corridor--one through which the inmates entered the 4-way, one which passes between Modules 3 and 4 and through which the inmates returned to the cellblock, one which leads to Module 5 and the Holding Unit, and one which leads to Module 9. (See Appendix B for diagram of the 4-way.) A CCTV camera is suspended from the ceiling of the 4-way and can be rotated through controls in the Central Control Station in Module 9. An intercom system provides a communication link between the 4-way and the Central Control Station and can be activated from the Central Control Station.

Shortly after the strip searches began, the CCTV camera ceased functioning. The OCCC ACO monitoring the CCTV screen in the Central Control Station testified that he reported it to the Command Post. However, the ACO stated that he was told to "forget it" by a supervisor whose identity he said he could not recall. Other staff members reported that the camera lens was covered by a cap to protect the privacy of the inmates during the strip searches because female staff members would otherwise have been able to view the searches on the CCTV screens.

The intercom system was turned off during most of the strip searches. The ACO in the Central Control Station indicated that although the system was periodically turned on, the only audible sounds were the strip search directives given by the ACOs.

Staff testimony was received that a portion of the clear plastic walls of the 4-way was covered during the strip searches to prevent observation by female employees and inmates. There was other staff testimony that the 4-way walls were not covered when the strip searches were conducted on Tuesday. However, the testimony that a portion of the walls was covered appears to be more credible.

The route taken by the inmates from the recreation field to the 4-way initially led them through a corridor past Module 13 and then past Module 11. Just past Module 11 is a dogleg in the corridor where Control Station 4 is located. The dogleg precludes Control Station 4 from being seen from either end of the corridor. After passing through the dogleg in the corridor, the route taken by the inmates continued on to a point at which two corridors intersect, referred to as the "T". One of the corridors leads directly to the facility kitchen and the other, into which the inmates made a left turn, leads to the 4-way. (See Appendix B for diagram.)

OCCC ACOs and three TOD police officers with their dogs were positioned along the route between the recreation field gate and the "T". The OCCC ACOs were stationed at the recreation field gate, the Module 13 alcove, the Module 11 alcove, and at the top of the "T" to block the corridor to the facility kitchen. The HPD officers were posted in or near alcoves outside the doors of Modules 13 and 11.

According to the OCCC Chief of Security, the doors to Control Station 4 and the corridor adjacent to it were to be locked so that the only route available to the inmates would be through the corridor to the "T". An ACO was to have been posted by the doors to insure that the inmates did not tamper with the door locks. However, neither was done.

OCCC ACOs escorted inmates from the recreation field gate through the corridor to the "T". After the inmates made the left turn at the "T" into the corridor leading to the 4-way, their custody was turned over to HHSF ACOs. The inmates then proceeded through the corridor to the 4-way.

The majority of the HHSF ACOs were positioned inside the 4-way. Both teams of HHSF ACOs assigned to assist in the shakedown participated in the strip searches since the team that was to have returned to the HHSF instead remained at the OCCC. Also present were HHSF supervisory personnel--the HHSF Administrator, the Program Control Administrator, two captains, and a lieutenant. Several OCCC ACOs were also present in the 4-way to collect and tag inmate property and to control movement through the 4-way doors.

Outside the 4-way, in the corridor leading to Module 5 and the Holding Unit, were a TOD sergeant and two TOD officers with dogs. Just outside the 4-way door, in that same corridor, were two National Guard medics. Periodically, CD and OCCC officials came to that door of the 4-way to observe the strip searches.

The HHSF ACOs in the 4-way were divided into six strip search teams. Each team was comprised of a sergeant with a baton, who monitored and supervised the two ACOs who actually conducted the search.

The six strip search teams were assigned to specific locations in the 4-way. (See diagram in Appendix B.) Each team was directed to remain at its assigned location. Inmates were assigned to the teams according to the order in which they arrived at the 4-way, i.e., the first inmate was assigned to Team #1, the second to Team #2, etc.

At times, a seventh team, comprised of a sergeant and ACOs, conducted strip searches in the corridor leading to the 4-way. The team conducted searches if there were more than six inmates in a group, if an inmate was suspected of concealing contraband, or for other similar reasons.

After an inmate was searched, he was taken out of the 4-way and into the corridor leading back to the cellblock between Modules 3 and 4. After all of the inmates in the group being searched were assembled, the group was escorted through the corridor by HHSF ACOs. (See diagram in Appendix B.) After

exiting the corridor, most of the inmates were permitted to walk the remaining distance to the cellblock unescorted. However, armed National Guardsmen formed a line to the cellblock to insure that the inmates proceeded directly to the cellblock.

Some inmates were not returned to the cellblock after they were strip searched but were individually escorted to the Holding Unit or to a holding room in Module 5 to await transfer to the HHSF. HHSF personnel testified that these inmates were found to be in possession of contraband or were assaultive during the strip search. They indicated that these inmates were not identified prior to the strip searches, and their transfer to the HHSF or placement in the Holding Unit was based entirely on the above reasons.

The strip searches in the 4-way were conducted over a six-hour duration under conditions that were described as "hot and crowded". In addition to the inmates who were being searched, there were about 25 to 30 staff members in the 400-square-foot area of the 4-way at any time. The duration of the searches and the crowded conditions seem to have had a fatiguing effect on the ACOs, possibly taxing their ability to tolerate any type of inmate resistance.

According to many ACOs of both facilities, conducting thorough strip searches is considered to be a dirty and distasteful task. It is definitely not a pleasant experience for the person who is searched. OCCC ACOs also testified that the OCCC inmates were infrequently strip searched prior to the shakedown and thus were unaccustomed to the thorough strip search procedures carried out by the HHSF ACOs. Staff members contended that the inmates, therefore, were prone to resist the searches.

It is evident that the strip searches on Tuesday were not conducted under ideal conditions. The searches were conducted on inmates who were unaccustomed to thorough strip searches, in hot and crowded conditions, and over an extended period of time. To compound the situation, the ACOs who conducted the inmate strip searches had been the targets of the inmates' abusive conduct. These conditions created a potentially volatile situation from which allegations of brutality emerged.

During the early evening, staff members of the OCCC Medical Unit became concerned with the number of injured inmates and the types of injuries they had seen and treated. They noted that one inmate, who was subsequently sent to a hospital for treatment, appeared to have been beaten as both of his eyes were swollen and his nose appeared to be misaligned. Another inmate reportedly rolled around on the Medical Unit floor and claimed that he had been beaten and had suffered serious injury to his testicles.

A dispute arose between the Medical Unit staff and HHSF ACOs as to whether the Medical Unit would be able to provide treatment to inmates as the medical staff deemed necessary. The dispute stemmed from the removal of two inmates, who seemed to be in need of medical attention, from holding rooms in Module 5 by HHSF ACOs before they could be medically evaluated. Because of the dispute, the Medical Unit staff called the Command Post to obtain clarification and, according to the medical staff, were informed that they had the authority to determine which inmates would receive medical treatment.

As a result of their concerns about the number of injured inmates and the types of injuries they treated, the Medical Unit staff telephoned the OCCC physician at his home and asked him to report to the facility. They also called the Command Post and asked that someone in authority report to the Medical Unit to observe the injured inmates. In response to their call to the Command Post, the OCCC Administrator and the Chief of Security reported to the Medical Unit. Other officials, including the CDA, the CDAA, and the Deputy AG also went to the Unit and observed the inmate whose testicles were reportedly injured.

The officials who reported to the Medical Unit testified that it was their impression that the inmate was feigning injury to his testicles, after observing him and learning that he would not permit medical staff to examine him at that time. Subsequently, the inmate was examined, and no physical injuries were found.

The OCCC Administrator testified that after leaving the Medical Unit, he went to the 4-way where he found the OCCC Program Control Administrator observing the strip searches through the door of the 4-way. He said the OCCC Program Control Administrator informed him that physical force was used by ACOs during the strip searches only when inmates resisted the search or were assaultive.

Meanwhile, the OCCC physician arrived at the facility. After viewing the injuries of the inmates in the Medical Unit, he asked medical staff to take him to the area where the inmates were injured.

The physician was escorted toward the 4-way and met the OCCC Administrator in the corridor to Module 5. The physician testified he told the Administrator that what was happening to the inmates was ridiculous and asked that the Administrator put a stop to it. The physician said he received no response from the Administrator.

The OCCC Administrator acknowledged that the physician might have asked that he put a stop to the injuring of inmates. However, he testified it was his feeling at that time that the

Medical Unit staff was unaware of the circumstances in which the inmates were injured. He noted that the Medical Unit only saw the results of the force used against the inmates, but did not know what prompted the use of such force. Because he had been informed by the OCCC Program Control Administrator that only necessary force was used against the inmates, he concluded that excessive force was not being used. He also testified that in the minute or two he remained at the 4-way, he saw many HHSF supervisors present, along with AG personnel, to supervise and monitor the searches. The Administrator testified that he was therefore satisfied that the searches were being adequately supervised and he returned to the Command Post.

Other than the Medical Unit's call to the Command Post, there appears to have been no official communication regarding the possible use of unnecessary force against inmates by the HHSF ACOs. However, rumors were apparently circulating among staff members. For example, a staff member stationed in the Command Post testified that he heard, prior to the Medical Unit's call, that inmates were being beaten. He heard such comments from ACOs who came to the Command Post.

The OCCC Chief of Security testified that a couple of hours after the strip searches began, he heard rumors that inmates were being "busted up" but that these were inmates who had resisted the strip search. OCCC ACOs, who were stationed throughout the facility, also stated that they heard rumors that the HHSF ACOs were beating some of the inmates during the strip searches. According to some of these ACOs, the inmates who were beaten were those who had behaved abusively while in the recreation field.

No action was apparently taken on the basis of such rumors. Although rumors appear to have been fairly widespread among the OCCC staff members, only the Chief of Security, among those with authority, admitted having had knowledge of the rumors.

By 8:15 p.m., all of the strip searches of the cellblock inmates were completed. Six inmates were transferred to the HHSF and a seventh inmate was transferred there a few days later, after he was treated at a private hospital and held at the OCCC for medical observation. The inmates who were transferred to the HHSF were sent there because they allegedly attempted to assault an ACO or were allegedly in possession of contraband during the strip searches. Misconduct charges were filed against each by the HHSF ACOs. In addition to these seven inmates, four inmates were placed in the OCCC Holding Unit after they were strip searched.

Quite a few staff members indicated that the use of force was necessary to recover contraband from many of the inmates. However, there were only three documented cases in which contraband was recovered from an inmate during the searches.

A total of 17 inmates received treatment at the OCCC Medical Unit for injuries they allegedly sustained during the strip searches on Tuesday. An additional two inmates, in the opinion of Medical Unit staff, were in need of treatment but were removed from Module 5 holding rooms before they could be evaluated.

The shakedown of seven residential modules and the Holding Unit--the third day. On Wednesday, December 16, 1981, the shakedown was conducted of Modules 1, 2, 3, 4, 7, 8, 11, and the Holding Unit. Approximately 360 inmates were housed in these residential units at that time. With the exception of the female inmates of Modules 7 and 8 and the inmates on the first floor of the Holding Unit, the inmates were moved to the recreation field while their quarters were searched. Strip searches of the inmates were conducted as the inmates went out to the field and before their return to their residential units.

The shakedown began with the evacuation of the inmates from Module 11. By 8:30 a.m., all of the inmates had been moved from Module 11 to the recreation field. Subsequently, the inmates of Modules 1, 2, and 3 were brought out of their rooms, strip searched by the OCCC ACOs inside the modules, and sent to the recreation field.

Staff members of the OCCC then conducted the searches of these modules. They were again assisted in the search for contraband by the TOD police officers and dogs and by National Guardsmen with metal detectors.

Nearly all of the staff members said that the module inmates, on Wednesday, were better behaved while in the recreation field than the cellblock inmates. The type of verbal abuse and disorderly conduct reportedly engaged in by the cellblock inmates generally did not take place on Wednesday.

At 11:20 a.m., the search of Module 11 was completed. Shortly thereafter, the Module 11 inmates were moved in pairs back to the module from the recreation field. They were strip searched by the OCCC ACOs in the alcove fronting the module door, with National Guardsmen present as a backup security force. The searches were completed and all of the inmates were returned to the module by 12:10 p.m.

Thereafter, at about 12:30 p.m., movement of the inmates of Module 3 back to the module began. The inmates were escorted by the OCCC ACOs along the same route taken by the cellblock inmates on the previous day, from the recreation field to the 4-way, where they were strip searched by the OCCC ACOs.

Subsequently, the inmates of Module 2 were returned to their module from the recreation field between 3:05 p.m. and 3:31 p.m.

The movement of the Module 1 inmates back to their module then commenced and their return was completed at 4:15 p.m. All of these inmates were strip searched in the 4-way by the OCCC ACOs.

A significant difference between the movement of the inmates of Modules 11, 1, 2, and 3 back to their residential units and the movement of the inmates back to the cellblock on the previous day was that the strip searches were conducted entirely by OCCC ACOs. Also, no TOD police officers with dogs were positioned in the vicinity of the 4-way nor in any corridor through which the inmates passed.

An OCCC captain testified that he ordered that the side of the 4-way facing Modules 7 and 8, where the female inmates were housed, be covered with paper. This was done to protect the privacy of the inmates being strip searched. Other staff members testified that additional sides of the 4-way were covered with paper. Thus, it seems that most of the 4-way walls were covered at some point during the strip searches.

The CCTV camera in the 4-way was covered during the strip searches on Wednesday for the stated reason of preserving inmate privacy. However, some inmates of Modules 1 and 2 were made to walk back to their modules from the 4-way in the nude, a practice which was inconsistent with the concern for inmate privacy. The inmates could be seen by female staff members and inmates through the clear plastic walls of the corridor. The OCCC Chief of Security stated that he stopped the practice when he learned of it.

In other respects, the OCCC strip search operation on Wednesday did not appear to be as well organized as that conducted by the HHSF on Tuesday. Conflicting testimony was received as to who was in charge of the strip searches of the module inmates in the 4-way. From the testimony, there appeared to be no particular staff member in charge of the total operation. Each of the strip search teams was not supervised by a sergeant or other ranking officer. Even the number of strip search teams that were in operation is uncertain, although it appeared that there were probably four teams in the 4-way and one in the corridor through which the inmates entered. There was, however, general agreement among staff members that the 4-way was extremely crowded with ACOs, perhaps even more crowded than when the strip searches were conducted by the HHSF ACOs.

To further illustrate the preceding point, during the strip searches of the inmates of Module 2 or Module 3, an incident occurred in the 4-way between some of the OCCC ACOs and a training instructor of the CTC. Some staff members said that the instructor told the ACOs that they were conducting the searches improperly; others testified that the instructor chastised the ACOs for behaving unprofessionally; and still others indicated

that the instructor accused the ACOs of using excessive force in carrying out the searches. Testimony was received that an ACO complained that the HHSF ACOs were allowed to do the very same thing the OCCC ACOs were doing, and it was therefore unfair for the instructor to criticize the OCCC ACOs. Most observers said that the instructor responded by swearing and several ACOs lunged at the instructor. Other ACOs intervened and the instructor was able to leave the 4-way before a physical altercation occurred.

At 4:25 p.m., shortly after the last of the Module 1 inmates returned to that module, the movement of the inmates from Module 4 to the recreation field began. Thereafter, the movement of the Holding Unit inmates from the second and third floors to the recreation field commenced. Inmates on the first floor of the Holding Unit were not sent to the field as they were strip searched inside the unit and were then returned to their cells. The search of Module 4 and the Holding Unit was then begun.

There was general agreement among staff members that the inmates of Module 4 and the Holding Unit were well behaved while in the recreation field as none of them engaged in verbal abuse against staff members or in other types of disorderly conduct.

After 9 p.m., Module 4 and the Holding Unit were ready to be reoccupied by the inmates in the recreation field. The Module 4 inmates were brought in from the field and escorted in small groups to the 4-way. They were strip searched and returned to their module. Thereafter, the inmates of the Holding Unit were returned to their quarters in similar fashion.

Most of the strip searches of the inmates of Module 4 and the Holding Unit were again conducted in the 4-way by the OCCC ACOs. However, to expedite the strip searches, at least two teams of HHSF ACOs conducted searches in the corridor leading to the 4-way.

Unlike the OCCC strip search operation conducted in the 4-way earlier that day, the strip searches of the inmates of Module 4 and the Holding Unit were conducted under the supervision of an OCCC lieutenant who was in charge of the total operation. However, many observers described the operation as more chaotic and disorganized than the earlier OCCC effort.

As in the earlier searches, there was no sergeant or other ranking officer in charge of each of the OCCC strip search teams. The number of strip search teams which conducted searches in the 4-way is uncertain and the number of ACOs that comprised a team varied. The 4-way was again described as having been extremely crowded, and ACOs reportedly moved from team to team at will. Several staff members indicated that unreasonable force was used. One ACO described what he saw in the 4-way:

> "...and was one chaos inside there, guys went berserk. The guards went berserk. Guards were jumping all over the place, trying to lick anybody they can. Was out of hand, was really out of hand."

Also, indicative of the lack of discipline and control during the searches was an altercation between two ACOs. The ACOs were physically restrained and separated by other ACOs and one of them was ordered to leave the 4-way.

HHSF ACOs who were conducting some of the strip searches in the corridor also testified that the OCCC strip search operation was chaotic and disorganized. After a while, the HHSF ACOs escorted the inmates whom they searched in the corridor through the 4-way. Most of the HHSF ACOs testified that this was to prevent the OCCC ACOs from conducting a second strip search of the same inmates. However, two HHSF ACOs testified that they escorted the inmates whom they had searched so that force would not be used by OCCC ACOs against those inmates, as they did not want to be blamed for any force used by OCCC ACOs.

There was testimony from many staff members that on at least two occasions during the strip searches of inmates of the Holding Unit, ACOs intervened to prevent other ACOs from continuing to use force against inmates. On both occasions, the inmates were separated from the ACOs and removed from the 4-way.

Other testimony indicated that several factors may have affected the manner in which the OCCC ACOs conducted the strip searches on Wednesday. Having heard rumors of the very strict, thorough, and forceful manner in which HHSF ACOs conducted the strip searches on Tuesday, staff members said that the OCCC ACOs wanted to conduct the searches in the same manner, thereby demonstrating that they could be as competent as their HHSF counterparts. The staff members believed that the HHSF ACOs immediately used force to overcome any resistance or delay.

The OCCC ACOs said that fatigue also influenced the manner in which they conducted the searches since by Wednesday, they were extremely tired and had been without adequate rest for three days. Most remained at the facility from the beginning of the shakedown. Mental and physical fatigue may have caused ACOs to be less tolerant to any resistance exhibited by inmates and their judgment may have been adversely affected.

Many staff members testified that prior to the shakedown, the inmates controlled the facility. However, by the third day of the shakedown, OCCC staff members sensed an intangible shift in power from the inmates to the staff, to a degree such that staff members felt that they were in control of the inmates and the facility. An ACO described the effect on the ACOs of this shift in power as follows:

"You know, I mean it's in front of you, in front of your eyes. Just by watching the boys walk around, you know, watch the guards how they walk around. Before this whole thing come up, you can more or less read the guy--'ahh, shit.' When something happen like this (the shakedown), the chest come out, different attitude altogether. Simple."

Staff members indicated that besides this shift in power and its resultant effect on the ACOs, the fact that OCCC ACOs had long suffered abuses at the hands of the inmates was another factor contributing to the use of unnecessary force against inmates. During the strip searches, the ACOs greatly outnumbered the inmates, felt that the "tables were turned," and that they were finally in control. What then occurred during the strip searches, according to these staff members, seemed to be in retaliation for past misdeeds. One ACO stated:

"See some of these ACOs have been...intimidated, have been harassed, have been punched, have been hit by some of the inmates. And I guess it was an opportunity to get back, and to vent, and to get their anger out."

Another ACO described the same circumstances in a less charitable manner:

"It was kind of a childish mentality type of a thing...I mean, you know, you can be a correctional officer and you don't have to do that....

"Some of it was frustration, some of it abuse that some of 'em had taken in the past, because there was quite an abuse taken prior to this shakedown. Some guys, you know, held past grudges and things like that because I don't believe that any of you sitting in here could have any idea of some of the things that went down prior to the shakedown.... And they felt that, 'so now it's my turn', you know, and they got their licks in."

Staff members said that another factor contributing to the use of unnecessary force against inmates was peer pressure from other ACOs. An ACO who seemed to have been influenced by such pressure stated:

"There was some type of noise coming from one of the troublemakers, one of these guys who had a real big mouth, and I guess being just human, you know, and basically kind of immature around all that, I picked up a little on the mass hysteria and I wanted to be part of it, I guess, at that point.

"...The adrenalin--you can feel it in the air and you realize all of a sudden that you're not in full, fully rational, fully reasonable. You're buying other values, you're moving more like with a pack."

Another experienced ACO described a conversation with two younger ACOs:

"That's why (a named ACO) and even (another named ACO) I talked to 'em and the feelings was like: 'Gee, if I don't do anything then I cannot be one of the boys. So, what, I punk, or mahu, or what?'

"So it's just, you know, that peer pressure of, well, you can stand on your own two feet or not? I guess they wanted to be accepted, be one of the boys. I guess made them come out swinging like that.

"I think even after this whole thing was over, I had talked to them again, and that's what came out: 'I didn't want them to think I was pussy, or, you know, no can duke 'em out kind.' And I told them they were still wrong."

A final factor which reportedly contributed to the use of unnecessary force against inmates was the lack of adequate supervision in the 4-way. Neither the OCCC Chief of Security nor any of the OCCC captains were reported to have spent any significant amount of time in the 4-way. The OCCC Program Control Administrator, who was not assigned to supervise the searches, only observed some of the searches. None of the other OCCC administrators were either assigned to supervise the searches or monitored the strip searches in the 4-way for any length of time. No OCCC staff member of a rank higher than a lieutenant exercised control and supervision over the strip searches in the 4-way.

In summary, several factors seemed to have contributed to the use of unnecessary force against the inmates during the OCCC strip search operation on Wednesday. These included an attempt by the OCCC ACOs to emulate their HHSF counterparts, fatigue on

the part of the ACOs, a perceived shift in power from inmates to staff, retaliation for past abuses suffered by the ACOs at the hands of inmates, peer pressure among the ACOs, and the lack of adequate supervision during the strip searches.

By 10:10 p.m. on Wednesday, the last of the Holding Unit inmates had been returned from the recreation field and all of the strip searches that day had been completed. While six inmates received treatment from the OCCC Medical Unit for injuries that were allegedly sustained during the strip searches in the 4-way, no inmates were transferred to the HHSF as a result of the day's activities. Also, there were no incident reports or misconduct charges indicating that contraband had been recovered from any inmates or that any inmates assaulted any ACOs.

The shakedown of Module 13 and the Keehi Annex--the fourth day. On Thursday, December 17, 1981, the shakedown of Module 13 and the Keehi Annex was conducted. Other sections of the facility, such as the trades training area, Hoomana School, and the kitchen were searched. The searches were again conducted by the OCCC personnel with assistance from the HPD and the HNG.

Approximately 180 inmates were strip searched and moved from Module 13 and the Keehi Annex to the recreation field, where they remained while their residential units were being searched. The inmates were strip searched again by the OCCC ACOs upon their return to their quarters.

Module 13 was searched first and it was not until the completion of the search and the return of the inmates to the module that the search of the Keehi Annex began. The OCCC Administrator and the Chief of Security monitored and observed the strip searches of the inmates of the Annex.

The inmates of Module 13 and the Keehi Annex were described as well behaved while in the recreation field. No testimony was received to indicate that any of the inmates engaged in verbally abusive or other disorderly types of conduct.

The shakedown tasks on Thursday were completed without significant incidents or major problems. Personnel of the shakedown support agencies--the HHSF, the HPD, and the HNG--departed the facility at about 5:30 p.m., and the shakedown Command Post terminated operations for the day about an hour later.

The most noteworthy occurrence on Thursday was the transmittal, by an OCCC ACO to an OCCC ACO supervisor, of a list of OCCC ACOs whom the ACO felt had used excessive force against inmates in the 4-way on Wednesday. Both the ACO and the ACO supervisor testified that the list was transmitted and received on Thursday. (See Example 3 in Appendix G for further details.)

The completion of assorted tasks--the fifth day. On Friday, December 18, 1981, the last day of the shakedown, the facility remained on "lockdown" status, with the inmates generally confined to their residential units, while staff completed assorted tasks. There was no large-scale movement of inmates as there had been on the previous days, nor were strip searches of large numbers of inmates conducted.

Chapter III

THE INVESTIGATION

The investigation was comprised of two phases. The first phase consisted of an information-gathering, fact-finding process during which many inmates and staff members were interviewed and pertinent reports compiled by the participating agencies were reviewed. The second phase involved the organization, analysis, and evaluation of the large amount of information that was gathered to determine the merits of the inmates' allegations. A description of each phase follows.

A. The Information-Gathering Process

Shortly after the shakedown was completed, the office received calls from inmates, friends and family members of inmates, and concerned private citizens alleging that many inmates were severely beaten. The alleged brutality was said to have occurred in the 4-way during the inmate strip searches. Assertions were made that high-ranking Corrections officials orchestrated the inmate beatings or knew of and condoned such beatings.

Reportedly, the most seriously injured inmates were being "hidden" by Corrections officials and housed separately from the general inmate population. Allegations were made that inmates were being denied required medical treatment. Concerns were expressed about the possibility of continued beatings and of a major inmate disturbance in response to the beatings.

Many of the office's 29 separate contacts with 19 private citizens occurred shortly after the shakedown. The private citizens were unable to provide direct testimony as to what occurred during the shakedown, as they were not witnesses to the incidents they described. Nevertheless, the information received from them was extremely helpful in providing "leads" to pursue and in identifying inmates and staff members who should be interviewed.

Persons interviewed were those who may have had force used against them, who may have witnessed the use of force, who were identified as having used force, or who had knowledge about how

the shakedown was conducted. As many persons fit into one of those categories, a total of 546 interviews of 398 individuals were conducted. Persons interviewed included inmates, DSSH and CD officials, OCCC and HHSF staff members, HPD officers, National Guardsmen, and AG personnel. A summarized listing of the interviews conducted is presented in Table 1.

Table 1

TOTAL INTERVIEWS CONDUCTED

	Number of Persons	Number of Interviews
Inmates	223	361
OCCC Personnel	109	113
HHSF Personnel	31	37
DSSH & CD Officials	7	7
HNG Personnel	17	17
HPD Officers	6	6
AG Personnel	5	5
Total	398	546

Initiation of Investigation

In response to the initial reports of alleged brutality, two staff members of the office interviewed inmates at the OCCC on Monday, December 21, 1981, the first workday following the shakedown. Inmates who were housed in the cellblock and in the Holding Unit and who reportedly were beaten were interviewed. Further, in response to concerns over the welfare of the seven inmates who were transferred to the HHSF during the shakedown, a staff member from the office interviewed the inmates on Wednesday, December 23, 1981, to ascertain their physical condition and to record their complaints, if any.

Following these initial inmate interviews, it became apparent that many additional interviews would be required to ascertain the number of inmates who were allegedly beaten and to obtain specific information regarding each alleged incident.

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Following these initial inmate interviews, it became apparent that many additional interviews would be required to ascertain the number of inmates who were allegedly beaten and to obtain specific information regarding each alleged incident.

The First Round of Inmate Interviews

The list of inmates to be interviewed steadily expanded as additional allegations that other inmates were beaten or witnessed beatings were brought to the attention of the office. Attempts were made to interview every such inmate and, eventually, 219 inmates were initially interviewed. All but two of these inmates were interviewed between December 21, 1981 and February 24, 1982.

Each inmate was asked whether force was used against him during the shakedown and, if so, by whom. Those who responded affirmatively were then asked to describe the force used, to provide the names of any inmate or staff witnesses, to indicate when and where the incident occurred, and to describe the circumstances. Inmate witnesses were asked to provide the identical information about the incidents that they reportedly observed.

The office was forewarned that many of the inmates called for interviews might be unwilling to discuss their experiences and observations because of fear of reprisal. In fact, 13 inmates with whom interviews were sought chose not to be interviewed, and a few others who consented seemed reluctant to speak freely. However, the majority of the inmates seemed willing to openly discuss their experiences and observations.

Upon completion of the first round of interviews, it was noted that a considerable number of inmates did not know the names of staff members who used, or witnessed the use of, force that they said was unnecessary. In other cases, inmates did not know the names of other inmates whose beatings they claimed to have witnessed.

Part of the difficulty in identifying staff members was the inmates' inability to name many of the involved HHSF and OCCC ACOs and staff members. Also, the vast majority of inmates did not know the names of the TOD police officers. Therefore, a method was sought for inmates to identify staff members and other inmates. This required a second round of inmate interviews.

The Second Round of Inmate Interviews

Under the circumstances, the most efficient method of obtaining positive identifications of staff members and other inmates was through the use of photographs. Therefore, photographs were obtained of all of the HHSF ACOs who participated in the shakedown, of all the OCCC ACOs who were identified as having used or having witnessed the use of unnecessary force, and of the six officers of the TOD. Photographs were also obtained of most of the inmates who were allegedly beaten. The OCCC, the HHSF, and the HPD were all very cooperative in providing the requested photographs.

The photographs were randomly placed in albums for viewing by the inmates. The names of the ACOs, police officers, and inmates were not visible on the front of the photographs. A numbering system was devised and a number was written on the back of each photograph. Each number corresponded with the name of the pictured ACO, police officer, or inmate on lists which were not shared with the inmate viewing the photographs. While viewing the photographs, an inmate did not know the number assigned to any photograph. Only after having identified the photograph of an ACO, police officer, or inmate would an inmate be shown its number. That identifying number was then noted in a statement of allegations signed by the inmate.

A total of 90 HHSF ACO photographs were placed in an album for viewing by inmates. The total included 31 HHSF ACOs who assisted in carrying out the shakedown and 59 ACOs who were uninvolved. Photographs of 82 OCCC ACOs, 6 TOD police officers, and 107 inmates were also placed in albums for inmate viewing.

The described photograph identification system was used to minimize collaboration and indiscriminate identification of persons by inmates who viewed the photographs. The amount of photographs used, their random placement in albums, and the numbering system were intended to insure, to the extent possible, the reliability of an inmate's identification of any particular ACO, police officer, or inmate.

Thereafter, interviews were conducted and the photograph albums were viewed by those inmates who, during the initial interviews, indicated that they could identify staff members who used or witnessed the use of unnecessary force. Inmates who indicated that they could identify other inmates whom they saw beaten were also re-interviewed. Four inmates who were not interviewed during the first round were shown photographs and interviewed. These four inmates raised the total from 219 to 223 inmates who were interviewed.

The objectives of the second round of interviews were to obtain positive identification of staff members and inmates and to obtain written statements from inmate victims or witnesses who were able to identify staff members who used unnecessary force. More detailed information about the inmate allegations, such as the exact location of an incident on a diagram, was also sought.

The office interviewed and showed photographs to 142 inmates. Of the 219 inmates initially interviewed, 138 were interviewed for the second time. The remaining 81 inmates were not re-interviewed because they had indicated that they would be unable to identify anyone, did not witness any beatings, or were released from the OCCC after their first interviews and either could not be located or were unwilling to be re-interviewed.

Most of the second-round interviews were conducted at the OCCC. However, three inmates were interviewed at the Kulani Correctional Facility, and one was interviewed at the HPD cellblock.

In addition, four inmates, who were held at the HHSF, were interviewed at the office. It was alleged that the interview rooms at the HHSF were "bugged" and that inmates were unable to speak freely there. This concern was shared with the HHSF Administrator, who readily agreed to transport the inmates to the office. Although there was no evidence to support the allegation, both the office and the HHSF Administrator wanted to provide the inmates with a setting which would assure them that the conversations would not be monitored by the HHSF staff members.

Furthermore, three former inmates were interviewed at the office because they were released from the OCCC subsequent to their initial interviews. With the cooperation and assistance of the Adult Probation Division and the Hawaii Paroling Authority, these former inmates were contacted and voluntarily agreed to come to the office for a second interview.

All 142 second-round interviews were conducted between March 22, 1982 and May 4, 1982. Varied responses were received from the inmates who were shown the photographs. Some identified staff members who allegedly beat them or other inmates and signed statements to that effect; others identified staff members but chose not to sign statements; and still others were either unable or unwilling to identify any staff members. The results of the viewing of photographs by inmates are set forth in Table 2.

Table 2

INMATE IDENTIFICATION OF STAFF MEMBERS
THROUGH PHOTOGRAPHS

	Identified Staff & Signed Statement	Identified Staff But Did Not Sign Statement	Did Not Identify Staff	Total Inmates
Inmate Victims	51	11	28	90
Inmate Witnesses	22	4	26	52
Total	73	15	54	142

Problems Encountered Regarding Inmate Interviews

In conducting the interviews of inmates, many problems were encountered, and the more significant ones are described.

The lengthy period of time to complete the inmate interviews. It required nearly four-and-a-half months to complete the first and second rounds of interviews of inmates. To obtain an accurate perception of what occurred and to conduct a thorough investigation, attempts were made to interview each inmate victim and witness. The large number of inmates to be interviewed and the inability of inmates to identify staff members and other inmates, which necessitated second interviews, prolonged the information-gathering phase.

Inability to identify ACOs or police officers. Even when shown photographs, as noted in Table 2, a total of 54 inmates were unable to identify the staff members whom they contended used unnecessary force.

Unwillingness to identify ACOs or police officers. As reported in Table 2, 15 inmates identified certain staff members as assailants but refused to sign written statements about what they observed. Several other inmates chose not to view the photographs of the ACOs and police officers at all.

Reasons for problems encountered. In summary, 69 inmates were unwilling or unable to identify staff members and to sign written statements. It appears that there were a variety of contributing factors: (1) fear of reprisal, which was cited by some inmates as the main reason; (2) faded memory, due to the lengthy period between the shakedown and the viewing of the photographs; (3) photographs which were dated; (4) the inmates had very little or no previous contact with some ACOs and police officers; and (5) inmates may have exaggerated their initial claims and were therefore unable to provide specific details.

Summary of Inmate Interviews

A total of 361 interviews of 223 inmates were conducted between December 21, 1981 and May 4, 1982. Although not by design, the inmates interviewed were fairly evenly distributed between those strip searched on Tuesday and those strip searched on Wednesday. A total of 113 inmates interviewed were housed in the cellblock, while 110 were housed in the modules and Holding Unit, at the time of the shakedown.

A Profile of the Inmate Allegations

(1) The number of inmates. From information received through inmate interviews, 109 male inmates against whom unnecessary force was allegedly used were identified. Of that total, 102 inmates alleged that such force was used against them and seven were identified by others as inmates against whom unnecessary force was used. Each of the seven inmates either denied the allegation made by the other inmates or refused to be interviewed. Nevertheless, these seven inmates were included as possible victims since they may have chosen not to become involved because of fear of reprisals or for other reasons. Subsequently, staff testimony corroborating the allegation that unnecessary force was used against two of these seven inmates was received.

At the time of the shakedown, 57 of the 109 inmates were housed in the cellblock, 36 in the modules, and 16 in the Holding Unit. There was no allegation that unnecessary force was used against any of the inmates of Keehi Annex. Although female inmates of Modules 7 and 8 were interviewed, there were no allegations that unnecessary force was used against any of them.

(2) The number of allegations (incidents). There were 131 separate allegations of the use of unnecessary force against the 109 inmates. The total number of allegations exceeds the total number of inmates since some inmates were involved in more than one incident. Each incident was counted as an individual allegation if it was separated from another by time or location. For example, when an inmate said that unnecessary force was used against him on Tuesday and Wednesday, it was counted as two allegations. Or when an inmate contended that such force was used against him in the 4-way and in his residential unit, it was counted as two allegations.

(3) Distribution of allegations by days. Although the shakedown continued through five days, the incidents allegedly occurred most frequently on Tuesday and Wednesday, as indicated in Table 3.

Table 3

DISTRIBUTION OF ALLEGATIONS BY DAYS

	Day of Alleged Occurrence					Total Allegations
	Monday	Tuesday	Wednesday	Thursday	Friday	
Number of Allegations	1	65	61	4	0	131

There were 65 allegations of the use of unnecessary force against inmates on Tuesday. All of the allegations involved inmates who were housed in the cellblock, and the incidents allegedly occurred as the inmates were returned to the cellblock from the recreation field.

There were 61 allegations that unnecessary force was used against inmates on Wednesday. All but two of the allegations concerned the use of unnecessary force against inmates during the shakedown activities or strip searches.

(4) Distribution of allegations by location. There was no single location where a majority of the 131 incidents occurred. Based on a compilation of the allegations, the initial impression that almost all of the incidents occurred during strip searches in the 4-way was incorrect, as noted in Table 4.

Table 4

DISTRIBUTION OF ALLEGATIONS BY LOCATION

Day	Location: Allegedly occurred in the 4-way	Location: Allegedly occurred at other locations	Total
Monday	0	1	1
Tuesday	29 (45%)	36 (55%)	65 (100%)
Wednesday	30 (49%)	31 (51%)	61 (100%)
Thursday	0	4	4
Friday	0	0	0
Total	59 (45%)	72 (55%)	131 (100%)

Only 59, or 45% of the 131 incidents in which unnecessary force was used against inmates, were alleged to have occurred in the 4-way as the inmates were strip searched upon their return from the recreation field. That percentage was similar for Tuesday and Wednesday.

On Tuesday, the majority of the remaining incidents, or 55% of the total, were alleged to have occurred in the corridor between the recreation field gate and the 4-way; in the corridor leading back to the cellblock; in the corridor to Module 5; or inside Module 5.

On Wednesday, the majority of the remaining incidents, or 51% of the total, allegedly occurred during the strip searches inside the modules; in the corridors between the residential units and the recreation field; during the strip searches outside the Module 11 door; or in other locations.

On Thursday, only one incident allegedly occurred, outside of Module 13, during the strip searches conducted that day. The remaining incidents allegedly occurred in other parts of the facility and were unrelated to the shakedown of Module 13 and the Keehi Annex.

The significance of the distribution by location is that it would have been extremely difficult, if not impossible, for any individual to have been in a position to observe a majority of the incidents in which unnecessary force was allegedly used. The distance through the corridor from the recreation field gate to the 4-way is approximately 248 feet and there are several 90-degree turns which preclude a direct line of sight through the corridor. The corridor from the 4-way to the cellblock is about 114 feet long, and the corridor from the 4-way to Module 5 is approximately 130 feet long. Since inmates were escorted from the recreation field through the different corridors to the 4-way and to their residential units, it is quite possible that unnecessary force could have been used against an inmate at any location along the way or in the 4-way without being seen by a single observer.

(5) Distribution of allegations and accusations by agency personnel. Collectively, the inmates alleged that unnecessary force was used by personnel of the HHSF, the OCCC, the HPD, and the HNG. The total number of inmates referred to in this section exceeds 109 because some of the inmates alleged that personnel from two or more of the above-mentioned agencies used unnecessary force against them.

The inmate allegations, with respect to the agencies involved, can be viewed from two perspectives. The first pertains to the number of inmates against whom staff members of the various agencies allegedly used unnecessary force. Table 5 categorizes the information we obtained in this regard.

Table 5

DISTRIBUTION OF ALLEGATIONS BY AGENCIES

	By HHSF Personnel	By OCCC Personnel	By HPD Officers	By HNG
Number of inmates against whom unnecessary force was allegedly used	53	54	8	1

The second perspective of the same allegations results from arranging, by agency, the number of staff members who were identified and accused of having used unnecessary force. Information regarding allegations in which the accused staff members were not identified is excluded. Table 6 summarizes the number of accusations by agencies and the number of staff members who were identified and accused of having used unnecessary force.

Table 6

DISTRIBUTION OF ACCUSATIONS AGAINST IDENTIFIED STAFF MEMBERS BY AGENCIES

Agency	Number of Accusations by Agencies	Number of Identified Staff Members Accused of the Use of Unnecessary Force
OCCC	140 (49%)	44 (57%)
HHSF	131 (45%)	29 (38%)
HPD	18 (6%)	4 (5%)
HNG	0 (0%)	0 (0%)
Total	289 (100%)	77 (100%)

The 77 identified employees of the OCCC, HHSF, and HPD noted in Table 6 were accused of having used unnecessary force against inmates in 289 instances. The total number of accusations exceeds both the number of inmates (109) and the number of allegations (131) because more than one ACO or police officer may have been identified and accused of having used unnecessary force against an inmate.

For example, four accusations were counted if three ACOs and a police officer were each identified and accused of having used unnecessary force against an inmate. The reason for counting four accusations in that allegation was to insure that the case against each of the four staff members would be separately and independently examined.

(a) Allegations and accusations against OCCC ACOs. A total of 54 inmates accused 44 OCCC ACOs of using unnecessary force against them. In the vast majority of the cases, the alleged incidents occurred during the movement of inmates to or from their residential units and the recreation field on Wednesday. Eighteen ACOs were accused of using unnecessary force against only one inmate, while one ACO was accused of using such force against 11 inmates.

(b) Allegations and accusations against the HHSF ACOs. A total of 53 inmates accused 29 HHSF staff members of using unnecessary force against them. In almost every instance, the alleged incidents occurred as the inmates returned to the cellblock from the recreation field on Tuesday.

A total of 26 of the 31 HHSF ACOs who were present at the OCCC and assisted in carrying out the shakedown were identified and accused of using unnecessary force against inmates. An additional three HHSF ACOs who were not employed at the HHSF at the time of the shakedown were nevertheless accused of using unnecessary force. Thus, accusations were made against a total of 29 HHSF ACOs or former ACOs. Some of the ACOs were accused of using unnecessary force against only a single inmate, while one ACO was alleged to have used such force against 14 different inmates.

(c) Allegations and accusations against HPD officers. A total of eight inmates accused four police officers of the TOD of using unnecessary force against them. In each case, the alleged incident occurred as the inmates returned to the cellblock from the recreation field on Tuesday. In almost every case, the alleged incident occurred in the corridor by Module 11 or in or by Control Station 4.

(d) Allegation and accusation against the HNG. An inmate alleged that he was struck with the butt of a rifle by a National Guardsman. The alleged incident occurred in the corridor between Modules 3 and 4 as the inmate returned to his module from the recreation field on Wednesday. However, the inmate could not identify the Guardsman. Therefore, no identified Guardsman was accused of having used unnecessary force against inmates.

(6) General description of alleged unnecessary force. The individual inmate allegations revealed a wide spectrum in the nature and degree of unnecessary force that was used. This made it difficult to precisely categorize or classify the allegations.

The more severe allegations involved repeated punches and kicks, delivered even while the inmate was on the ground, to the area of the head and face; choke holds that were applied; blows struck with batons; and a blow struck with a rifle butt. Many inmates alleged that a combination of these types of force was used against them, and many contended that more than one staff member was involved.

The less severe allegations involved slaps and shoves which did not result in serious injury to the inmate. However, only a relatively small portion of the 109 inmates alleged that they

received only a single slap or shove. Other inmates who stated that they were slapped or shoved contended that this was done repeatedly, or that the slaps or shoves were delivered in addition to more forceful blows.

Other Inmate Allegations

Inmates related other alleged improprieties by staff members which did not relate to specific incidents in which unnecessary force was used. However, some of the inmate statements seemed pertinent to the general allegations that unnecessary force was used during the shakedown. Those considered significant are described hereafter.

Inmates who behaved abusively toward staff members were beaten in the 4-way on Tuesday. It was alleged that the HHSF ACOs identified inmates who behaved abusively toward staff members while in the recreation field on Monday and Tuesday. It was also alleged that a list of these inmates was compiled, and the listed inmates were singled out for beatings during the strip searches on Tuesday. Some of the inmates said that while awaiting their return to the cellblock from the recreation field, an OCCC ACO warned them that the HHSF ACOs were beating inmates who had behaved abusively toward staff members. Other inmates alleged that through hand signals, OCCC ACOs identified inmates who were to be beaten by the HHSF ACOs. They were identified in this manner because the HHSF ACOs were unfamiliar with most of the OCCC inmates.

The HHSF ACOs alerted each other of the approach of "outsiders". It was alleged that the HHSF ACOs conducting the strip searches alerted each other as non-HHSF personnel approached the 4-way. In this manner, the HHSF was able to prevent others from witnessing their use of unnecessary force against inmates.

The OCCC ACOs "evened old scores" with inmates during the shakedown. Inmates alleged that the OCCC ACOs "got even" with certain inmates for past occurrences. A few inmates related past altercations with ACOs and alleged that these same ACOs used unnecessary force against them during the shakedown. One inmate stated that he heard an OCCC sergeant tell other ACOs in the 4-way during the strip searches on Wednesday: "Now's the time to take out your frustrations."

There was an attempt to conceal the beatings which occurred in the 4-way. Inmates alleged that the clear plastic walls of the 4-way were covered during the strip searches on Tuesday and Wednesday to conceal the beatings of inmates from persons not

in the 4-way. To support their contention that the staff intent was to prevent outside observation of the beatings taking place in the 4-way, inmates of a module stated that on Tuesday, the OCCC ACOs entered the module, ordered the inmates who were watching away from the windows, and threatened them. Similarly, inmates of other modules stated that on the order of the OCCC Administrator, ACOs ordered them away from their windows on Wednesday.

After the strip searches were completed on Tuesday and Wednesday, the 4-way was covered with blood. Some inmates alleged that after the completion of the strip searches on both days, a large amount of blood was splattered all over the 4-way walls and floor. The inmates said that there was so much blood that the OCCC ACOs had to wash it away with buckets of water. The inmates referred to the large amount of blood to indicate the excessive degree of force used by the ACOs and the great number and extent of injuries incurred by the inmates.

Various administrators, supervisors, and other officials were aware that inmates were being beaten but took no action. Inmates stated that the OCCC Administrator, the HHSF Administrator, AG personnel, or captains and lieutenants from both the OCCC and the HHSF were present when beatings that the inmates described allegedly took place. The inmates said that these supervisors failed to intervene.

The inmates therefore concluded that those supervisors were aware of and condoned the beating of inmates. The allegations suggested the existence of a conspiracy between the ACOs and their supervisors. In describing what he claimed to have seen on Tuesday, an inmate wrote:

> "...am writing this letter after ive wittnessed the most TRAGIC, most MASSACERED shakedown ever to be seen throughout my entire imprisonment.... For all the while this UNMERCIFULL action was taking place, our ATTOURNEY GENERAL AND ADMINISTRATOR just walked on by with a smile on there faces as if they were saying good work, keep it up boys! which at NO!!! one time during this period made any effort to stop this insaine act of constant beatings that was beeing inflickted upon 100 or more inmates...."

Some of the ACOs from both the OCCC and the HHSF did not approve of the conduct of their fellow ACOs. Several inmates contended that ACOs sometimes intervened to stop the beatings of inmates, and other inmates said they were "saved" by ACOs who prevented other ACOs from continuing to beat them.

A few inmates indicated that ACOs later apologized, either for their own conduct or for the conduct of their fellow ACOs. Some inmates alleged that a few OCCC ACOs were so disgusted over the use of unnecessary force during the shakedown that they terminated their employment.

The Discontinuance of Six Inmate Complaints

In July, 1982, while the investigation was ongoing, six of the 109 inmates against whom unnecessary force was allegedly used filed a civil rights suit, Civil Number 82-0358, in the United States District Court for the District of Hawaii. After review, their civil complaint was found to contain essentially the same allegations as their complaints to the office.

According to the policy of the office, when a complaint is filed in court, an investigation is discontinued. The basis for the policy is that the court will decide the issues, and the decision of the court will be binding on all parties to the proceeding. Thus, the office does not wish to jeopardize, through an investigation, the case of either party. Therefore, after notification to the six inmates in writing, the investigation of the 10 allegations and 56 accusations involving the six inmates was discontinued.

Interviews of Staff Members and Other Agency Personnel

Between January and October, 1982, interviews were conducted of 175 staff members and personnel of the DSSH, the CD, the OCCC, the HHSF, the HPD, the AG and the HNG. The interviews conducted totalled 185, as 10 individuals were interviewed twice. A total of 109 staff members of the OCCC, 31 staff members of the HHSF, seven officials of the DSSH and CD, 17 National Guardsmen, six police officers, and five employees of the AG were interviewed.

Preparing for and conducting the interviews. For nearly every interview, a written list of questions was prepared. The questions were based on information received from persons previously interviewed and pertained to specific incidents about which the interviewee was reported to have knowledge. Because a great many individuals and incidents were involved, such preparation was necessary to insure that each interviewee was asked about every incident or occurrence that he was reported to have participated in or to have witnessed.

The majority of the interviews of staff members were conducted from May through October, 1982. Prior to the interview, by a prepared statement, each person was informed of our investigation, the purpose of the interview, and that any finding of the

use of unreasonable force would be reported to the appropriate authority. In addition, each person was notified that sections 710-1060, 710-1061, and 710-1062 of the Hawaii Revised Statutes (HRS), pertaining to perjury, false swearing in official matters, and false swearing, respectively, may be applicable to him or her with regard to any statements made under oath. Each person was also notified of section 96-19, HRS, which provides that a fine of up to $1,000 may be levied by a court of law against any person who willfully hinders the lawful actions of the Ombudsman or who willfully refuses to comply with the Ombudsman's lawful demands.

Each interviewee was told that the warnings in the prepared statement were not for the purpose of intimidation. Rather, fairness required that each person be forewarned of the possible consequences of his acts once placed under oath. Individuals who expressed a desire to have legal counsel present during the interview were afforded the opportunity to make the necessary arrangements. Eight ACOs were assisted by an attorney during their interviews.

Thereafter, the following oath, provided for in section 621-12, HRS, was administered: "Do you solemnly swear or affirm that the testimony you are about to give will be the truth, the whole truth and nothing but the truth?"

Each interview was tape recorded. The preservation of an accurate record of the testimony received was necessary to protect the interests of the person interviewed, the interests of the person about whom the testimony was received, and the interests of the office.

Initial Staff Interviews

The first staff members interviewed were officials of the DSSH, the CD, the OCCC, and the HHSF, including a DSSH Deputy Director and the CDA and the CDAA. Seventeen interviews were conducted in January, 1982, to obtain general information so as to better understand the sequence of events and to evaluate subsequent testimony.

Interviews of Personnel of the Participating Agencies

Personnel of the AG, HNG, and HPD were sometimes positioned in the vicinity of locations where inmates alleged that unnecessary force was used. Those who may have witnessed some of the complained about incidents were interviewed. Another reason for

interviewing personnel from the HPD and the HNG was that four police officers and one unidentified Guardsman were accused of using unnecessary force.

AG interviews. Interviews were conducted of all five of the AG staff members--the First Deputy AG, a Deputy AG, and three AG investigators--who were present at the OCCC during the shakedown. The interviews were conducted in January and February, 1982.

HNG interviews. The Deputy Adjutant General was contacted on December 31, 1981, and he reported that an HNG colonel had served as the HNG commanding officer at the OCCC during the shakedown. In January, 1982, interviews were conducted of the colonel, who stated that he was present at the OCCC through most of the shakedown; a lieutenant colonel, who was in command during the colonel's absence; and a major and a captain who supervised the Guardsmen at various times during the shakedown.

From these officers, the HNG assignments and the positioning of the Guardsmen during the shakedown were learned. As an alternative to interviewing the 96 Guardsmen who participated in the shakedown, the names of Guardsmen who may have witnessed the use of force against inmates were requested.

The names of 13 Guardsmen, including three HNG medics who were assigned to the OCCC Medical Unit to assist the facility's medical staff, were provided. Between late January and early March, 1982, individual interviews of these Guardsmen were conducted.

HPD interviews. On December 29, 1981, the Chief of Police was apprised of our investigation. Information about the TOD was requested, and the Chief was notified that interviews with some of the police officers who were present at the OCCC during the shakedown would be necessary.

Although other HPD officers were present during the shakedown, the only officers who spent a significant amount of time inside the facility were those of the TOD who assisted in securing the corridors through which the inmates were returned to the cellblock from the recreation field on Tuesday. Therefore, interviews were limited to the TOD sergeant and the five TOD officers who handled the police dogs.

Because police officers were alleged by some of the inmates to have used unnecessary force, interviews with the six officers of the TOD were not conducted until information from inmates and some staff members was received and organized. Interviews with the six officers were then conducted in July and August, 1982. Each of the officers was placed under oath and the interviews were tape recorded.

Problems encountered. A significant problem encountered during interviews of personnel of the participating agencies was their lack of familiarity with the OCCC inmates and the Corrections staff members. Even when specific incidents or occurrences were recalled, the observer nearly always was unable to state which inmates or staff members were involved. Like the inmates who viewed staff member photographs, personnel from participating agencies had difficulty identifying, from photographs, persons with whom they had very little or no contact.

Another problem was that some of the personnel of the participating agencies were reluctant to describe all that they observed. It appeared that they did not want to become entangled in a possible disciplinary or legal proceeding as a witness.

Interviews of OCCC and HHSF Staff Members

A total of 150 interviews of 140 staff members or former staff members of the OCCC and the HHSF were conducted since 10 staff members were interviewed twice. Of the 140 staff members interviewed, 120 were ACOs and 20 occupied other types of positions at the time of the shakedown. Most of the interviews were conducted from May through October, 1982.

OCCC Interviews. Most of the high-ranking officials of the OCCC who were initially interviewed in January, 1982 were re-interviewed and their testimony was taken under oath and tape recorded.

Between January and March, 1982, other staff members were interviewed. Included were employees other than ACOs, i.e., staff members of the facility's Medical Unit, lower level administrators, counselors, and other support services personnel; and four ACOs, two of whom had terminated employment at the OCCC.

Beginning on May 13, 1982, an additional 87 individuals who were employed as OCCC ACOs at the time of the shakedown were interviewed. Most of the interviews were completed prior to August 6, 1982. With three exceptions, all individuals were interviewed in the office, were placed under oath, and their testimony was tape recorded.

The three exceptions were interviews conducted over the telephone. The persons interviewed were no longer employed at the OCCC and were not on Oahu. In two of these cases, the individuals were employed at a correctional facility on another island, while in the third case, the former employee was residing in Texas. In each case, a telephone interview was considered to be adequate to obtain the needed information.

As in the case of inmate interviews, the list of OCCC ACOs expanded as the ACOs interviewed identified other ACOs who may have used or who may have witnessed the use of unnecessary force against inmates. Each available ACO who was identified in this manner was interviewed.

In summary, 113 interviews were conducted of 109 OCCC staff members or former staff members, 91 of whom were ACOs or former ACOs.

HHSF interviews. All of the high-ranking HHSF officials who were initially interviewed in January, 1982 were re-interviewed by the end of October, 1982. They were placed under oath and their testimony was tape recorded. Six HHSF administrators and high-ranking ACOs were interviewed in this manner.

Between August 9 and September 9, 1982, 25 individuals who were employed as HHSF ACOs and who participated in the shakedown were interviewed. The HHSF ACOs were interviewed in the office, were placed under oath, and their testimony was tape recorded. Thus, except for two ACOs who were no longer employed at the HHSF and who could not be located, every HHSF ACO and staff member who participated in the shakedown was interviewed.

In summary, 37 interviews were conducted of 31 HHSF staff members or former staff members, 29 of whom were ACOs or former ACOs.

Problems encountered. During interviews of staff members of the OCCC and the HHSF, several problems were encountered, some of which are described.

(a) Scheduling interviews. Problems in scheduling interviews occurred because of the large number of staff members to be interviewed, the rotational shift work of the ACOs, and a desire not to disrupt the staffing of either the OCCC or the HHSF. However, the scheduling problems were minimized through the cooperation of the administration of both the OCCC and the HHSF. Both facilities provided the work schedules of the ACOs and ordered their employees to appear at the office at the scheduled interview time.

(b) Termination of employment by certain individuals. Another problem was the difficulty in locating individuals who terminated employment before they were interviewed. Four former employees were located, and three voluntarily complied with the request for interview while a fourth was interviewed after being subpoenaed.

However, there were other former employees who could not be located. A former OCCC staff member left the State and failed to respond to a written inquiry. Although one former OCCC ACO and two former HHSF ACOs were subpoenaed, they could not be located and the subpoenas were not served.

(c) Unwillingness to testify. At the request of the office and pursuant to Chapter 621C, HRS, the AG submitted applications to the First Circuit Court of the State of Hawaii for transactional immunity for five individuals who appeared reluctant to testify. The court approved the applications and issued orders authorizing the office, if necessary, to grant transactional immunity to any of the five individuals and to thereafter compel their testimony. Once granted, transactional immunity would protect the individual from criminal prosecution regarding any matter included in his testimony. However, the grant of immunity would also compel the individual to testify and, if he refused, his employment with the State could be terminated pursuant to section 78-9, HRS. (See Appendix C for AG opinion.)

Thereafter, the office issued subpoenas to require the appearance of the five individuals. However, three of the individuals were former employees who, as noted in the preceding section, could not be located and the subpoenas could not be served. A fourth individual was served, but after consulting with his therapist, he was notified by the office that he need not appear. Therefore, only a single individual was granted transactional immunity and compelled to testify.

Subpoenas were served on two other individuals who appeared to be unwilling to testify and both thereafter testified.

(d) The passage of time. Because of the large number of inmates and staff members that had to be interviewed, many staff members were not interviewed until several months after the shakedown. Most of the ACO interviews were conducted during a period ranging from five to nine months after the shakedown. Some ACOs said their ability to recall specific details was adversely affected by the passage of time.

(e) Lack of openness. The most significant problem encountered in interviewing staff members was their reluctance to candidly discuss their actions and observations. Their lack of openness was the major obstacle in the fact-finding process.

Several OCCC staff members said they were made aware, through innuendo, of the possibility of reprisals being taken against staff members who revealed what other staff members had done. The fear of possible reprisal appeared to inhibit some staff members.

Even without the threat of reprisals, the reluctance of ACOs to openly describe what their fellow ACOs may have done is not surprising. In our society, "squealers" are not glorified. This sentiment appears to be magnified in the prison environment, since ACOs must rely on other ACOs for their well-being. Such sentiments are not reinforced through the official communication and disciplinary systems of a prison, but as suggested by Crouch, through the code of an informal subculture:

> "The recruit learns how to be a guard most directly by observing, listening to and imitating the veterans with whom he works. Those veteran guards constitute an important reference group, physically backing him up, offering advice, reinforcing him, and judging him. Through interaction with them over time, the new man picks up the values of the officer subculture and what other officers expect of him."[1]

The less than candid testimony received was partly due to the values of this subculture. Thus, the ACO who finds the conduct of his fellow officers to be objectionable is faced with a dilemma in trying to resolve the conflict between his personal values and that of the subculture. This dilemma was described by an OCCC ACO:

> "...I have my conscience to live with and I've wrestled with this goddamn thing since December. I've wrestled with it; that there's no one to go to with the whole damn thing. No one. And when you go to 'em, you know, it becomes a publicized thing. Names, dates, places, times--everything gets back. And I'm still stuck working with these assholes.
>
> "The worst, probably the worst thing of all, is the fact that although I did nothing wrong in this and I done what I

[1] The Keepers, Prison Guards and Contemporary Corrections, 1980, pp. 78-79, Edited By Ben M. Crouch, Ph.D.

could to protect the inmates and to do what I thought had to be done for 'em, the bottom line is if I don't come forward and tell what I know, then I'm as guilty as the ones that done it, in my own conscience and my own mind."

Another ACO described his dilemma in more practical terms. He testified that during the strip searches in the 4-way, three or four ACOs were asked to leave because they were "getting hot", were "in a higher gear or something", and needed to "cool off". The ACO stated that he knew the names of these ACOs, but would not reveal them. He explained:

"The thing is, you gotta understand, is I gotta work there. You guys are over here, and though you guys are doing your job, I gotta do mines back there and these are the guys that can protect me, not you folks. So I'm not going to hang nobody. You gotta understand that. You know, cause they're watching my back and I gotta watch their back and, you know, what you guys are doing is fine but I'm not going to accuse nobody."

However, considering the prison environment, the ACO subculture, and the assumption that most of the ACOs would continue their employment as ACOs, it is commendable that a significant number were willing to make statements that incriminated themselves and to candidly relate what they saw.

B. The Organization, Analysis, and Evaluation of Information Obtained

Sources of Information

The office reviewed reports by the participating agencies, including written materials pertaining to the shakedown plans, activity logs, inmate medical records, debriefing evaluations, and training documents. Each of the agencies was very cooperative in providing the requested materials.

In addition, reports compiled by others who investigated the alleged beatings of inmates were shared with the office. These included an "in-house" report by former CDAA Edith Wilhelm, the report of the Governor's Blue Ribbon Committee, and the report of the Senate Committee on Judiciary.

However, the primary sources of information were interviews of inmates and staff members. Each interview was reduced to written notes immediately after the interview was completed and these notes collectively constituted thousands of typewritten pages. The information was organized to facilitate analysis and evaluation of each allegation and accusation.

Organization of Information

The information was organized by relevancy to each inmate allegation and to each identified staff member. Some of these staff members were alleged to have witnessed certain incidents, others were accused of having used unnecessary force against certain inmates, and others possibly committed supervisory breaches of duty. To organize the huge amount of information, case files were opened for each of these inmates and staff members.

To illustrate how the organizational system functioned, assume that testimony was received from 25 inmates and staff members regarding the alleged use of unnecessary force against a particular inmate. Some of the testimony indicated that the force used was unnecessary; some indicated that the force used was necessary; and some indicated that no force at all was used. All such testimony was considered to be relevant to the particular inmate's allegation. Photocopies of the relevant portions of the notes of the 25 inmate and staff interviews would be placed in the inmate's file.

In the same example, if the inmate accused three ACOs of using unnecessary force against him and said a corrections administrator witnessed the entire incident and failed to intervene, photocopies of the relevant portions of the notes of the inmate's interview would be placed in the case files of each ACO and the administrator.

Again in the same example, if 10 of the inmate and staff witnesses said that one or more of the accused ACOs used unnecessary force against the inmate and that five other witnesses testified that the corrections administrator was present during the incident, photocopies of the relevant portions of the notes of the 10 inmate and staff interviews would be placed in the case files of each of the accused ACOs; and the same would be done with the relevant testimony of the five witnesses in the case of the administrator.

Upon the completion of this process, the inmate's case file would contain not only his allegation but the relevant testimony of the 25 inmate and staff witnesses. The case files of each of the accused ACOs and the administrator would contain the inmate's accusation against them, as well as the pertinent testimony of all witnesses.

In addition, other information relevant to the inmate's allegation or accusation would be entered in the appropriate case file. For example, if one of the three accused ACOs was found to have been absent from work on the day that the incident reportedly occurred, a notation of this finding would be entered in the case files of the inmate and the ACO.

In summary, the information was organized in a manner that insured the analysis and evaluation of all relevant information before findings were made about a particular incident or individual. However, the large volume of information compiled made this a very time-consuming process.

Analysis and Evaluation of Relevant Information

Since the investigation of the complaints of the six inmates who filed suit was discontinued, no attempt was made to analyze and evaluate the 10 allegations and 56 accusations pertaining to their cases. The number of ACOs and police officers who were identified and accused of having used unnecessary force was thereby reduced from 77 to 72, as five were accused of having used such force solely against one of the inmate plaintiffs. As a result, the cases of 103 inmates, involving 121 allegations and 233 accusations against 72 identified ACOs and police officers, were analyzed and evaluated.

The purposes of the review, analysis, and evaluation of the information were to ascertain:

(1) Whether there was sufficient evidence to conclude that unreasonable force was used against inmates during the shakedown. To make a determination, a finding was made with respect to each of the 103 inmates against whom unreasonable force was allegedly used.

(2) Whether there was sufficient evidence to refer identified persons to their appropriate departments for having used unreasonable force against individual inmates. Each of the 233 accusations was analyzed and evaluated to determine whether there was sufficient evidence to support the accusation.

(3) Whether there was sufficient evidence to refer identified supervisors to their appropriate departments for breaches of duty. Although most of these cases involved failure to intervene to stop the use of unreasonable force, a few pertained to breaches of supervisory duties on a broader scale.

As a first step in the analysis and evaluation of the information, written summaries of the pertinent testimony and other evidence were prepared for each individual inmate and staff

member case files. Summaries were thus prepared for the 233 accusations, for the 121 allegations, and for each case involving a possible supervisory breach of duty.

After preparing the written summaries, the written representation of testimony from key witnesses was checked against the tape recordings of those witnesses to eliminate the possibility of errors in the written summaries.

Thereafter, a series of internal reviews and discussions were conducted on the merits of each of the accusations and allegations on the basis of the written summaries. Each written summary was reviewed by several staff members to obtain differing perspectives of each case and opinions concerning the weight of the evidence.

No fixed formula or numerical test was employed in analyzing and evaluating the evidence obtained. Instead, the analysis and evaluation required a case-by-case assessment which was qualitative in nature. The amount of evidence and credibility of the testimony of inmates and staff members were weighed in each case. As the accuser, the burden of proof rested with the inmate. An allegation, absent any other corroborating evidence, was considered insufficient to overcome that burden.

In each case, the initial step was to determine whether there was sufficient evidence to conclude that force was used against an inmate. If there was sufficient evidence, it was then necessary to determine whether the force used was reasonable or unreasonable. After a review was conducted of statutes, DSSH rules, regulations, policies, and procedures pertaining to the use of force, a standard was developed. The standard was applied to cases in which there was sufficient evidence to indicate that force was used against an inmate, and the determination as to whether such force was reasonable or unreasonable was made in this manner. (The standard used is described in Chapter IV.) Thereafter, if the force used was found to be unreasonable, a determination was made as to whether there was sufficient evidence of the persons responsible.

Therefore, it was possible to arrive at a finding that there was sufficient evidence to support an allegation that unreasonable force was used against a particular inmate, while also finding that there was insufficient evidence to support an accusation against a particular ACO or police officer in the same case. This type of result occurred when the evidence indicated that unreasonable force was used against a particular inmate, but the evidence was insufficient to establish the identity of the persons responsible.

Review of Identified Cases with the DSSH

The internal reviews resulted in identified cases in which there appeared to be sufficient evidence to refer the cases to the appropriate department. None of these identified cases involved personnel from the HPD or the HNG. Thus, only the DSSH was consulted.

In a series of meetings with the DSSH, the identified cases were reviewed and discussed. At the initial meeting, the standard used to determine whether the force used in each of the cases was reasonable or unreasonable was presented. It was important that, prior to the review and discussion of actual cases, a standard to evaluate force that was used be agreed upon. The intent was to prevent personal biases from coloring the discussion and so that decisions would be made as objectively as possible. After reviewing the proposed standard and after the inclusion of a modification suggested by the Deputy AG, the standard was found to be acceptable and all parties agreed to be guided by it in reviewing the cases.

Subsequently, a series of four meetings was held in late April and early May, 1983. Prior to each meeting, written summaries of cases to be discussed were shared with each participant, under a requirement of strict confidentiality. At each meeting, the DSSH representatives were asked for their impressions and opinions of the cases.

After obtaining and considering the opinions of the DSSH, a determination was tentatively made as to which cases constituted a possible breach of duty or misconduct on the part of a departmental employee.

Consultation with Employees

Questions were raised on two sections of Chapter 96, HRS, regarding the Ombudsman's legally required course of action when he thinks there is a breach of duty or misconduct by an officer or employee of an agency. Section 96-11, HRS, entitled Consultation with agency, states:

> "Before giving any opinion or recommendation that is critical of an agency or person, the ombudsman shall consult with that agency or person."

Section 96-15, HRS, entitled Misconduct by agency personnel, states:

> "If the ombudsman thinks there is a breach of duty or misconduct by any officer or employee of an agency, he shall refer the matter to the appropriate authorities."

It appeared that the sections could be read together or separately. If read together, the Ombudsman must consult with the affected personnel before he refers to the appropriate authorities a case that he thinks is a breach of duty or misconduct. If read separately, the Ombudsman may make such referrals to the appropriate authority without consultation.

Therefore, clarification was sought from the AG regarding the proper application of the above two sections of Chapter 96, HRS. The AG advised that, in their opinion, the Ombudsman was required to consult with the affected personnel before referring what he thinks are breaches of duty or misconduct to the appropriate authorities. The AG stated: "...we believe that agency personnel should be informed of any allegation of wrongdoing and given a chance to explain or rebut such allegation under section 96-11, before the matter is referred to an appropriate agency under section 96-15." (See Appendix D for AG opinion.)

In accordance with the AG opinion, letters were sent to the affected employees or former employees. Each individual was notified of the inmate involved, the date, the location of the incident, and the breach of duty or misconduct involved. Each individual was informed that referral of the matter to the DSSH was being considered and each was afforded an opportunity to consult with the office, with the assistance of a representative of his choice, before a final determination was made. The individuals were informed of the purpose of consultation and of the limitations imposed by the requirement of confidentiality.

Consultation is viewed as an opportunity for a person to provide information that would exonerate him and thus avoid the Ombudsman's commission of a gross error. Consultation is not part of an administrative disciplinary process, nor is it a discovery process or an opportunity to identify witnesses and to analyze and weigh the specific testimony and information on which the tentative finding is based. Because of the purpose of consultation and because section 96-9, HRS, requires the Ombudsman to maintain secrecy with respect to all matters and the identities of complainants or witnesses, except as may be necessary to carry out his duties and to support his recommendations, the information that was shared with employees during the consultation was limited. Each individual was apprised of these constraints.

Consultation with most of the affected individuals was held during a two-week period in July, 1983. During consultation, each individual was orally apprised of the basis for the tentative findings and each was afforded an opportunity to respond. The consultation was tape recorded. Many individuals were assisted by a representative of their choice. (See Appendix D for further details regarding the consultations.)

After analyzing the information received from consultations, the tentative findings were finalized. Each employee was notified by letter as to whether his case would be referred to the DSSH. These findings are reported in Chapter V.

Consultation with DSSH and HPD Regarding Report

Pursuant to section 96-11, HRS, quoted in the preceding subsection, a draft of this report was shared with the DSSH and the HPD. Thereafter, consultation was held with both agencies and their comments were obtained. The report was then finalized.

Chapter IV

A DISCUSSION OF REASONABLE FORCE
AND THE EVOLUTION OF A STANDARD

This discussion centers on the use of non-deadly force. It is generally agreed by those in the criminal justice system that correctional officers may use reasonable force under certain circumstances.[1] A representative statement of those agreed-upon circumstances appears in a resource and training publication by O'Brien, Fisher, and Austern:

> "Generally, there are four circumstances in which a correctional officer has the right to use force:
>
> "1. self-defense;
>
> "2. defending or aiding another officer (or inmate);
>
> "3. enforcing institutional regulations; and
>
> "4. preventing commission of a crime, including escape."[2]

Although there is general agreement as to the circumstances in which reasonable force may be used, one must examine Hawaii's law to determine whether the nature or the degree of force used in those circumstances was reasonable.

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[1]For example, see Model Correctional Rules and Regulations, Correctional Law Project of the American Correctional Association, 1977; Model Act for the Protection of Rights of Prisoners, National Council on Crime and Delinquency, 1972; Standards on Rights of Offenders, National Advisory Commission on Criminal Justice Standards and Goals, 1973; Constitutional Rights of Prisoners, John W. Palmer, 1973.

[2]Practical Law for Correctional Personnel, a resource manual and training curriculum by the National Street Law Institute, 1981, by adjunct professors of law Edward O'Brien, Margaret Fisher, and David Austern, pp. 25-26.

Statutes

Section 703-309, HRS, authorizes the use of force by persons with the responsibility for the care, discipline, or safety of others. Subsection (5) is applicable to the correctional setting and justifies the use of force under the following circumstances:

> "(5) The actor is a warden or other authorized official of a correctional institution, and:
>
> "(a) He believes that the force used is necessary for the purpose of enforcing the lawful rules or procedures of the institution; and
>
> "(b) The nature or degree of force used is not forbidden by other provisions of the law governing the conduct of correctional institutions; and
>
> "(c) If deadly force is used, its use is otherwise justifiable under this chapter."

The commentary on section 703-309(5), HRS, aids in understanding the statutory provision:

> "Subsection (5) justifies force used by a warden or other authorized prison official to enforce prison rules and discipline. The force used must not be in excess of that permitted by statutes relating to prisons, and deadly force may be used only when justified under other sections of this Code."

The allegations of the inmates about the type of force used against them during the shakedown generally did not appear to fit within the statutory definition of deadly force stated in section 703-300(4), HRS, as:

> "...force which the actor uses with the intent of causing or which he knows to create a substantial risk of causing death or serious bodily harm. Intentionally firing a firearm in the direction of another person or in the direction which another person is believed to be constitutes deadly force. A threat to cause death or serious bodily injury, by the production of a weapon or otherwise, so long as the actor's intent is limited to creating an apprehension that he will use deadly force if necessary, does not constitute deadly force."

Therefore, the focus of this discussion is on the provisions of paragraphs (a) and (b) of section 703-309(5), HRS, in this report.

Paragraphs (a) and (b) of section 703-309(5), HRS, are significant to the discussion of the use of reasonable force since it identifies the following essential elements: (1) the use of force must be necessary; (2) the force must be used for the purpose of enforcing the lawful rules and procedures of the institution; and (3) the nature and degree of force used is limited to that which is not forbidden by other provisions of law governing correctional institutions.

In order to determine the lawful rules and procedures of a correctional institution, and the degree of force which is not forbidden by other provisions of law governing correctional institutions, requires reference to section 353-3, HRS, entitled Powers of the director; rules, which states:

> "The director of social services and housing shall have the entire government, control and supervision of state correctional facilities except intake service centers and of the administration thereof. The director may make and from time to time alter or amend rules relating to the conduct and management of such facilities and the care, control, treatment, furlough and discipline of persons committed to his care, which rules must be approved by the governor, but shall not require publication in order to be valid and binding upon all inmates, officers, and employees of such institutions, and which rules shall be printed from time to time.
>
> "The director, subject to the rules, shall enforce the rules and prescribe the disposition of committed persons for any breach of correctional facility rules or other misconduct." (underscoring for emphasis only)

Therefore, the rules which were adopted by the Director of the DSSH and approved by the Governor must be examined.

Director's Rules

The Director's rules are contained in the Inmate Handbook. Two sections of the rules pertain to the use of force against inmates:

Section 600.660.001, Use of Force, states:

> "The use of force is limited to that amount which is reasonably necessary under the circumstances. Any use of force more than that which is reasonably necessary to preserve the security and good order of the facility is prohibited. All personnel are to use their own judgment in each circumstance. Brutality or corporal punishment is prohibited." (underscoring for emphasis only)

Section 200.200.006, Punishment, states in pertinent part:

> "...Corporal punishment is prohibited provided, however, that physical force may be employed for self-defense or defense of others, to maintain the immediate order and security of the prison, to remove an inmate/ward pursuant to a lawful order, or any other reason demanded by the exigencies of institutional safety and correctional goals...."

It is clear from the above sections of the rules that corporal punishment is not allowed, that force must be necessary and reasonable, and that force may be used for certain purposes, such as self-defense, etc.

Further clarification of the rules is obtained by reviewing the Corrections Division Policies and Procedures Manual.

Corrections Division Policies and Procedures Manual

In addition to the rules, the CD adopted the Corrections Division Policies and Procedures Manual, which applies to all branch facilities. Subsection 1.0, Purpose, of Section 440.000, Use of Force, states:

> "To set forth policies supplementing rules and regulations of the Corrections Division regarding the use of force by branch facility personnel."

Subsection 6.0 of Section 440.000 states:

> ".1 Basic rules and regulations regarding the use of force by facility personnel are contained in Section 600.660 of the Rules and Regulations of the Corrections Division. Under that provision, the use of force is limited to that amount which is reasonably necessary under the circumstances.

> ".2 The use of force shall be limited to situations where it is necessary to protect one's self or others from injury, to prevent escape or serious injury, or to preserve the order and sound government of the facility. Only that amount of force necessary to serve a legitimate purpose is permissible. Where the use of force is initially reasonable and permissible, its continued application is not justified absent a continuing need therefore [sic]."

Essentially, the Manual: (1) requires that the force used be necessary to serve a legitimate purpose; (2) lists the legitimate purposes such as self-defense, defense of others, prevention of serious injury or escape, etc.; and (3) requires that the force used be only that amount necessary to obtain or secure those legitimate purposes.

Further clarification of the CD policies and procedures is obtained by reviewing the OCCC regulations and procedures.

Oahu Community Correctional Center Regulations and Procedures

The regulations and procedures of the OCCC, formerly the Hawaii State Prison, were adopted in January, 1975, and are contained in the Hawaii State Prison Employee Handbook. Section P4.512 addresses the use of physical force:

> "Employees shall not strike in any way or lay hands on inmates except in self-defense or to prevent escape or serious injury to persons or property, or when it is necessary to move an inmate following his refusal to obey a reasonable order. Only that amount of force necessary to accomplish the act is authorized. In all instances where physical force is used, the employee shall immediately submit a detailed report of the incident via his Watch Supervisor to the Hawaii State Prison Administrator. The State Prison Administrator shall conduct an investigation to determine if such use of force was necessary."

The OCCC regulations and procedures provide somewhat clearer guidelines to ACOs about what the administration considers to be reasonable force. The regulation and procedure are quite specific in prohibiting striking or laying hands on inmates. The list of enumerated circumstances when force may be used, as contained in the CD regulations, is clarified by providing that force may be used when it is necessary to move an inmate following his refusal to obey a reasonable order. It also limits

the amount of force only to that which is necessary to accomplish the authorized act.

Confusion in the Ranks

Even after a close reading of all of the foregoing statutes, rules, regulations, policies, and procedures, a reasonable man would still be in a quandry as to whether the use of force (type and degree) in differing institutional situations would or would not be reasonable. This lack of clear and specific guidelines as to the type and degree of force that may be used in different circumstances leads to confusion among the ACOs when confronted with institutional situations which may require the use of force to carry out their duties.

To illustrate, even the branch (facility) administrators disagreed on whether the use of a certain type of force is reasonable or unreasonable in the hypothetical case of an inmate who refuses to obey an ACO's order to remove his clothes for a strip search. One branch administrator stated that it is reasonable to slap an inmate's face after an ACO conveyed the order to an inmate two or more times and the inmate refused to comply. But another branch administrator stated that it is improper to slap the inmate under those circumstances and, instead, force should be used to strip the inmate. He also stated that a slap is proper only if the inmate physically resisted the efforts to strip him.

Given this confusion, it would be difficult for administrators and supervisory personnel to hold their subordinates accountable for the improper use of force, other than in extreme cases. The current situation is most unfair to the ACOs. The ACOs are placed in situations where the immediate use of force may be necessary, and where the only specific guideline given in the rules is to "act on their own judgment". The ACO is thus not provided with clear and specific guidelines on what is and is not permissible, but is still held accountable, after the fact, for misjudgment. The current situation is also eminently unfair to inmates, for they suffer physical or mental harm as a result of ACO misjudgment in applying the generally stated guidelines regarding the use of force.

Analysis of the Statutes, Rules, Regulations, Policies and Procedures

An analysis of the foregoing provisions was made to determine if there were general principles which would aid in developing a meaningful and more precise standard which can be used in daily

operations. There are several common threads in the provisions governing the use of force against inmates. According to those provisions, to constitute reasonable force:

The objective to be attained must be lawful. Objectives such as defending oneself, defending others, preventing the commission of a crime (such as escape or destruction of property), or enforcing institutional regulations (preserving the order and sound government of the facility or securing compliance to a reasonable order) are all lawful objectives. Reasonable force may be used to carry out these objectives, provided that the following items are also met.

Resistance to the attainment of the lawful objective must be evident. Resistance must be evident to justify the use of force. Although this principle is usually assumed, it is made explicit in the OCCC regulations:

> "Employees shall not strike in any way or lay hands on inmates except...."

The type of resistance--whether verbal or physical--is significant in deciding the nature or degree of force that may be used to overcome the resistance. It is, therefore, necessary that the type of resistance and the force that was used to overcome it be described in behavioral terms. It is inadequate to say simply that: "the inmate resisted" or "the inmate was subdued."

Reasonable alternatives, other than the use of force, were either unavailable or were tried and were unsuccessful. In certain circumstances, force may be the only alternative available--as in the case when one is physically attacked without warning. However, in many circumstances, force does not become necessary until other options are tried and are unsuccessful. As described by O'Brien, Fisher and Austern:

> "Traditionally, force also could be used to enforce institutional regulations, but this often resulted in what many people felt was unnecessary corporal punishment. Modern correctional philosophy calls for personnel to use force only as a last resort to enforce regulations, and even then to use only the minimum amount required. In describing its model rule on the use of force to enforce institutional regulations, the American Correctional Association Law Project states that: 'While the model allows physical methods to enforce institutional regulations, it is hoped that the trend toward less physical control of inmates will be undertaken. Control and management of offenders should be by sound scientific methods, stressing moral values and organized persuasion, rather than primary dependence upon physical force'.

"Therefore, to grab or strike an inmate who is talking out of turn or walking out of line could give rise to liability if the officer did not first attempt to correct the situation through a verbal reprimand. On the other hand, an inmate who is found writing on the wall in a jail dormitory and continues to do so after an officer tells him to stop, can be physically moved away from the wall. Again, the standard will be whether what the officer did under the circumstances was 'reasonable'."[3] (underscoring for emphasis only)

It appears that the CD adheres to the view that force should be used only as a last resort and that reasonable alternatives, which do not unduly expose an ACO or an inmate to the risk of injury, should be attempted before force is used. The Manual states: "The use of force shall be limited to situations where it is necessary to protect one's self or others from injury,..." The OCCC regulations state: "Employees shall not strike in any way or lay hands on inmates except in self-defense,..."

It should also be noted that if an inmate refuses to obey an order, and is thereafter advised that force will be used to make him comply, the inmate will often comply without the ACO having to resort to the use of force. However, if minimal force must be used after such warning is given, most observers (including other inmates) and the subject inmate (upon reflection) will feel that the use of force was reasonable. As a result, much of the potential negative aftermath of the use of force in an institutional setting may be dissipated.

The force used must be minimal under the circumstances, or just that amount of force which is sufficient to overcome the resistance. The principle of minimum force is recognized by the CD, as is evident by policy statements and in the regulations. The Manual states: "Where the use of force is initially reasonable and permissible, its continued application is not justified absent a continuing need therefore [sic]." The OCCC regulations state: "Only that amount of force necessary to accomplish the act is authorized." It should also be recognized that the principle of minimal force includes the concept of escalating force--that force may be incrementally escalated if resistance by the inmate increases.

[3] Practical Law for Correctional Personnel, supra, p. 27.

The minimal force used must be directly related or limited to the attainment of the lawful objective. The direct relationship between the type of minimal force used and the attainment of the lawful objective is implicit in the policies, procedures, rules and regulations. The Director's rules state: "Corporal punishment is prohibited provided, however, that physical force may be employed for self-defense or defense of others,..." The CD Manual states: "Only that amount of force necessary to serve a legitimate purpose is permissible." The OCCC regulations state: "Only that amount of force necessary to accomplish the act is authorized."

If the type of minimal force used is directly related or limited to the attainment of a lawful objective, there can be no question that the ACO acted in good faith and within the law. If, however, minimal force is not directly related or limited to the attainment of the lawful objective, then the force used is either corporal punishment or the use of unreasonable force.

For example, the type of force used in physically grabbing and moving an inmate into his cell when he refuses to reenter his cell is directly related or limited to the attainment of a lawful objective. There can be no doubt that the ACO or ACOs used force in good faith to attain a lawful objective--placing the inmate in his cell. However, if the ACO shoved the inmate with such force that he bounced off the opposite wall of his cell and was injured, then the degree of force used was neither minimal nor limited to the attainment of the lawful objective.

In the same example, if the ACO slapped the inmate's face to force compliance or to "get his attention," then the type of force used was not directly related to the attainment of the lawful objective. The slap constitutes corporal punishment or the use of unreasonable force against an inmate for refusing to obey an order, much as an adult might spank a disobedient child. For those who argue that a slap is permissible, the questions that would follow are: If a slap is initially permissible, why is it not initially permissible to punch, kick, or choke an inmate to secure compliance? Is it permissible to repeatedly slap an inmate, after each refusal, until he complies? If he continues to refuse after being slapped, is it then permissible to punch, kick, choke, or use more drastic types of force to make an inmate comply?

Reviewing the Standard and Its Application

From the foregoing discussion, it is evident that to constitute reasonable force:

(1) The objective to be attained must be lawful;

(2) Resistance to the attainment of the lawful objective must be evident;

(3) Reasonable alternatives, other than the use of force, were either unavailable or were tried and were unsuccessful;

(4) The force used must be minimal under the circumstances, or just that amount of force which is sufficient to overcome the resistance; and

(5) The minimal force used must be directly related or limited to the attainment of the lawful objective.

The above standard is in compliance with the Director's rules and the CD and OCCC policies, procedures and regulations, rather than in conformity with court decisions interpreting 42 U.S.C. §1983, which protects individuals against deprivations of constitutional rights by persons "acting under color of State law." Since the conduct of corrections officers and employees at the time of the shakedown must be measured against the standard derived from the then existent statute, and the DSSH rules, regulations, policies, and procedures, rather than the standard developed by the Federal courts as they interpret 42 U.S.C. §1983, we did not find it necessary to state or apply the Federal standard in this investigation. The issue of whether the force used was reasonable or unreasonable must be determined by measuring the actions of corrections officers and employees against the standard provided in the statutes and the DSSH rules, regulations, policies and procedures, and not against the decisions of the Federal courts as they interpret 42 U.S.C. §1983.

To correctly apply the standard to situations where force was used, the following must be determined:

(1) What was the objective to be attained? Was it lawful?

(2) Was resistance to the lawful objective evident? How did the inmate resist? Did the inmate use force? If he did, what was the nature and degree of force used by the inmate?

(3) Were reasonable alternatives available or unavailable? If available, what were those reasonable alternatives? Were they tried and were they unsuccessful?

(4) Was the force used minimal under the circumstances? What were the circumstances? Was the force used just that amount of force which was sufficient to overcome the resistance? What was the nature and degree of force used? What was the nature of the injuries received by the inmate?

(5) Was the minimum force directly related or limited to the attainment of the lawful objective?

To test whether the standard is appropriate, apply the questions to a situation in which a relatively small amount of force is used. Assume that three ACOs are conducting a strip search during a prison shakedown. One of the ACOs orders the inmate to face the wall, to lean on the wall by placing his feet far from the wall, and to spread his hands and legs far apart. The inmate responds by saying, "Hell no, I'm not going to let you strip search me." The ACO then repeats the order to the inmate and advises him that if he does not obey, physical force will be used to make him comply. The ACO receives the same response from the inmate. The ACO then slaps the inmate on the face. The slap is a stinging blow. The inmate then complies and the strip search is completed without further incident. In applying the standard, the answers to the questions would be:

(1) The objective was to strip search the inmate. The objective was lawful.

(2) Resistance was evident by the inmate's verbal refusal, defiance, and noncompliance.

(3) After the first command, the order was repeated. That was a reasonable alternative, and further, notice was served that force would be used to secure compliance. Thus, a reasonable alternative to the use of force was tried and was unsuccessful.

(4) The nature and degree of force used was a slap--a stinging blow. The inmate was not seriously injured and did not require medical attention. For this example, let us assume that it is minimum force.

(5) The slap to the face was corporal punishment or the use of unreasonable force which was applied to the inmate for refusing to obey an order and was not directly related or limited to the attainment of the lawful objective--the strip search of the inmate. The initial step in the strip search process was to get the inmate against the wall. If the ACOs had grabbed the inmate, turned him around, placed his hands on the wall and made him assume the search position, the force used would certainly be deemed minimal and directly related and limited to the furtherance of the lawful objective. Even if the ACO were to state that the slap was applied to secure compliance, it was, in fact, a situation where corporal punishment or unreasonable force was used to secure compliance. If the inmate, subsequent to and as a result of the slap, then faced the wall, the use of corporal punishment or unreasonable force to secure compliance would not be justified. The argument that "the ends justify the means" is unacceptable when applying the standard. Rather, the means and the ends must be directly related and both must be lawful. Further, the use of minimum force which is directly related or limited to the lawful objective presumptively displays the ACO's good faith and lack of malice.

Slapping someone on the face to secure compliance with an order is demeaning. It may also provoke a like physical response by the inmate, either at that moment or at a later time. If the slap is taken as a personal challenge, it may escalate the amount of force necessary to subdue the inmate.

Conclusion

A review of the statutes, rules, regulations, policies and procedures leads to the conclusion that the principles to determine what is reasonable and unreasonable force are contained in those materials. However, the principles are stated in so general a manner that it is difficult to apply them to differing factual situations with any degree of certainty or predictability. Their usefulness in day-to-day operations is therefore limited.

The salient principles were extracted, assembled, and arranged in a logical order. That arrangement is in the form of a standard which will aid CD personnel, inmates, and the public in determining where the line should be drawn between reasonable and unreasonable force.

The standard was applied in the individual cases which were investigated. The standard had, and if adopted by the DSSH will have, the following advantages:

(1) The standard provides a logical framework to objectively determine whether force used is reasonable or unreasonable. Because the standard provides a clearer delineation between reasonable and unreasonable force, the acceptance of the standard by all concerned will result in greater certainty and predictability in the future.

(2) The standard focuses attention on the essential facts which are necessary to an objective determination. The ACO knows in advance the type of specific information that must be included in his report regarding the use of force. Such a report is presently required by the OCCC regulations and procedures. The ACO realizes that he must provide specific information about the inmate's actions, as well as his own. The administration knows what facts it must obtain during the course of an investigation to make an objective decision.

(3) The standard subjects arguments for or against a particular determination to one or more of five tests and decision making becomes less difficult and subjective.

(4) The standard can be fleshed out by subsequent decisions regarding particular incidents, if the decisions of the administration regarding the use of force in individual incidents are

consistently shared with and explained to the ACOs during their watch briefings. This would lessen the current confusion among ACOs as to when, what type, and what amount of force is permissible. Better understanding of what constitutes reasonable and unreasonable force will make ACOs less susceptible to being influenced by the inmate who threatens, "If you touch me, I will sue you."

(5) The application of the standard can strengthen training of ACOs regarding reasonable alternatives which can be tried before force is used, the definition of minimum force, and the necessary direct relationship between minimum force and the attainment of the lawful objective.

(6) If inmates, ACOs and the administration know in advance when and to what degree force can be used, there should be less use of and fewer complaints about unreasonable force.

The standard is a starting point in the development of operational definitions for reasonable and unreasonable force. By using the "case-by-case" method and by disseminating the decisions to the ACOs, more decisive and reasoned actions should follow.

Chapter V

FINDINGS

The findings of the investigation are included in this chapter. Although allegations were made that unreasonable force was used against 109 inmates, the findings relate to 103 inmates because no findings were made about the allegations and accusations regarding six inmates who filed suit in the U. S. District Court. (See Chapter I for definitions of allegations and accusations.)

Table 7

NUMBER OF ALLEGATIONS AND ACCUSATIONS INVESTIGATED

	No. of Inmates against Whom Unreasonable Force Was Allegedly Used	No. of Allegations	No. of Identified ACOs and HPD Officers Accused of Having Used Unreasonable Force	No. of Accusations against Identified ACOs or HPD Officers
Total number	109	131	77	289
Less number attributed to the 6 inmate plaintiffs	- 6	- 10	- 5	- 56
Total number investigated and on which findings were made	103	121	72	233

As shown in Table 7, 103 inmates were involved in 121 allegations which included 233 accusations against 72 identified ACOs and police officers. A finding was made with respect to each of the allegations and accusations.

Other allegations which did not involve the use of unreasonable force against a specific inmate, but were related to the use of unreasonable force during the shakedown, were also investigated. The findings regarding these allegations and other conclusions are included in this chapter.

This chapter is divided into two sections. Findings regarding the alleged use of unreasonable force against the 103 inmates are reported in the first section, and the findings pertaining to other allegations and conclusions are reported in the second.

A. Findings Regarding Inmate Allegations

The findings are organized and reported in relation to the following objectives of the investigation:

(1) To determine whether unreasonable force was used against inmates.

(2) To identify, if unreasonable force was used, the responsible officers and employees.

The findings are reported in numerical terms. Descriptive narratives of cases are not included in this chapter. Several summarized case examples are included in Appendices E and F to illustrate the nature of the allegations, the kinds of evidence obtained, and the process of analysis and evaluation. The names of inmates and staff members in the case examples have been omitted.

The Use of Unreasonable Force Against Inmates

Findings of whether unreasonable force was used against inmates are summarized in Table 8.

Table 8

FINDINGS REGARDING THE USE OF
UNREASONABLE FORCE AGAINST INMATES

	No. of Inmates	No. of Allegations
Total number investigated	103 (100%)	121 (100%)
Findings of insufficient evidence	- 59 (57%)	- 73 (60%)
Findings of sufficient evidence	44 (43%)	48 (40%)

Findings regarding the 103 inmates. There was insufficient evidence to conclude that unreasonable force was used against 59, or 57%, of the 103 inmates. However, the findings should not be construed to mean that there was no evidence that unreasonable force was used against any of the 59 inmates. Instead, the findings indicate that the evidence was insufficient to sustain the allegations that unreasonable force was used against those inmates. In a number of cases, some of the evidence supported an inmate's allegation but was insufficient to sustain it.

There was sufficient evidence to conclude that unreasonable force was used against 44, or 43%, of the 103 inmates. Of the 44 inmates, 18 were treated at the OCCC Medical Unit for injuries such as bruises, contusions, abrasions, or lacerations.

At the time of the shakedown, 19, or 43%, of the 44 inmates were housed in the cellblock; 16, or 36%, were housed in modules; and 9, or 21%, were housed in the Holding Unit. Thus, the assertion initially made that unreasonable force was used primarily against cellblock inmates is not supported.

Some CD staff members said the use of force against inmates was frequently necessary to overcome resistance or assaultive conduct or to recover contraband. However, in the cases of 43 of the 44 inmates, there was insufficient evidence that force was used for such purposes. In addition, other staff testimony was to the effect that the vast majority of inmates were well behaved and compliant. Thus, the claim that force was frequently necessary for those purposes is seriously questioned.

Findings regarding the 121 allegations. As indicated in Table 8, there was insufficient evidence to conclude that unreasonable force was used in 73, or 60%, of the 121 total allegations. The findings should not be construed to mean that each

of the 73 allegations was totally without merit. Instead, the findings indicate that there was insufficient evidence to sustain the allegations.

There was sufficient evidence to conclude that unreasonable force was used in 48, or 40%, of the allegations. These 48 allegations stemmed from the 44 inmate cases in which unreasonable force was used. There are four more allegations than inmates because unreasonable force was used on two separate occasions against four inmates.

In most cases, the entire allegation could not be proven. Sufficient evidence was obtained to support a portion of the entire allegation or to support a finding that some form of unreasonable force, differing from that described in the allegation, was used. For example, an inmate may have alleged that three ACOs repeatedly punched and kicked him, but there was sufficient evidence only to conclude that he was punched once by a single ACO. Or an inmate may have alleged that he was punched by an ACO, but the evidence was sufficient only to establish that he was slapped.

The findings were limited to what was supported by the evidence, although it was sometimes suspected that a greater degree of force had been used. For example, an inmate alleged that he was punched several times by an ACO near Control Station 4. The ACO testified that he only shoved the inmate, in a thrusting manner, with an open hand against the inmate's shoulder. Another ACO, who said he was present, corroborated the ACO's statement as to the force used. However, testimony from staff members who observed the inmate's physical condition, after he had passed Control Station 4, seemed to indicate that a greater degree of force was used. In addition, other staff testimony refuted other portions of the accused ACO's testimony. Despite reservations about the accused ACO's credibility, the ACO was found responsible only for shoving the inmate since there was no other direct evidence that the ACO repeatedly punched the inmate.

Of the 48 allegations where there was sufficient evidence to conclude that unreasonable force was used, 20, or 42%, occurred on Tuesday, December 15, 1981, during the return of the inmates from the recreation field to the cellblock. One occurred in the corridor by Module 11, four in or by Control Station 4, two in the corridor leading to the 4-way, six in the 4-way, six in the corridor from the 4-way to the cellblock, and one in a holding room inside Module 5.

A total of 26 of the 48 allegations, or 54%, occurred on Wednesday, December 16, 1981. Fourteen of the 26 cases occurred in the 4-way. Of the remaining 12 cases, one occurred in the corridor leading to the 4-way; one in a corridor just outside the 4-way after the inmate was searched; five in the modules as the inmates were initially strip searched or just outside the module as the inmates left; three during the return of the inmates from the recreation field to a module; and two were unrelated to the shakedown activities and occurred in other parts of the facility.

Only two of the 48 allegations, or 4%, occurred on Thursday, December 17, 1981. One was related to the shakedown, and it occurred during the return of the inmates to a module from the recreation field. The other case took place in the Holding Unit and was unrelated to the shakedown.

Thus, of the 48 allegations, 20, or 42%, occurred in the 4-way and 28, or 58% of the total, occurred in other areas of the facility.

Findings regarding the 44 inmates in which there was sufficient evidence that unreasonable force was used. In 15 of the 44 inmate cases in which unreasonable force was used, there was insufficient evidence to prove which person or persons were responsible. In some cases, the inmates were unable to identify the persons responsible. In other cases, although the inmates identified and accused certain staff members, there was insufficient evidence to prove that such persons were responsible.

However, in 29 of the 44 inmate cases, there was sufficient evidence of the persons responsible for the use of unreasonable force.

Findings regarding the 48 allegations. In 17 of the 48 allegations in which there was sufficient evidence of the use of unreasonable force, there was insufficient evidence to prove which person or persons were responsible. However, there was sufficient evidence to prove which persons were responsible for the use of unreasonable force in 31 of the 48 allegations. The 31 allegations stemmed from 29 inmate cases because two inmates each had two allegations in which there was sufficient evidence of the persons responsible.

Findings concerning the inmate cases and allegations in which there was sufficient evidence of persons responsible are summarized in Table 9.

Table 9

INMATE CASES AND ALLEGATIONS IN WHICH THERE WAS SUFFICIENT EVIDENCE OF PERSONS RESPONSIBLE

	No. of Cases (Inmates)	No. of Allegations
Number with sufficient evidence of unreasonable force	44 (100%)	48 (100%)
Number in which insufficient evidence of persons responsible	-15 (34%)	-17 (35%)
Number in which sufficient evidence of persons responsible	29 (66%)	31 (65%)

Summary of findings regarding the use of unreasonable force against inmates. The analysis and evaluation of the inmate cases and allegations required sifting through all of the cases and allegations. Cases and allegations with insufficient evidence were identified and set aside. We found that unreasonable force was used against 44 inmates. Thereafter, cases and allegations in which there was insufficient evidence as to the persons responsible were also set aside. The remaining cases and allegations were those with sufficient evidence of persons responsible for the use of unreasonable force. The process of elimination is summarized in Table 10.

Table 10

SUMMARY OF FINDINGS REGARDING THE USE OF UNREASONABLE FORCE

	Number of Cases (Inmates)	Number of Allegations
Total number	103	121
Less those with findings of insufficient evidence	-59	-73
Findings of sufficient evidence	44	48
Less those with insufficient evidence of persons responsible	-15	-17
Findings of sufficient evidence of persons responsible	29	31

The 29 inmate cases and the 31 allegations with sufficient evidence of persons responsible for the use of force are further discussed in the following section.

The Staff Members Responsible for the Use of Unreasonable Force

Reported in this section are findings regarding staff members found to be responsible for the use of unreasonable force.

Findings regarding accusations against staff members. As noted in Table 11, a total of 233 accusations against identified ACOs and police officers were investigated.

Table 11

FINDINGS REGARDING ACCUSATIONS AGAINST IDENTIFIED STAFF MEMBERS

	Against OCCC ACOs	Against HHSF ACOs	Against HPD Officers	Total
Number of accusations against identified persons	132 (100%)	88 (100%)	13 (100%)	233 (100%)
Number of accusations with insufficient evidence	-100 (76%)	-80 (91%)	-13 (100%)	-193 (83%)
Number of accusations with sufficient evidence	32 (24%)	8 (9%)	0 (0%)	40 (17%)

Of the 233 accusations, there was insufficient evidence to support 193, or 83%. There was sufficient evidence to support 40, or 17% of the total. The 40 accusations outnumber the 31 allegations noted in Table 10 because more than one person was found responsible for the use of unreasonable force against a single inmate.

Of the 132 accusations against OCCC ACOs, there was sufficient evidence to support 32, or 24%. The 32 accusations involved the use of unreasonable force by 17 OCCC ACOs, since several ACOs used unreasonable force against more than one inmate.

Of the 88 accusations against HHSF ACOs, there was sufficient evidence to support eight, or 9%. The eight accusations involved the use of unreasonable force by seven HHSF ACOs, since one ACO used unreasonable force on two occasions.

There was insufficient evidence to support the 13 accusations against the four HPD officers. Although there was sufficient evidence that unreasonable force was used in two instances against inmates in Control Station 4 by police officers, there was insufficient evidence to prove which police officers were responsible.

Findings regarding accused staff members. As noted in Table 12, there was sufficient evidence to conclude that 24 identified ACOs, 17 from the OCCC and 7 from the HHSF, were responsible for the use of unreasonable force against inmates.

Table 12

FINDINGS REGARDING ACCUSED STAFF MEMBERS

	OCCC ACOs	HHSF ACOs	HPD Officers	Total
Number of persons accused	42 (100%)	26 (100%)	4 (100%)	72 (100%)
Number of persons against whom there was insufficient evidence	-25 (60%)	-19 (73%)	-4 (100%)	-48 (67%)
Number of persons against whom there was sufficient evidence	17 (40%)	7 (27%)	0 (0%)	24 (33%)

There were four instances in which there was insufficient evidence to prove which person or persons used unreasonable force against an inmate while the inmate was strip searched. However, there was sufficient evidence that such force was used against the inmate while being searched by a team under the supervision of an identified sergeant. It was the responsibility of the sergeant to prevent the use of unreasonable force against inmates as they were searched by his team. Therefore, the sergeant was held responsible for the use of unreasonable force in those four instances.

For example, a sergeant and one of the two ACOs who were members of the sergeant's strip search team acknowledged

searching a particular inmate. Both the sergeant and the ACO stated that the search was routine and that no force was used against the inmate. However, several staff members and inmates testified that the inmate was punched, slapped, and shoved during the search. There was insufficient evidence to prove which specific individuals used such force against the inmate. However, because there was sufficient evidence that the sergeant's team searched the inmate and that unreasonable force was used against the inmate during the search, the sergeant was held responsible.

Disposition of cases with sufficient evidence of persons responsible for the use of unreasonable force. Of the 24 ACOs found to have used unreasonable force, two were not interviewed. Their cases were transmitted to the DSSH for informational purposes. The cases involving the remaining 22 ACOs were referred to the Department, for action deemed appropriate, through a confidential attachment to this report.

The confidential attachment is composed of written summaries of all 24 cases. The summaries include the identities of inmates and staff members involved in each case and the supporting or contradicting testimony of each. The Department was advised that a written response, explaining its decision in each case, was required.

Summary of Findings Regarding Inmate Allegations and Accusations

There was sufficient evidence to conclude that unreasonable force was used against 44 inmates during the shakedown. There was also sufficient evidence that 24 ACOs from the OCCC and the HHSF were responsible for the use of such force. In nearly every case, corroborating testimony was received from staff members. The number of staff members responsible for the use of unreasonable force actually exceeds 24, as there was insufficient evidence to prove which staff members were responsible for having used such force against 15 inmates.

B. Other Findings and Conclusions

This section reports the findings with regard to the general allegations that were received by the office, as well as other significant findings which resulted from the investigation.

There Was Sufficient Evidence of Breach of Duty or Misconduct by Supervisory Personnel

There was sufficient evidence of breaches of duty or misconduct by 12 OCCC and HHSF supervisory personnel, ranging in rank from ACO sergeants to corrections administrators. None of the supervisors were responsible for using unreasonable force against an inmate. Instead, the cases involved the failure of supervisory personnel to intervene when unreasonable force was used in their presence, the failure to subsequently report the use of such force to their superiors, the failure to adequately investigate after receiving information that such force may have been used, or other administrative failings. A few summarized case examples are included in Appendix G of this report.

Disposition of cases in which there was a possible supervisory breach of duty or misconduct. The 12 cases of supervisory breaches of duty or misconduct were referred to the DSSH through a confidential attachment to this report. Written summaries similar to those already described were included in the attachment. The cases were referred for action deemed appropriate by the Department, and the Department is to respond to each referral in the same manner as required in the 22 ACO cases referred.

There Was Insufficient Evidence to Conclude that the Use of Unreasonable Force Against Inmates Was Planned and Directed by High-Ranking Officials of the DSSH, CD, OCCC, and HHSF

There was insufficient evidence to support the allegation that high-ranking officials directed or planned the beating of inmates. To the contrary, there was poor coordination and communication between high-ranking officials and the personnel who performed the shakedown tasks. For example, the OCCC Administrator, who had authority over all matters pertaining to the shakedown, testified that he was unaware of the decision to permit the HHSF personnel to conduct the strip searches of the inmates as they returned to the cellblock until after the strip searches had commenced.

On Tuesday, December 15, 1981, personnel from the HHSF were in total control of the strip search operation in the 4-way. High-ranking officials of the DSSH, CD, and OCCC were usually in the Command Post and, to a large extent, were uninformed as to what was actually taking place in the 4-way. On Wednesday, December 16, 1981, the OCCC ACOs were in control of the 4-way and the high-ranking officials were usually in the Command Post. They were again generally uninformed as to what occurred in the 4-way.

There was insufficient evidence to prove that high-ranking DSSH, CD, OCCC, or HHSF officials planned or directed the use of unreasonable force against any of the 44 inmates in whose cases the use of unreasonable force was found. There was insufficient evidence to prove the existence of a plan or that unreasonable force against inmates was used in an organized manner. Nor was there evidence that such officials engaged in a "cover-up" or attempted to stymie our investigation. To the contrary, the officials were cooperative with our investigative efforts.

There Was Insufficient Evidence to Conclude that A Plan of Reprisal Was Implemented Against Inmates, Who Engaged in Abusive Conduct Toward Staff Members, on Tuesday, December 15, 1981

There was insufficient evidence to conclusively prove the existence of a plan to identify and beat inmates who were abusive toward staff members while in the recreation field during their return to the cellblock on Tuesday. There was also insufficient evidence that OCCC ACOs identified inmates to be beaten, through hand signals to HHSF ACOs, and that an OCCC ACO warned inmates in the recreation field that those who behaved abusively were to be beaten during their strip searches. However, there was some evidence to suggest that identification and selection of inmates may have occurred.

There was evidence that unreasonable force was used against two inmates in a retributive manner. Both cases involved the use of such force by OCCC ACOs, in retaliation for verbal abuse, as the inmates were enroute to the 4-way.

In addition, two OCCC staff members who were present in the 4-way during the strip searches testified that HHSF ACOs appeared to be getting back at inmates who had behaved abusively. One staff member said he heard HHSF ACOs select the inmates whom they wanted to search, and it was his feeling that the ACOs were retaliating against these inmates. Another staff member stated that HHSF ACOs talked about the identity of inmates who behaved abusively and that not many inmates other than those who were talked about "went down."

Additional staff testimony implied that HHSF ACOs may have retaliated against inmates for having engaged in abusive conduct toward staff members. The former CDAA stated that the HHSF Administrator expressed anger and commented that "no way" would he allow HHSF staff members to be subjected to the kind of verbal abuse that was received by OCCC staff members. Other HHSF personnel were also upset over the abuse that they themselves received from the inmates. Testimony was received that HHSF personnel

attempted to identify abusive inmates and one staff member testified that before the searches of the inmates began, he saw a list of inmates to be transferred to the HHSF. High-ranking OCCC officials testified that the HHSF volunteered to conduct the strip searches to identify and pull aside inmates who behaved abusively for transfer to HHSF. One staff member reportedly overheard the HHSF Administrator comment, with regard to the inmates, "We going teach them to be respectful."

However, the HHSF personnel vehemently denied using retaliatory force against inmates. HHSF personnel also denied any attempt to identify abusive inmates and that a list of such inmates was compiled. They said that they received a written list of inmates to be transferred from the OCCC, and the evidence indicated that the list was compiled by an OCCC staff member and represented inmates who were taken to Module 5 for transfer to the HHSF. The HHSF Administrator denied commenting that they would teach the inmates to be respectful. HHSF personnel maintained that they volunteered to conduct the strip searches only to prevent the inmates from smuggling contraband back into the cellblock. High-ranking HHSF staff members contended that the transfer of inmates to the HHSF was determined solely by the conduct of the inmates during the strip search in the 4-way.

Similarly, the TOD police officers each testified that they did not use force against any inmates in retaliation for abuse received, although they generally acknowledged that they were targeted for verbal abuse from the inmates in the recreation field. None of the officers indicated that they used any force against any of the 103 inmates whose cases were investigated. However, one officer said that there were many challenges from the inmates and he provided the following testimony:

> "And there was a number, sure, I would have like to have been in a situation to allow them to try, but in there, there was no time. And like I said, I couldn't I.D. the sources of these comments, so there was nothing I could come out and say, 'Oh, this is the guy that did this.'
>
> "There were comments from the guards, like if there were guys that we wanted to do anything to, you know, we could be put in a position, if we wanted to, to 'talk' to these guys, whatever was necessary in this 'talking' process. But I told the guy, I cannot I.D. If I cannot I.D., then...."

Although the officer indicated that he could not identify the inmates who were abusive toward him and was therefore unable to accept the ACOs' offer, it is significant that such an offer was made. The offer implied more than the opportunity to

converse with an inmate and suggested that the ACOs making the offer sanctioned retaliation against inmates for their abusive behavior.

There was sufficient evidence that unreasonable force was used in 20 instances on Tuesday, December 15, 1981. However, in nearly all cases, there was insufficient evidence that retaliation was the motive for the use of unreasonable force. Although there were a few sporadic instances in which force was used in a retaliatory manner, such force was used by staff members acting individually rather than in accordance with a plan of reprisal.

There Was Sufficient Evidence to Conclude that OCCC ACOs Used Unreasonable Force Against Inmates because of Past Grudges and that, at Times on Wednesday, December 16, 1981, the Prevailing Sentiment Encouraged the Use of Unreasonable Force

A convincing amount of testimony was received from staff members that OCCC ACOs "evened old scores" with inmates during the shakedown. For example, one ACO, when asked if there was a feeling among the ACOs to "get even" with the inmates during the strip searches in the 4-way on Wednesday, responded:

> "There was that kind of feeling. I'm not going to deny the fact, yeah, there was that kind of feeling.... They had that feeling, the 'gung ho' feeling, you know, 'this is our time'."

Another ACO described a more specific example of the use of unreasonable force in retaliation for past conduct by inmates. He indicated that prior to the shakedown, an inmate had assaulted him. The ACO recounted his own use of unreasonable force against the inmate, with the assistance of other ACOs, as the inmate returned to his module from the recreation field:

> "The men were quite aware of the fact that [inmate's name deleted] had attacked me in the backyard. So they wanted to set him up for me, to whack him.... When he came back through, they detained him for me. They stood him up against the wall.... I just slapped him.... I was criticized later for not hitting him harder."

Other testimony indicated that peer pressure influenced some ACOs to use unreasonable force against inmates. One ACO testified that he and another ACO intervened after an ACO delivered a hard slap to an inmate's face without reason. That ACO described a subsequent conversation with the ACO who slapped the inmate:

> "He told me that everyone else was doing it so he just lost his head and he just joined in. It seemed to be the thing to do."

Other examples of similar testimony, indicating that ACOs "evened old scores" or were influenced by peer pressure to use unreasonable force, are found on pages 26 and 27 of this report.

Some of the testimony indicated that ACO supervisors also contributed to the prevailing sentiment among the ACOs. For example, one ACO said that he was upset about the unreasonable use of force in the 4-way and related what he said to the highest-ranking ACO who was present and supervised all of the ACOs in the 4-way:

> "I told [name deleted] that, as far as I was concerned, that I knew what was going on in the 4-way and I did not condone that bullshit and I would not have any part of it in any manner. And that probably the wisest thing he could do was to make damn sure that I was assigned duties somewhere away from the 4-way.... And that I would be able to remember and record quite vividly what I saw...."

The only reaction of the ACO supervisor was to assign the ACO to a post away from the 4-way, rather than attempting to determine whether there were substantive reasons for the ACO's concerns that unreasonable force was being used. Although other inferences can be drawn from the reaction of the supervisor, in the context in which the ACO testimony was received, the impression of the office was that the ACO supervisor condoned the use of unreasonable force.

Other testimony was received which implicated OCCC ACO supervisors in the use of unreasonable force against specific inmates in retribution for past acts. For example, an ACO testified that he was told by an OCCC ACO supervisor to position himself outside the 4-way and to point out a particular inmate, who had previously "wised off", when the inmate approached the 4-way. He said that the inmate was taken into the 4-way, was kicked, and bled from the forehead.

Based on the cumulative effect of all testimony received, it was concluded that OCCC ACOs occasionally used unreasonable force against inmates because of past grudges and that, at times, the prevailing sentiment among the ACOs and their supervisors encouraged the use of unreasonable force against inmates. Both occurrences seemed spontaneous, rather than planned.

There Was Sufficient Evidence to Conclude that the CCTV Camera and Some of the 4-way Walls Were Covered on Tuesday and Wednesday, but There Was Insufficient Evidence to Conclude that the Coverings Were Intended to Conceal Inmate Beatings

Inmates stated that measures were taken to conceal beatings in the 4-way. These included covering the clear plastic walls of the 4-way, covering the CCTV camera positioned in the 4-way, and the issuance of orders to inmates housed in rooms of modules with a view of the 4-way to cease their observations.

Although there was testimony that the walls were not covered on Tuesday, on the basis of more reliable testimony it was concluded that at least one of the 4-way doors and the corner of the 4-way closest to the modules in which the female inmates were housed were covered. An OCCC ACO testified that he personally covered those areas of the 4-way on Tuesday before the strip searches began. Based on the consensus of the testimony, it was concluded that most, if not all, of the 4-way walls were covered on Wednesday. However, some of the walls were not covered until a portion of the strip searches that day had been completed.

Despite the allegation that the 4-way walls were covered to conceal inmate beatings, staff members contended that the intent was to protect the privacy of the inmates, since female inmates and staff members would otherwise be able to observe the strip searches.

Similarly, the covering of the CCTV camera in the 4-way was intended to protect the privacy of the inmates during the strip searches. Reportedly, during the initial minutes of the strip searches on Tuesday, female staff members witnessed the searches through a CCTV monitor in the Central Control Station. The camera was reportedly covered to prevent such observations, and there was no dispute that it was covered during almost all of the strip searches on Tuesday and Wednesday.

The staff explanation for the covering of both the 4-way walls and the CCTV camera, although plausible, was undermined by several related factors. For example, female employees could have been ordered away from the CCTV monitors. Corrections officials acknowledged that this was a viable option.

None of the staff members acknowledged covering the camera, ordering that it be covered, or having any precise knowledge as to how that decision was made. According to one of the OCCC ACOs who manned the Central Control Station, where the CCTV screens are monitored, the decision to cover the camera was apparently made in the 4-way. However, they received no communication from the 4-way of the reason the camera was covered. Nor was the

decision to cover the camera made in the Command Post, or reported to the Command Post by personnel in the 4-way, according to the testimony of high-ranking officials. That the decision was made in the 4-way, that it was not communicated directly to either the Central Control Station or the Command Post, and that persons who were in the 4-way subsequently professed a lack of knowledge as to the manner in which the decision was made, makes suspect the stated rationale for covering the camera.

Another occurrence on Tuesday appears to be inconsistent with the stated concern for inmate privacy. A training instructor of the CTC operated a video camera within, and immediately outside, the 4-way. According to his testimony, his intent was to produce a videotape for training purposes. Although much of the film was inadvertently ruined, the videotape did include portions of the search of a naked inmate. The filming of inmate strip searches, for use in the training of staff members, seems similar to the intrusion on inmate privacy that would have occurred if the CCTV camera or the 4-way walls had not been covered. However, there was no objection to videotaping the process.

Testimony was also received that, on Wednesday, inmates were forced to walk naked out of the 4-way and back to their modules until the practice was stopped by high-ranking officials. Both the former CDAA and the OCCC Chief of Security acknowledged that this occurred and the Chief of Security noted that the practice negated the intended purpose of covering the 4-way walls since the naked inmates could be observed by female inmates and staff members. That occurrence casts doubt as to whether those conducting the strip searches were, in fact, concerned about the privacy of the inmates.

Rather than attempting to protect the privacy of inmates, other testimony suggested that the ACOs conducting the strip searches on Tuesday wished to conceal from witnesses possible improper conduct on their part. A few staff members testified that the HHSF ACOs warned each other of the approach or presence of "outsiders", such as OCCC officials or AG personnel. One ACO testified that it appeared to him that the HHSF ACOs "settled down" when such warnings were given and that they were not "dumb enough to do it in front of somebody." However, another ACO described the circulation of such warnings as a routine occurrence in an institution. The HHSF ACOs and officials, with one exception, denied that any such warnings were circulated.

Staff testimony indicated that orders were issued to inmates in rooms of modules overlooking the 4-way to cease their observation of the activities in the 4-way on Tuesday and Wednesday. The orders were issued because staff members felt that the strip search operation was not the affair of inmates, and the inmates made obscene gestures to staff members who were in the corridors and in the 4-way. Corroborating testimony was received from some inmates that they pounded on the windows of their rooms and gestured at the staff members.

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In summary, there is no doubt that some of the walls of the 4-way and the CCTV camera in the 4-way were covered during the inmate strip searches. The high-ranking officials in the Command Post did not make the decisions to cover the CCTV camera and the 4-way walls. Rather, the decisions were made by those in the 4-way, without the knowledge and consent of officials in the Command Post. Upon learning of the coverings, the officials failed to take any action. The stated rationale for those coverings was to protect the privacy of the inmates who were being searched, but there was evidence which was inconsistent with that rationale.

Although the stated rationale can be questioned, there was insufficient evidence to prove that the coverings were intended to conceal inmate beatings in the 4-way.

There Was Sufficient Evidence to Conclude that Unreasonable Force Was Used Against Inmates in 48 Instances but There Was Insufficient Evidence to Conclude from Those Instances that the Inmates Were Brutalized during the Shakedown

Since the investigation was focused on determining whether unreasonable force was used against inmates, and because any form of unreasonable force is prohibited, it was unnecessary to operationally define differing degrees of unreasonable force. However, since allegations were made that many inmates were brutalized, an opinion should be expressed as to whether the unreasonable force used rose to the level of "brutality."

The term "brutality" is emotionally charged and means different things to different people. However, Webster's Third New International Dictionary defines the word "brutal" as: "...stemming from or based on crude animal instincts: grossly ruthless: devoid of mercy or compassion: cruel and cold-blooded." Thus, brutality was considered to be an extremely cruel, grossly ruthless, or animalistic form of unreasonable force. While brutality is one form of unreasonable force, obviously not every instance of the use of unreasonable force constitutes brutality.

In order to express an opinion, the 44 inmate cases in which it was found that unreasonable force was used were reviewed and the definition from the dictionary was applied. In many cases, the evidence was sufficient to conclude only that a single ACO employed unreasonable force against an inmate, usually in the form of one or two blows. There was insufficient evidence to support allegations that inmates were struck in the genitals, or that inmates were beaten to the point of being comatose, or that other very serious allegations of this nature occurred. In fact, many of the allegations made by the inmates themselves did not appear to rise to the level of brutality.

There was, however, some evidence of the use of unreasonable force that others may label "brutality." For example, there was evidence that some inmates may have been struck with batons on Tuesday, December 15, 1981. The facility physician and a Medical Unit staff member both testified that they saw bruises or welts, several inches long and an inch or two wide, on the bodies of inmates. The Medical Unit staff member concluded that the inmates had been struck with an object. Two HNG medics also testified that they saw long, narrow welts on inmates' bodies and one of the medics was of the opinion that the welts were of the sort that would be incurred by a person who was struck with a stick. Two OCCC ACOs testified that they observed inmates with long, narrow welts or bruises on their bodies and one of the ACOs stated that it looked as though the inmates had been struck with a hose or a stick. However, with one exception, the inmates could not be positively identified, since the welts were not documented in the medical records or other inmate records.

In addition, there were cases in which unreasonable force used was demeaning to the inmates. For example, an ACO forcibly shoved a bar of soap into an inmate's mouth. This was apparently done because the inmate was suspected of throwing a bar of soap which struck another ACO, requiring treatment of that ACO at a hospital, in an incident prior to the shakedown. While the motive of the ACO who shoved the soap into the inmate's mouth may be considered by some as "rough justice", it was concluded that unreasonable force was used against the inmate. The method of retribution was clearly beyond the prescribed means of dealing with suspected inmate misconduct and was demeaning.

There were also several cases in which more than one ACO was found to be responsible for the use of unreasonable force against an inmate. In two of these cases, there was sufficient evidence that other ACOs intervened and physically prevented the continued use of unreasonable force against an inmate. An ACO, who intervened in one of the incidents, described it in the following manner:

> "...I couldn't stand it already.... First they went tune him up. I seen guys walk up to him when he came down for the search and they went whack him, two or three whacks, big guys. But he no say nothing, the kid, he took the licking. I figure pau already, whack him four or five times, pau.
>
> "Then after that, the other guys start jumping in, start hitting him this and that, guys start yanking him. Just like the guy was, you know, just like when you one prisoner of war. The mob go crazy, that's exactly what happened to the kid.

"So I saw that, I went grab the kid. Put my hand inside, I pull him, I grab him, I lift him right up. The kid maybe 150 pounds, I went lift him right up.... I went pick up the kid, I went carry him down [the corridor away from the 4-way].

"I think I did wrong, because right there the staff looking funny kind towards me. Then the prisoners went go spread the news I went go save the kid. Then that's bad, just like I backing up the prisoners. Nah, I never go there for back up nobody. I went there because I felt what they was doing, they was overdoing it. So I felt that was time for stop already."

Testimony from other staff members corroborated the ACO's contention that more than one ACO was involved in the use of unreasonable force against the inmate and that the ACO intervened and removed the inmate from the 4-way. However, the net effect of all the testimony received about this case was that there was sufficient evidence to only conclude that the inmate was slapped by one ACO and struck by two others.

There was insufficient evidence to prove that the unreasonable force used against the 44 inmates rose to the level of brutality. The office is cognizant that, in those cases in which other ACOs felt compelled to intervene, or in the case of an inmate being struck by a baton, the label of "brutality" may arguably be used. However, the opinion of the office is that the term "brutality" would misrepresent the proof of the severity and nature of the unreasonable force used. Thus, while unreasonable force was used against 44 inmates, there was insufficient evidence to conclude from those cases that the inmates were brutalized.

There Was Insufficient Evidence to Conclude that, after the Strip Searches on Tuesday and Wednesday, the 4-way Was Covered with Blood

Some inmates alleged that during the strip searches, many inmates were beaten so severely that blood was on the floor and splattered on the walls throughout the 4-way. However, the testimony from staff members and most inmates did not support the allegation. Such testimony indicated that there were a "few drops" or small quantities of blood in a few areas, including the corridor from the 4-way to Module 5, and in the 4-way itself; or that there was no blood at all. Thus, there was insufficient evidence to conclude that the 4-way was covered with blood.

There Was Sufficient Evidence to Conclude that Nearly All Inmates Received Timely Medical Treatment; However, in Two Instances, Timely Medical Treatment Appears to Have Been Prevented by HHSF ACOs

As documented in inmate medical records, timely medical attention was provided to 23 inmates for injuries they reportedly sustained during the shakedown. After the strip searches were completed on both Tuesday and Wednesday, medical staff members went to the inmate residential units to check on inmates who might require medical attention and inmates who were in need of such treatment were sent to the Medical Unit. On Wednesday evening, the medical staff directed ACOs to bring injured inmates from the Holding Unit to the Medical Unit for treatment. In addition, medical staff continued to make its scheduled rounds through the facility during the shakedown.

However, on Tuesday evening, there were two instances in which timely medical attention was prevented. In one case, the inmate was reportedly beaten, while handcuffed, by an HHSF ACO. Staff testimony was received that the inmate was struck as he was escorted to Module 5 and again after he was placed in a holding room in the module. The inmate's medical records indicate that he was removed from the holding area before he could be medically evaluated. The inmate stated that it was not till nine days after his transfer to the HHSF that he received medical care.

In the other case, it was noted in the medical records that the inmate appeared to have been hit and was bleeding from the forehead. However, this inmate was also removed from a holding room before he could be medically evaluated. Medical staff testified that although they wanted to examine the inmate, they were prevented from doing so by an HHSF ACO who swore at them and told them to "mind your own business." The HHSF ACO reportedly stated that the inmate would receive medical attention at the HHSF after he was transferred. However, the medical staff noted that the OCCC physician, who was at the OCCC at the time, also served as the physician for the HHSF and would be unavailable to the inmate at the HHSF that evening. The inmate stated that he assumed he would not receive medical treatment at the HHSF, even if he requested it, and he therefore made no such request.

The dispute between the HHSF ACO and the OCCC Medical Unit staff raised the issue as to whether the medical staff had the authority to provide treatment to inmates as they deemed necessary. According to the medical staff, they posed the question to a staff member in the Command Post and were initially told that the HHSF was in control. Therefore, the medical staff requested written orders stating that HHSF personnel were authorized to determine which inmates the Medical Unit would be permitted to

treat. The staff member, after consulting with someone in the Command Post, then advised the medical staff that they retained the authority to provide treatment to inmates as they deemed necessary. When the staff member in the Command Post was interviewed, he essentially denied the above version of the interaction.

In addition to the cases of the two inmates described above, a few inmates alleged that they were either denied medical attention that they requested or that the attention they received was delayed by a day or two because of the failure of ACOs to permit them access to the Medical Unit. However, their allegations could not be proven. Nearly all inmates indicated that they were not denied medical attention or stated that such attention was provided on a timely basis.

In summary, adequate and timely medical treatment was provided in nearly all cases; and the OCCC Medical Unit staff cannot be faulted for the manner in which they carried out their responsibilities. In those cases in which inmates were denied medical attention or when such attention was delayed, the problem was allegedly due to the failure of ACOs to follow through.

There Was Sufficient Evidence to Conclude that the OCCC Strip Search Operation in the 4-way on Wednesday Was Disorganized and Poorly Supervised

Many staff members, including OCCC ACOs, felt that the OCCC strip search operation was very disorganized and confused. The assignment of ACOs to the 4-way appeared to have been done in a haphazard manner, and ACOs came to the 4-way as they completed other assignments or left the 4-way to perform other duties. The 4-way appeared to be a gathering place for ACOs who were not assigned other specific duties during the time that the strip searches were being conducted.

The membership of the OCCC strip search teams was ill-defined. ACOs moved from team to team, apparently at will, and the number of ACOs on a team ranged from three to six.

The OCCC strip search teams were not as structured as the HHSF strip search teams of the previous day, as each team was not supervised by a sergeant who had responsibility to monitor the searches and control the ACOs on the team. Since many of the teams were without a ranking ACO in charge, ACOs testified that they "guessed" that the ACO on their team with the most seniority was the person in charge. Thus, there were no clearly defined lines of authority within each strip search team.

According to some staff members, another factor which contributed to the disorganization and confusion during the OCCC strip searches was the lack of leadership over the total operation. Based on their testimony, the highest-ranking officer present in the 4-way for any significant period of time during the strip searches was a lieutenant. The Chief of Security and all of the ACO captains did not spend any significant amount of time in the 4-way while the strip searches were being conducted.

Adding to the confusion was the lack of prior training and practice of OCCC ACOs in properly conducting strip searches. Many ACOs testified that they felt they were inadequately trained, since they had infrequently conducted strip searches prior to the shakedown.

In summary, all of the above-mentioned factors contributed to the disorganization and confusion during the OCCC strip search operation.

There Was Sufficient Evidence to Conclude that Many OCCC Staff Members Believed that the OCCC Administration Knew of and Condoned the Inmate Beatings

Many OCCC staff members believed that unreasonable force was used against inmates during the shakedown, and some expressed anger or disappointment that this occurred. They felt that the OCCC administration was aware that unreasonable force was used. Since they perceived no administrative attempt to halt its use, these staff members concluded that the administration condoned the use of unreasonable force against inmates.

Their belief that the administration knew of and condoned the use of unreasonable force was generally not supported by the staff members' knowledge of any administrative failure to act in response to a specific incident. Instead, staff members concluded that it was common knowledge among those present at the facility that unreasonable force was used and, therefore, they believed that its use was known to the administration.

For example, a staff member testified that the OCCC ACOs behaved unprofessionally and retaliated against inmates for past grievances. When asked if the OCCC administration knew what occurred, the staff member provided the following testimony:

> "Yes, sir, definitely. Everybody that worked at OCCC, I think, was aware of what was taking place. Not only with Halawa, but also with the shakedown that OCCC was involved in."

When asked if the OCCC administration knew what was happening in the 4-way, another staff member responded:

> "Well...tempers were hot, there's no doubt about it, and I kept hearing rumors from where I was, you know, at the places I was working...certain people got hit up there in the 4-way.... I assume all heads were up in the Command Post on the second floor of Module 9. So, unless they sat around and drank coffee, they basically had to know at the time things were going on what was happening."

The statements cited above are representative of the testimony of staff members who believed that the OCCC administration knew of and condoned the use of unreasonable force.

Even if the OCCC administration was unaware of the use of unreasonable force against inmates, the fact that many staff members believed that the administration knew of and condoned the use of such force portends continued problems. If employees believe that the administration condones or tacitly approves the use of unreasonable force, they are more likely to use such force; and the control of staff conduct is more difficult. Indicative of this problem is the following testimony from the OCCC Administrator, who described meetings that were held with ACOs after four ACOs were arrested and criminally charged for having used unreasonable force against an inmate after the shakedown:

> "There were a few ACOs...from that meeting, they were saying: 'Eh, what about you guys during the shakedown...when Halawa was busting up guys, you guys never do nothing. Then we do the same thing, we get arrested.'
>
> "You know, that kind of thing, they trying to tie in different kind of things, different kinds of incidents into the same situation. And we tell them that--and it was very hard to talk to them at that point because their fellow ACOs got arrested--we tried to explain to them that at the time that the shakedown was going on, the kind of information we were receiving, or not receiving, was there was no indication that such was the case. The matter of the four ACOs being arrested deals with an entirely separate issue. But I know there were some ACOs who to this day are tying in all these different situations and feel that we are not backing them up."

The OCCC Administrator stated that the administration has tried to convince ACOs that it does not condone the use of excessive force against inmates, but that this has been a difficult point to get across:

> "We've tried to push this across to them time, and time, and time again. Even till today, even till today, guys still don't understand that."

However, in several instances during the shakedown, inadequate action was taken when information pertaining to the possible use of unreasonable force came to the attention of various high-ranking officials of the OCCC. It is reasonable for staff members to construe the lack of adequate action by the administration as tacit approval of the use of unreasonable force and words alone will not suffice to convince them otherwise. To convince staff members that the OCCC administration will not tolerate the use of unreasonable force against inmates, thorough investigation and disciplinary action against employees, if warranted, must be carried out in a timely and consistent manner.

There Was Sufficient Evidence to Conclude that There Was Collaboration by HHSF Personnel in Preparing Incident Reports Documenting Inmate Misbehavior and, in Some Cases, the Accuracy of the Reports Can Be Questioned

HHSF ACOs prepared incident reports pertaining to eight inmates. Each of the inmates was charged with committing a misconduct during the strip search on Tuesday, December 15, 1981, and seven of the inmates were transferred to the HHSF. The eighth inmate, described as being hysterical after he was strip searched, was also to have been transferred but was not.

The incident reports were used to support charges against each of the seven inmates transferred to the HHSF, and each was found guilty of misconduct. No disciplinary action was apparently taken against the inmate who was not transferred to the HHSF, although the inmate was charged with assaulting and threatening a correctional worker.

Collaboration in report writing. In each of the eight cases, three HHSF ACOs prepared incident reports describing the same incident. Based on testimony of HHSF administrators, incident reports are to be prepared independently by each ACO, with each ACO describing what he personally recalled of the incident.

However, the ACO descriptions in the reports of the same incidents were nearly identical and what an inmate reportedly said was frequently quoted "word-for-word" by each ACO. It is unlikely that each of three ACOs, who prepare their reports independently, would be able to relate what the inmate said in exactly the same words.

A total of 24 incident reports were prepared by 18 HHSF ACOs. Fifteen of these ACOs were asked whether there was any collaboration in preparing the reports.

Of the 15 ACOs, eight testified that the reports were independently prepared and that there was no collaboration among the ACOs who reported on the same incident. However, such testimony was questionable for reasons as illustrated in the following exchange with an ACO who indicated that he had independently written his report:

Ombudsman's Office (O): "You mention in your report that [an inmate] had 'contusions' and 'abrasions'. What do you mean by 'contusion' and 'abrasion'?"

ACO: "In other words, what? I don't even know what is that word, is 'contusion'. What is that, 'contusion'?"

O: "Well, it's in your report, see."

ACO: "Yeah, but the word you using, what is that, 'contusion'?"

O: "Contusion."

ACO: "Contusions. And the other one was what?"

O: "Abrasion."

ACO: "In other words, what that means?"

O: "That's what I'm asking you, what did you mean when you wrote it in your report?"

ACO: "What you saying? What is that word? I don't know.... 'Contusions', first time I ever heard the word."

The exchange clearly indicated that the ACO was unfamiliar with the words "contusion" and "abrasion", although those words were contained in an incident report that he claimed he prepared independently.

The remaining seven ACOs acknowledged that they discussed the incident with the other ACOs who wrote reports on the same incident or that they reviewed each other's reports. One ACO stated:

> "On this one, on the report writing one, we did it all together, you know.... I not going lie. We did it together, we discussed things."

The ACO went on to say that it was a routine practice among HHSF ACOs to discuss an incident when they were required to write reports. Two other ACOs also testified that it was a routine practice. In addition, a high-ranking HHSF staff member testified that HHSF ACOs worked on their reports together on Wednesday, December 16, 1981, in a room in Module 9. The staff member stated that there was collaboration among the ACOs in writing the reports and acknowledged that the similarities in the reports were due to such collaboration.

Therefore, there was sufficient evidence to conclude that HHSF ACOs collaborated in preparing the incident reports.

Accuracy of the incident reports. There is also reason to question the accuracy of some of the HHSF reports. Staff testimony, by others or by those who prepared the reports, contradicted what was stated in the incident reports. Examples of some of these contradictions are summarized.

Example 1. According to the incident reports submitted by three HHSF ACOs, they strip searched a certain inmate in the 4-way. During the search, in response to an order to spread his legs and to place his hands against the wall, the inmate swore at one of the ACOs and punched the ACO on the left side of the head. The other two ACOs then reportedly subdued the inmate, while the inmate attempted to punch and kick the ACOs. The reports indicate that after the inmate was subdued, he was calmed, the search was completed, and the inmate was escorted to Module 5 pending his transfer to the HHSF.

In contrast, a high-ranking OCCC official testified that the inmate was searched in the corridor leading to the 4-way, and not in the 4-way. The official stated that his recollection was very clear because he wanted to talk to the inmate and, to do so, he had to walk through the 4-way and into the corridor where the inmate was being searched. The official wanted to talk to the inmate because the inmate had thrown rocks at him from the recreation field, and he had already decided that the inmate would be transferred to the HHSF.

The OCCC official testified that the inmate had his shirt off, and the search had just begun when he arrived at the location in the corridor where the inmate was being searched. The official stated that the inmate did not want to spread his legs and place his hands against the wall, and the ACOs had to grab his hands and place them against the wall. However, the official testified that he did not witness the inmate strike any ACO during the search, nor did he see the ACOs physically subdue the inmate at any time. The official testified that he informed the inmate that he would be transferred to the HHSF. After the search was completed, he escorted the inmate from the corridor through the 4-way and to Module 5. Nothing happened in the 4-way as he escorted the inmate through.

The OCCC official stated that he did not recall that any of the three ACOs who submitted incident reports regarding the inmate were involved in searching the inmate. He testified that he was acquainted with one of those three ACOs and that he would have been able to recall if that ACO had been involved in searching the inmate.

According to the OCCC official, it was on his order that the inmate was transferred to the HHSF. The basis for the transfer was that the inmate had thrown rocks at him from the recreation field, not because the inmate struck an ACO during the strip search. The official testified that he did not witness any occurrence even resembling an assault of an ACO by the inmate.

The testimony of the OCCC official contradicts the HHSF incident reports in many respects. Most importantly, his testimony indicates that the inmate was not assaultive. The OCCC official's testimony is partially supported by the statement made by the inmate himself, as the inmate denied he was assaultive and testified that he was searched in the corridor leading to the 4-way, not in the 4-way.

Example 2. Three ACOs submitted incident reports indicating that they searched a certain inmate in the 4-way. According to the reports, the inmate swore at the ACOs, was verbally abusive, and refused to place his hands against the wall and to spread his legs for the search. The reports indicate that when an ACO grabbed the inmate's hand to place it against the wall, the inmate punched the ACO in the chest. The other two ACOs then reportedly forced the inmate to the ground and restrained him. According to the reports, the search was completed while the inmate was restrained on the ground because the inmate continued to attempt to punch and kick the ACOs. After the search was completed, the inmate was taken to Module 5 pending his transfer to the HHSF.

However, pertinent testimony was received from five OCCC ACOs who were present in the 4-way. Each ACO indicated that he was acquainted with the inmate and each testified that he

recalled having seen the inmate in the 4-way. Each ACO said that no physical force was used against the inmate and each indicated that the inmate did not strike an ACO. One of the ACOs provided the following statement:

> "Nothing happened to him. They just strip searched him and they put the cuffs on him and they took him away.... He didn't resist.... He was very cooperative.... They just took him away, that's all. I don't know why they took him away."

Another ACO testified as follows:

> "...I know they took him to the Holding Unit, they may have took him to Halawa, I'm not sure. He was down there but he didn't do anything that I seen, and they chained him, and I asked about him because I know [the inmate] and he's a pretty calm guy. And they just said it's security procedure because he's such a big guy, but I don't recall any incident with him having any problem."

The testimony of the five OCCC ACOs refutes the incident reports by the HHSF ACOs. The inmate's own statements lend credibility to the testimony of the OCCC ACOs, since the inmate denied having struck an ACO and stated that no force was used against him in the 4-way by HHSF ACOs.

In addition to the above-noted examples, the HHSF ACOs quite often contradicted their own reports through their own testimony. For example, according to the incident reports, a certain inmate struck an ACO in the 4-way. However, two of the three ACOs who prepared the reports of the incident testified that the incident occurred in the corridor leading to the 4-way, not in the 4-way. When this contradiction was pointed out to one of the ACOs, the ACO responded that all three reports were incorrect because the three ACOs collaborated in writing the reports.

Summary. It was concluded that there was collaboration among the HHSF ACOs in the preparation of their incident reports. In some cases, testimony from other staff members contradicted the incident reports and raised serious questions about the accuracy of those reports.

It is unfair to the inmate when misconduct charges against him are supported by reports which are the result of collaboration. It is even more unfair when there is reason to doubt the accuracy of the reports. One of the goals of the CD's inmate disciplinary process is to attain fundamental fairness, but that goal is subverted when staff members collaborate in the preparation of incident reports.

There Was Sufficient Evidence to Conclude that an Inadequate Attempt Was Made to Document Inmate Misconducts or Incidents Involving the Use of Force by ACOs during the Shakedown

According to HHSF and OCCC staff members, numerous incidents of inmate misbehavior occurred. The incidents involved inmates who allegedly failed to obey the strip search orders, were in possession of contraband, or were assaultive toward the ACOs during the strip searches on Tuesday and Wednesday. However, only eight of the alleged incidents were documented.

High-ranking HHSF officials testified that approximately one-third of the inmates who were strip searched on Tuesday resisted the search and that, in about 20% of these cases, the use of force was necessary to restrain the inmate. The only HHSF incident reports were about the seven inmates who were transferred to the HHSF and an eighth inmate whose planned transfer was not carried out. The HHSF ACOs testified that other inmates whose identities were known to them were assaultive or were found in possesssion of contraband. However, no incident reports were prepared with regard to any of these inmates. It thus appears that the HHSF incident reports were prepared to justify the transfer of the inmates to the HHSF.

Similarly, some OCCC ACOs testified that on Wednesday, inmates were resistive to the strip search, assaultive toward the ACOs, or in possession of contraband. However, in none of these cases were the alleged incidents documented and misconduct charges were not brought against a single inmate.

Staff members stated that part of the reason for the failure to document these incidents was the large number of inmates who committed misconducts during the strip searches on both Tuesday and Wednesday. These staff members said that because many inmates misbehaved and since staff members were occupied with many other shakedown duties and responsibilities, there was insufficient time to adequately document inmate misconduct.

It is reasonable that other staff duties may be given priority over the documentation of every instance in which an inmate resisted a strip search. However, serious inmate misconduct, such as the assault of an ACO or the possession of contraband, would seem to require documentation by CD personnel. Such documentation is important so that disciplinary proceedings can be initiated to maintain order within the facility. It is also important for future decision-making purposes; e.g., an inmate's assault of an ACO is pertinent in evaluating the inmate's request for release on parole soon thereafter.

The lack of documentation also makes it difficult, and in some cases impossible, to subsequently determine what occurred. The accuracy or veracity of orally recounted descriptions, particularly when they are related after a substantial amount of time has elapsed, is questionable.

A less than diligent approach in preparing incident reports, particularly by OCCC officials, partially explains the lack of documentation. Testimony from inmates and staff members indicated that in several instances, OCCC supervisors witnessed the use of force against an inmate. Apparently, these supervisors did not require the submission of reports by the ACOs involved, since none were filed. In the only case where an OCCC supervisor required the submission of an incident report by a staff member, the requirement was not enforced and, after approximately nine months, was withdrawn. Thus, a report was never submitted.

When incidents are not documented in a timely manner and when oral descriptions of inmate misconduct surface only after the inmate accuses the ACO of mistreatment, such descriptions are often inaccurate, can be viewed as self-serving, and may be retributive.

Finally, failure to submit a written report when force is used against an inmate is a violation of the established regulations and procedures of the OCCC. Section P4.512 of the Hawaii State Prison Employees Handbook states in part: "In all instances where physical force is used, the employee shall immediately submit a detailed report of the incident via his Watch Supervisor to the Hawaii State Prison Administrator." It is obvious that this requirement was not enforced during the shakedown, although none of the administrators acknowledged suspending or waiving the requirement.

There Was Sufficient Evidence to Conclude that Staff Members Are Unable to Articulate an Operational Definition of Unreasonable Force

As was noted in Chapter IV, the parameters in which force may be used are stated in general terms in the rules, regulations, policies, and procedures of the CD and the OCCC. Except in extreme cases, they are difficult to apply to factual situations and are therefore of limited use in day-to-day operations.

According to CD officials, the reason for the imprecise language in the CD and OCCC rules, regulations, policies, and procedures is that the determination of reasonable or unreasonable force necessarily rests on an evaluation of the circumstances in each instance in which force is used and must be made on a case-by-case basis. Force used may be reasonable under one set of circumstances and unreasonable under another.

Nevertheless, it was found that the CD and OCCC rules, regulations, policies, and procedures provided inadequate guidance to staff members about the permissible and impermissible uses of force. Staff members lack a thorough understanding of the circumstances under which the use of force is permissible and about the degree of force that may be used. The Inmate Handbook, Section 600.660.001, reinforces the use of personal judgment by an ACO when it states in part: "All personnel are to use their own judgment in each circumstance." The use of personal judgment by individual staff members, as sanctioned by the rules, permits each staff member to act in accordance with personal values and biases and results in numerous and varying interpretations as to what constitutes reasonable and unreasonable force.

Chapter VI

RECOMMENDATIONS

The recommendations that follow relate to the use of force during the shakedown and are made to correct noted shortcomings and prevent or at least minimize the recurrence of similar problems. It is recognized that the recommendations will not be the panacea for the problems which beset the Division in these specific areas.

The impetus for meaningful attitudinal changes and improvement of the system must emanate from the administration and permeate the system to its lowest level. Unless a serious and concerted effort is made with confidence, the Department will find itself plagued with the same problems and will become more reliant on strategies devised to cope with crises as they occur.

Cases Referred to the DSSH

The DSSH should review the cases referred to it by the office and take action as it deems appropriate. Pursuant to section 96-12, HRS, the Ombudsman requests that the DSSH inform him of its decision, and the reasons for its decision, for each referred case.

Adoption of a Standard for Use of Force

The CD should adopt and implement a standard to determine whether the force used is reasonable or unreasonable. A starting point in developing such a standard is contained in Chapter IV. That standard provides a logical framework to objectively determine whether the use of force is reasonable or unreasonable.

In each instance where force is used at any CD facility, the involved ACOs should be required to write a timely incident report, specifying: (a) the behavior of the inmate; (b) the force used; and (c) the circumstances in which force was used. Such a requirement should be incorporated in the CD rules and regulations and consistently enforced by the CD.

The facility administrator should review the reports on the use of force in every case and arrive at and record a finding as to whether the force used was reasonable or unreasonable. The facility administrator's finding should be reviewed thereafter by the CD for correctness when applied against the established standard and for consistency within the entire Division. The decisions of the CD should also be recorded and disseminated to all branch administrators. Those decisions should, in turn, be distributed or made available to supervisory personnel for on-the-job training of ACOs and as a supplement to more formal classroom instruction. The branch administrators and the CD should develop and maintain a central case file on all such decisions for future reference.

The advantages of such a system are that individual ACOs will be able to predict what constitutes reasonable or unreasonable force in a particular set of circumstances. They may also be able to generalize from that set of circumstances the type and degree of force that can be used in similar circumstances. In addition, consistency of decisions and case-by-case clarification of the standard will be natural consequences from such a system.

Training

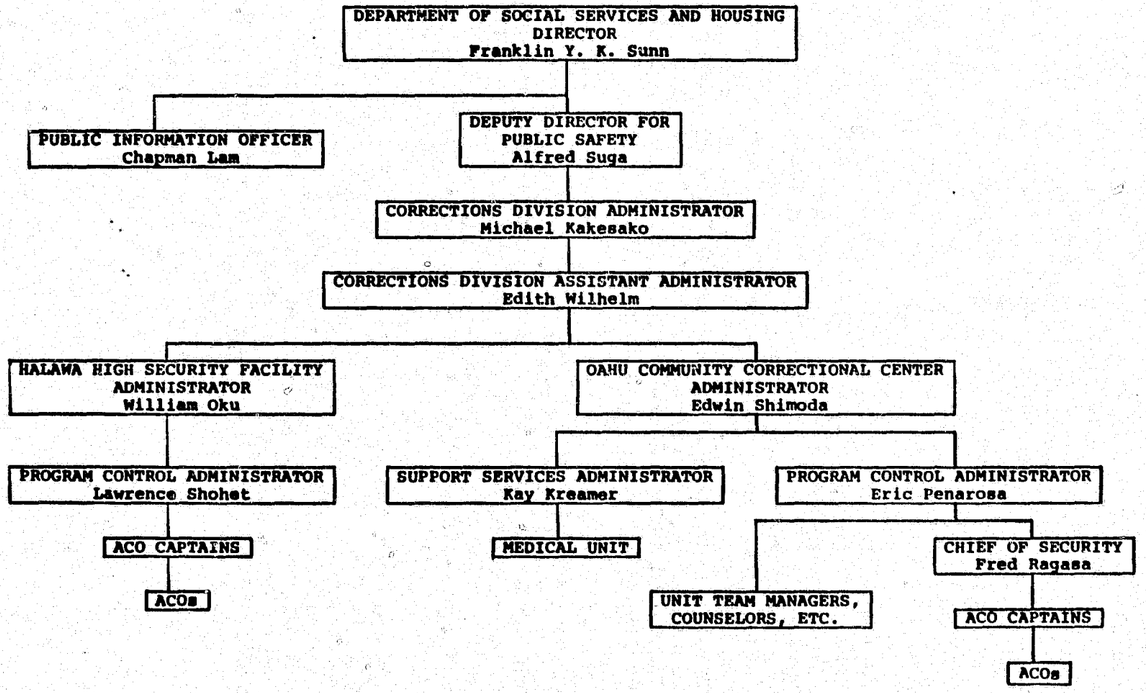
In addition to formal classroom instruction, branches should provide continuous in-service training to its ACOs regarding the standard governing the permissible and impermissible use of force, the necessity of documenting the use of any type of force and any serious inmate misconduct, and proper strip search procedures. Without adequate training, the public cannot expect the ACOs to perform at their highest level.

Training should not be limited to ACOs but should also include administrative staff and supervisory personnel. For each staff member to completely understand his role, duties, and responsibilities, he must understand the responsibilities of the total organization and the significance of his role in relation to the whole. The responsibility of administrators and supervisors in the prevention, intervention, investigation and reporting of employee misconduct should receive special attention.

Appendix A

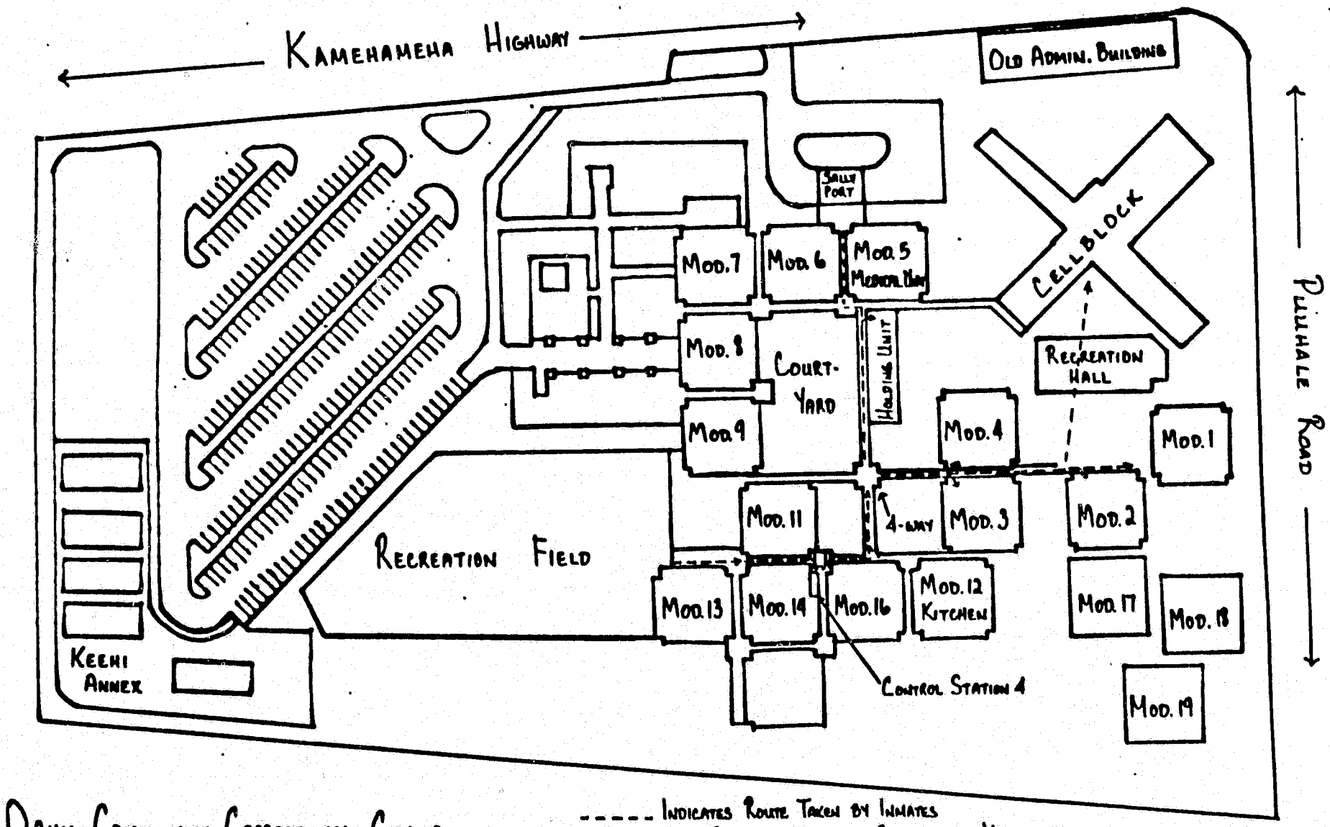
This is a partial organizational chart of the DSSH, identifying high-ranking officials of the DSSH, CD, OCCC, and HHSF and the positions that they occupied at the time of the shakedown.

DSSH Participating Agencies And Personnel In The OCCC Shakedown Of December, 1981



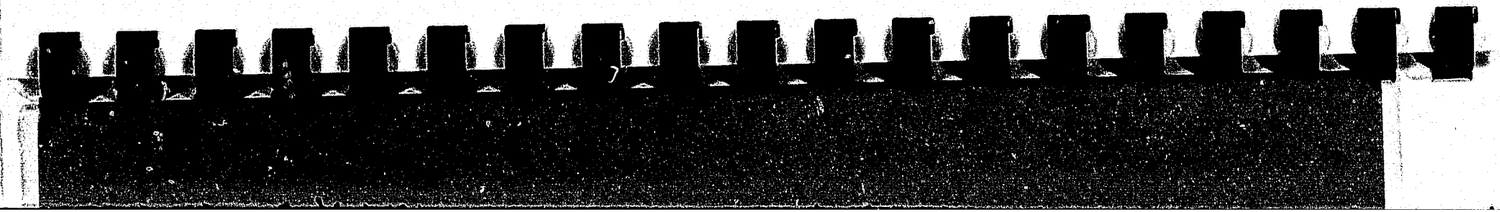
Appendix B

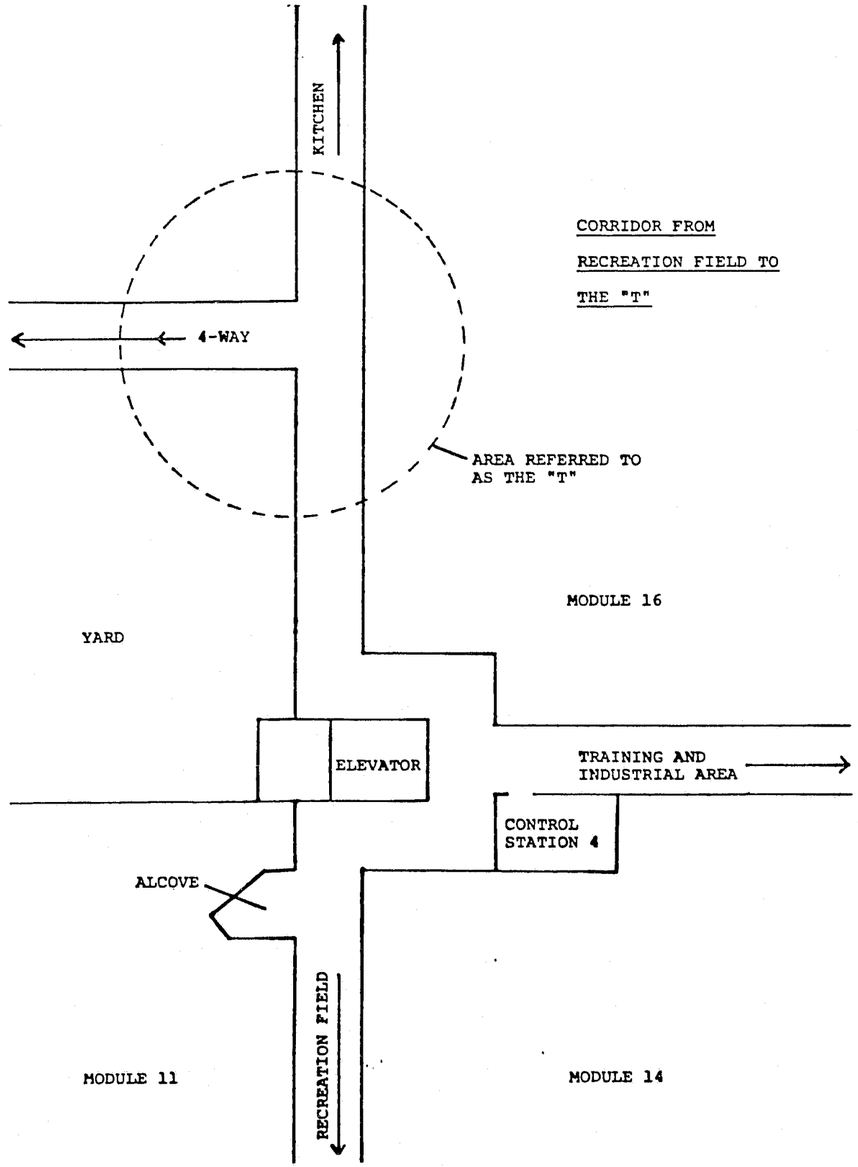
These are diagrams of portions of the OCCC to assist the reader in finding locations referred to in the text of this report. The diagrams are not drawn to scale.

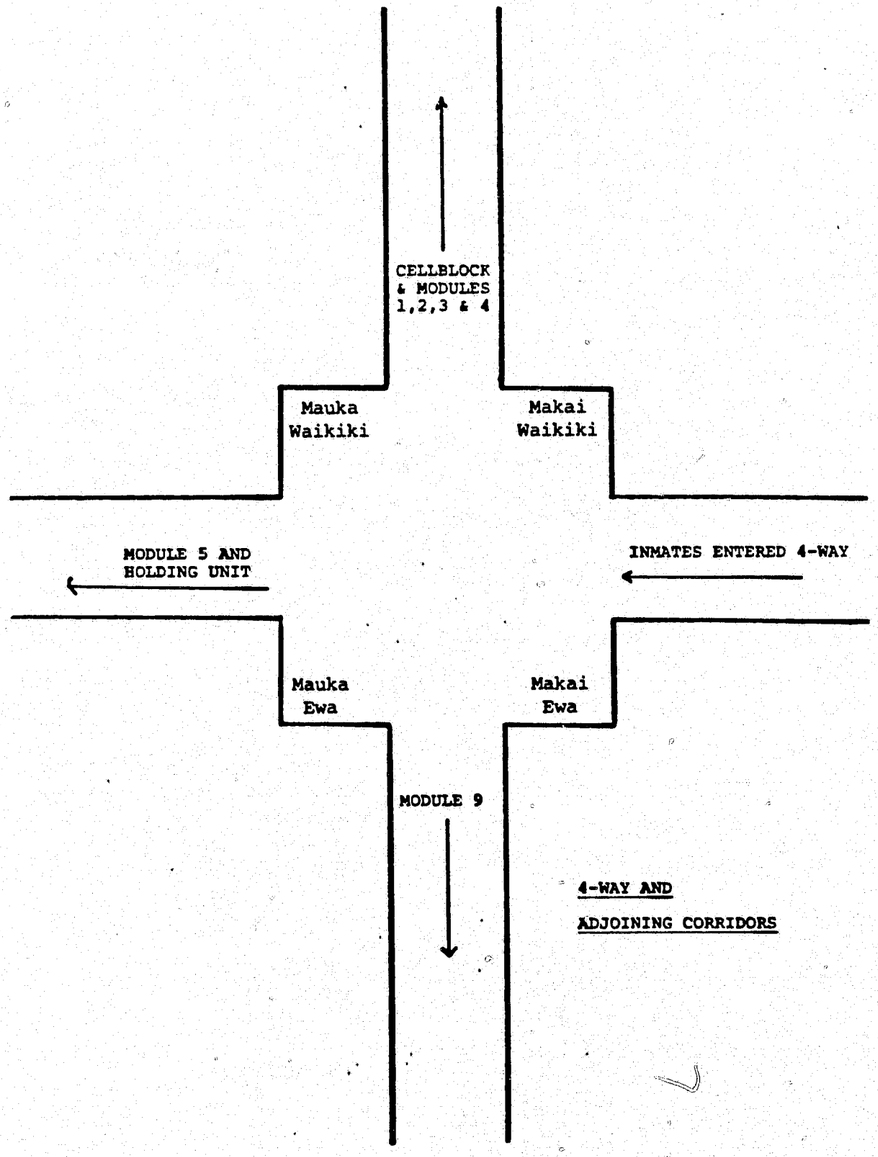


OAHU COMMUNITY CORRECTIONAL CENTER

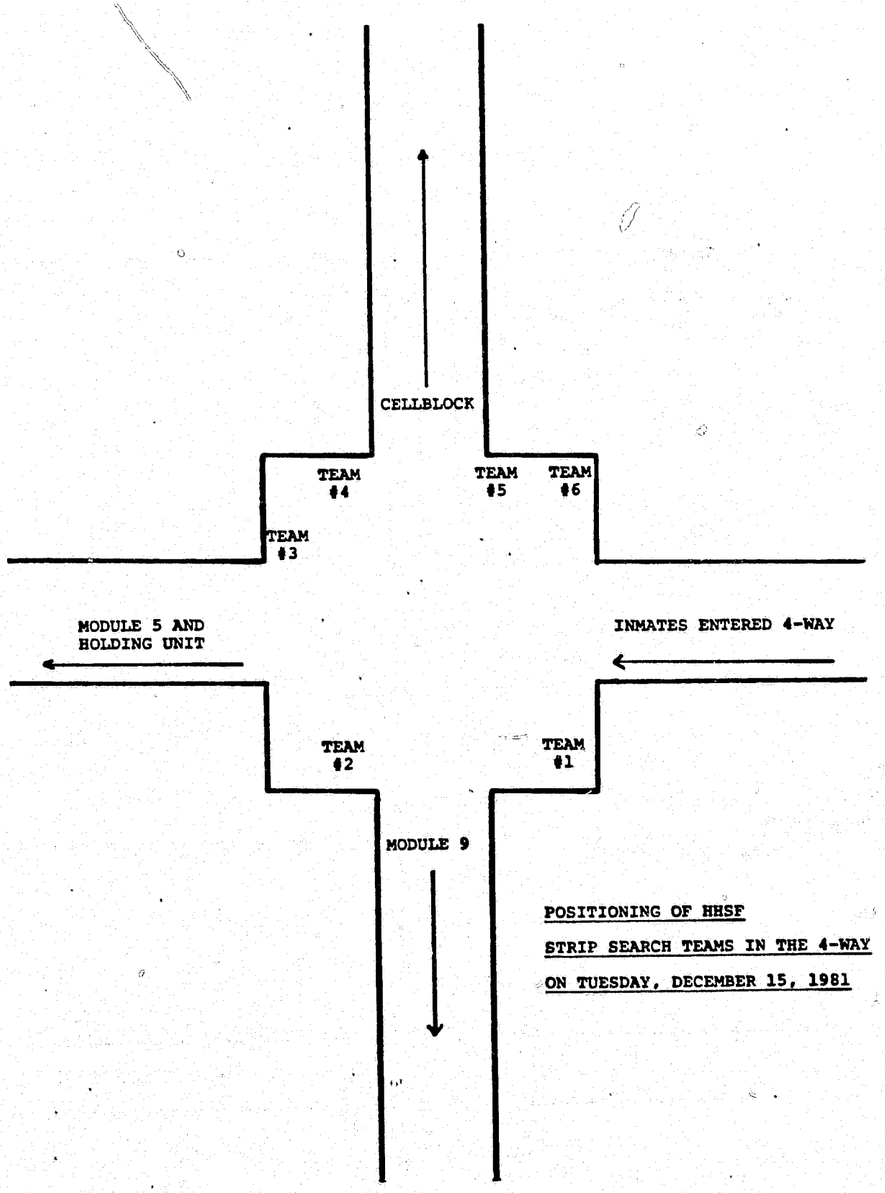
----- INDICATES ROUTE TAKEN BY INMATES FROM RECREATION FIELD TO RESIDENTIAL UNITS




KITCHEN
4-WAY
CORRIDOR FROM
RECREATION FIELD TO
THE "T"
AREA REFERRED TO
AS THE "T"
MODULE 16
YARD
ELEVATOR
TRAINING AND
INDUSTRIAL AREA
CONTROL
STATION 4
ALCOVE
RECREATION FIELD
MODULE 11
MODULE 14

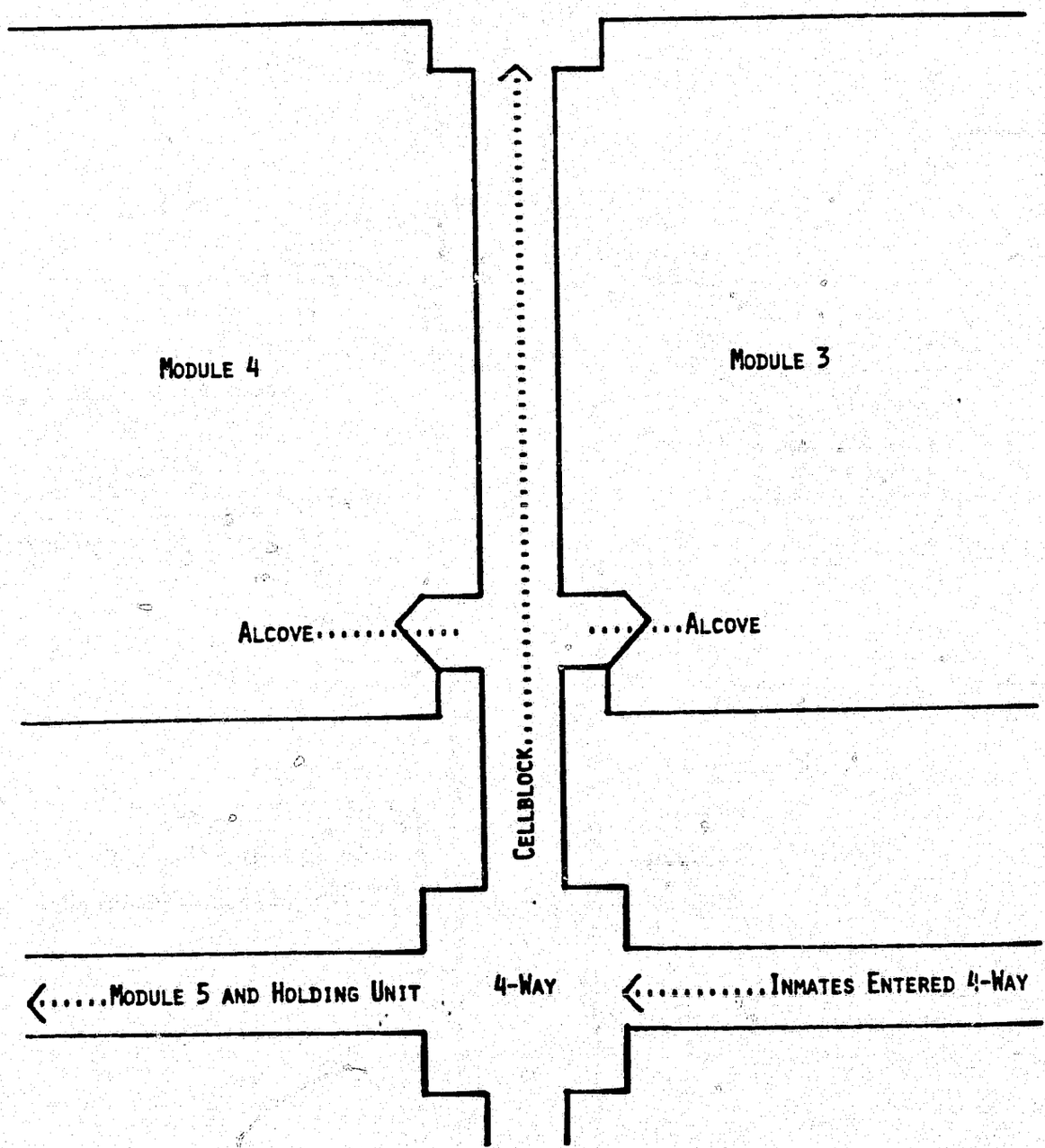


4-WAY AND
ADJOINING CORRIDORS



POSITIONING OF HHSF
STRIP SEARCH TEAMS IN THE 4-WAY
ON TUESDAY, DECEMBER 15, 1981

CORRIDOR FROM 4-WAY TO CELLBLOCK



Appendix C

This is an AG opinion regarding the termination of employment provisions of section 78-9, Hawaii Revised Statutes.

GEORGE R. ARIYOSHI
GOVERNOR

STATE OF HAWAII
DEPARTMENT OF THE ATTORNEY GENERAL
STATE CAPITOL
HONOLULU, HAWAII 96813
(808) 548-4740

TANY S. HONG
ATTORNEY GENERAL

MICHAEL A. LILLY
[redacted]
FIRST DEPUTY ATTORNEY GENERAL

June 4, 1982

The Honorable Herman S. Doi
Ombudsman
Kekuanaoa Building
Fourth Floor
465 South King Street
Honolulu, Hawaii 96813

Dear Mr. Doi:

This is in response to your oral request for an opinion relating to the enforceability of the termination of employment provisions of Section 78-9, Hawaii Revised Statutes. That section states:

> "Failure to appear or testify, termination of employment. If any person subject to sections 78-8 to 78-11, after lawful notice or process, wilfully refuses or fails to appear before any court or judge, any legislative committee, or any officer, board, commission, or other body authorized to conduct any hearing or inquiry, or having appeared refuses to testify or to answer any question regarding (1) the government, property or affairs of the State or of any political subdivision thereof, or (2) the person's qualifications for public office or employment (including matters pertaining to loyalty or disloyalty), or (3) the qualifications of any officer or employee of the State or any political subdivision thereof, on the ground that his answer would tend to incriminate him, or refuses to testify or to answer any such question without right, his term or tenure of

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> office or employment shall terminate and the office or employment shall be vacant, and he shall not be eligible to election or appointment to any office or employment under the State or any political subdivision thereof. To the extent that the State is without authority to require, under the constitution or laws of the United States, compliance by any public officer or public employee herewith, sections 78-8 to 78-11 shall not apply to the officer or employee, but the sections shall apply to the extent that they or any part thereof can lawfully be made applicable."

We understand that your office is interested in subpoenaing certain corrections officers at the State prison to question them about alleged abuses of prisoners during the recent National Guard takeover. You wondered whether, pursuant to Section 78-9, Hawaii Revised Statutes, a subpoenaed corrections officer who refuses to answer certain questions asked of him on the grounds that his answer would tend to incriminate him could be terminated from his employment.

Initially, a review of the relevant case law in this area may be helpful.

The starting point for analysis is Garrity v. New Jersey, 385 U.S. 493 (1967). In that case, Appellants, police officers in certain New Jersey boroughs, were questioned during the course of a state investigation concerning alleged traffic ticket "fixing." Each officer was first warned that: anything he said might be used against him in a state criminal proceeding; he could refuse to answer if the disclosure would tend to incriminate him; if he refused to answer he would be subject to removal from office.

The officers answered the questions. No immunity was granted, as there was no immunity statute applicable in these circumstances. Over their objections, some of the answers given were used in subsequent prosecutions, resulting in the officers' convictions. The New Jersey Supreme Court on appeal upheld the convictions, despite the officers'

claim that their statements had been coerced, by reason of the fact that, if they refused to answer, they could, under the New Jersey forfeiture of office statute, lose their positions with the police department.1/ The New Jersey Supreme Court declined to pass on the constitutionality of the statute, but considered the statute relevant for the bearing it had on the voluntary character of the statements used to convict the officers. The officers appealed to the United States Supreme Court, which dismissed the appeal but granted certiorari to hear the case.

The United States Supreme Court reversed the convictions, concluding that the statements obtained were coerced and, therefore, inadmissible in the subsequent criminal proceeding:

> The choice given petitioners was either to forfeit their jobs or to incriminate themselves. The option to lose their means of livelihood or to pay the penalty of self-incrimination is the antithesis of free choice to speak out or to remain silent. That practice, like interrogation practices we reviewed in Miranda v. Arizona, 384 U.S. 436, 464-465, is "likely to exert such pressure upon an individual as to disable him from making a free and rational choice." We think the statements were infected by the coercion inherent in this scheme of questioning and cannot be sustained as voluntary under our prior decisions.

1/ That statute provided that a public employee shall be removed from office if he refused to testify or answer any material question before any commission or body which has the right to inquire about matters relating to his office or employment on the ground that the answer may incriminate him.

> It is said that there was a "waiver." That, however, is a federal question for us to decide. * * *
>
> Where the choice is "between the rock and the whirlpool," duress is inherent in deciding to "waive" one or the other.

385 U.S. at 497-498.

The Court then went on to enunciate a rule of broad constitutional protection:

> We held in Slochower v. Board of Education, 350 U.S. 551, that a public school teacher could not be discharged merely because he had invoked the Fifth Amendment privilege against self-incrimination when questioned by a congressional committee:
>
> "The privilege against self-incrimination would be reduced to a hollow mockery if its exercise could be taken as equivalent either to a confession of guilt or a conclusive presumption of perjury. . . . The privilege serves to protect the innocent who otherwise might be ensnared by ambiguous circumstances." Id., at 557-558.
>
> We conclude that policemen, like teachers and lawyers, are not relegated to a watered-down version of constitutional rights.
>
> There are rights of constitutional stature whose exercise a State may not condition by the exaction of a price. * * * We now hold the protection of the individual under the Fourteenth Amendment against coerced statements prohibits use in subsequent criminal proceedings of statements obtained under threat of removal from office, and that it extends to all, whether they are policemen or other members of our body politic. (Emphasis added.)

385 U.S. at 499-500.

Justice Harlan, with whom Justices Clark and Stewart joined, dissented, primarily, it would appear in retrospect, because he feared that the majority opinion seemed to nullify the effect of past decisions upholding the dismissal of public employees for refusal to answer questions related to their official duties -- irrespective of whether the refusal was grounded upon the fifth amendment privilege.

In the following year, however, the United States Supreme Court decided the companion cases of Gardner v. Broderick, 392 U.S. 273 (1968) and Uniformed Sanitation Men Assn., Inc. v. Commissioner of Sanitation of the City of New York, 392 U.S. 280 (1968), (hereafter Uniformed Sanitation Men I), which indicated clearly that Garrity would have no such effect.

In Gardner, appellant, a police officer, was subpoenaed by and appeared before a grand jury which was investigating alleged bribery and corruption of police officers, and was advised that the grand jury proposed to examine him concerning the performance of his official duties. He was advised of his privilege against self-incrimination, but was asked to sign a "waiver of immunity" after being told that he would be fired if he did not sign. He refused to do so, was given an administrative hearing, and was discharged solely for his refusal, pursuant to Section 1123 of the New York City Charter.2/

2/ That section provided:

> "If any councilman or other officer or employee of the city shall, after lawful notice or process, wilfully refuse or fail to appear before any court or judge, any legislative committee, or any officer, board or body authorized to conduct any hearing or inquiry, or having appeared shall refuse to testify or to answer any question regarding the property, government or affairs of the city or of any county included within its territorial limits, or regarding the nomination, election, appointment or official conduct of any officer or employee of the city or of any such county, on the ground that his answer

The Appellate Division of the New York Supreme Court dismissed the policeman's petition for reinstatement and payment of back wages, and the decision was affirmed by the New York Court of Appeals. On appeal to the United States Supreme Court, the case was reversed, and the charter provision was held unconstitutional.

Likewise, in Uniformed Sanitation Men I, fifteen New York City sanitation employees were summoned before the Commissioner of Investigation and advised that, if they refused to testify with respect to their official conduct on the ground of self-incrimination, their employment would terminate, in accordance with Section 1123 of the City Charter. Twelve of the employees refused to testify and were dismissed after a disciplinary hearing. The remaining three answered the questions without asserting the privilege, but denied the charges and were suspended. Subsequently, these three were summoned before a grand jury and asked to sign waivers of immunity. They refused and were dismissed pursuant to Section 1123 of the City Charter. The United States District Court dismissed the action brought by all fifteen for injunctive and declaratory relief. The Court of Appeals for the Second Circuit affirmed. On certiorari to the United States Supreme Court, the case was reversed.

In both cases, the Court's reversal of the employees' discharges was based on the ground that the employees were "not discharged merely for refusal to account for their conduct as employees of the city. They were dismissed for invoking and refusing to waive their constitutional right against self-incrimination. They were discharged for refusal to expose themselves to criminal prosecution

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(Footnote 2 continued)

> would tend to incriminate him, or shall refuse to waive immunity from prosecution on account of any such matter in relation to which he may be asked to testify upon any such hearing or inquiry, his term or tenure of office or employment shall terminate and such office or employment shall be vacant, and he shall not be eligible to election or appointment to any office or employment under the city or any agency."

based on testimony which they would give under compulsion, despite their constitutional privilege." Uniformed Sanitation Men I, id. at 392 U.S. 283. See also Gardner, id., at 392 U.S. 278.

The Court did, however, qualify both decisions by suggesting that public employees may be dismissed for failure to answer relevant questions about their employment. In Gardner, the Court stated:

> If appellant, a policeman, had refused to answer questions specifically, directly, and narrowly relating to the performance of his official duties, without being required to waive his immunity with respect to the use of his answers or the fruits thereof in a criminal prosecution of himself, Garrity v. New Jersey, supra, the privilege against self-incrimination would not have been a bar to his dismissal. 392 U.S. at 278.

Similarly, in Uniformed Sanitation Men I, the Court said:

> As we stated in Gardner v. Broderick, supra, if New York had demanded that petitioners answer questions specifically, directly, and narrowly relating to the performance of their official duties on pain of dismissal from public employment without requiring relinquishment of the benefits of the constitutional privilege, and if they had refused to do so, this case would be entirely different. In such a case, the employee's right to immunity as a result of his compelled testimony would not be at stake. But here the precise and plain impact of the proceedings against petitioners as well as of § 1123 of the New York Charter was to present them with a choice between surrendering their constitutional rights or their

> jobs. Petitioners as public employees are entitled, like all other persons, to the benefit of the Constitution, including the privilege against self-incrimination. [Citations omitted.] At the same time, petitioners, being public employees, subject themselves to dismissal if they refuse to account for their performance of their public trust, after proper proceedings, which do not involve an attempt to coerce them to relinquish their constitutional rights. 392 U.S. at 284-285.

The Supreme Court thus indicated that a public official who refuses to testify about the performance of his official duties may be discharged "after proper proceedings" if: (1) the questions asked of him specifically, directly and narrowly relate to the performance of his official duties; and (2) there is an absence of an attempt to coerce from him a waiver of immunity.

Following these rulings, several lower courts attempted to interpret the words "proper proceedings," as used in the Uniformed Sanitation Men I case.

In Uniformed Sanitation Men Association, Inc. v. Commissioner of Sanitation of the City of New York, 426 F.2d 619 (C.A. 2, 1970), cert. denied, 406 U.S. 961 (1972) (hereinafter Uniformed Sanitation Men II), for example, the Second Circuit Court of Appeals interpreted the phrase to mean a proceeding in which the employee is asked pertinent questions about the performance of his duties and is duly advised of his options and the consequences of his choice. In that case, certain city department sanitation employees brought action seeking reinstatement to positions from which they had been discharged. The plaintiff employees were under investigation for allegedly receiving cash instead of tickets for the privilege of using city waste disposal facilities, and for diverting the cash to their own use. They were called to appear at an inquiry and were granted "use" immunity from prosecution. The employees, however, still refused to answer questions related to their official duties on the ground of their privilege against self-incrimination and the further ground that the inquiry was based upon wire-tapping in violation of their constitutional rights. Their

discharges were upheld by the Second Circuit Court of Appeals and the United States Supreme Court refused to grant a writ of certiorari to hear the case. The Court of Appeals concluded that "use" immunity from prosecution legitimizes the sanction of discharge for failure to account for the employee's job performance stating:

> . . . "after proper proceedings" means proceedings, such as those held here, in which the employee is asked only pertinent questions about the performance of his duties and is duly advised of his options and the consequences of his choice. The proceeding here involved no attempt to coerce relinquishment of constitutional rights, because public employees do not have an absolute constitutional right to refuse to account for their official actions and still keep their jobs; their right, conferred by the Fifth Amendment itself, as construed in Garrity, is simply that neither what they say under such compulsion nor its fruits can be used against them in a subsequent prosecution. (Emphasis added.)

426 F.2d at 626-627. See also: Kalkines v. United States, 473 F.2d 1391 (Ct. Cl. 1973), where the Court of Claims deemed "being advised of his options and the consequences of his choice" as including being adequately "assured of protection against use of his answers or their fruits in any criminal prosecution," 473 F.2d at 1394; and Confederation of Police v. Conlisk, 489 F.2d 891 (C.A. 7, 1973), cert. denied, 416 U.S. 956 (1974), where the Seventh Circuit Court of Appeals concluded:

> [A] public employer may discharge an employee for refusal to answer where the employer both asks specific questions relating to the employee's official duties and advises the employee of the consequences of his choice, i.e. that failure to answer will result in dismissal but that answers he gives and fruits thereof cannot be used against him in criminal proceedings.

489 F.2d at 894.

Subsequently, in 1973, in the case of Lefkowitz v. Turley, 414 U.S. 70 (1973), the United States Supreme Court was called upon to review the constitutionality of certain New York statutes, which provided that, if a contractor refused to waive immunity or to testify concerning his state contracts, his existing contracts may be cancelled and he shall be disqualified from further transactions with the State for five years. In holding that the State could not compel testimony that had not been immunized, the Court said:

> We should make clear, however, what we have said before. Although due regard for the Fifth Amendment forbids the State to compel incriminating answers from its employees and contractors that may be used against them in criminal proceedings, the Constitution permits that very testimony to be compelled if neither it nor its fruits are available for such use. Kastigar v. United States, supra. Furthermore, the accommodation between the interest of the State and the Fifth Amendment requires that the State have means at its disposal to secure testimony if immunity is supplied and testimony is still refused. This is recognized by the power of the courts to compel testimony, after a grant of immunity, by use of civil contempt and coerced imprisonment. Shillitani v. United States, 384 U.S. 364 (1966). Also, given adequate immunity, the State may plainly insist that employees either answer questions under oath about the performance of their job or suffer the loss of employment. By like token, the State may insist that the architects involved in this case either respond to relevant inquiries about the performance of their contracts or suffer cancellation of current relationships and disqualification from contracting with public agencies for an appropriate time in the future. But the State may not insist that appellees waive their Fifth Amendment privilege against self-incrimination and consent

> to the use of the fruits of the interrogation in any later proceedings brought against them. Rather, the State must recognize what our cases hold: that answers elicited upon the threat of the loss of employment are compelled and inadmissible in evidence. Hence, if answers are to be required in such circumstances States must offer to the witness whatever immunity is required to supplant the privilege and may not insist that the employee or contractor waive such immunity. (Emphasis added.)

414 U.S. at 84-85.

Summarizing the above cases, a public employee is not subject to disciplinary sanction solely by reason of his exercise of his privilege against self-incrimination during the course of official interrogation unless he has first been accorded the protection of use immunity barring admission in a subsequent criminal proceeding of any statement he may make. The conceptual basis of this doctrine is the recognition that when a public employee makes a self-incriminatory statement in response to a threat of discharge, that statement must necessarily be regarded as coerced and, therefore, as secured in violation of the employee's constitutional privilege not to incriminate himself. If, however, he is protected from the normal consequences of a self-incriminatory statement, that is, if the statement may not be used against him in a subsequent criminal proceeding, then the choice he must make between the loss of his employment and the giving of the statement, however much it may be a Hobson's choice, does not offend his constitutional privilege. The offer, therefore, of use immunity when the statement is solicited is constitutionally prerequisite to the imposition of the disciplinary sanction for failing to give it. Banca v. Town of Phillipsburg, 436 A.2d 944 (N.J. Super. 1981).

In Hawaii, the procedures for conferring immunity upon a witness who refuses to testify in an official proceeding conducted under the authority of any agency of the State, on the basis of the privilege against self-incrimination, is set forth in Chapter 621C, Hawaii Revised Statutes. That chapter provides for the granting of both "use" and "transactional" immunity.

It should be noted, however, that the Hawaii Supreme Court, in State v. Miyasaki, 62 Haw. 269 (1980), struck down as violative of the State Constitution's privilege against self-incrimination, the general witness immunity statute, authorizing grants of use and derivative use immunity. The Supreme Court concluded that a grant of use and derivative use immunity does not maintain a person in substantially the same position as before being summoned to produce evidence because while the statute precludes use of the testimony, the witness remains subject to prosecution. The Court said that none of these constitutional problems would arise if transactional immunity were granted instead. Presumably then, in Hawaii a public employer who seeks to discharge a public employee for failing to account for the public trust must first afford the employee the protection of transactional immunity against all prosecution arising from the transaction.

With these principles in mind, it appears that the corrections officers subpoenaed to testify during your office's investigatory proceedings may be discharged from their employment, only if they fail to answer questions narrowly, specifically and directly related to the performance of their official duties, if they have been advised that failure to answer will result in their dismissal, and if they have been afforded transactional immunity from prosecution for their answers and the fruits thereof.

Please feel free to call us, if you have any question on the above.

Very truly yours,

Corinne K. A. Watanabe

Corinne K. A. Watanabe
Deputy Attorney General

APPROVED:

Tany S. Hong
Attorney General

Appendix D

This appendix includes: (1) further information about the consultation process; and (2) an AG opinion interpreting sections 96-11 and 96-15, Hawaii Revised Statutes.

Before the consultation process began, tentative findings were made that 37 employees or former employees of the CD committed breaches of duty or misconducts. As a consequence, the referral of cases pertaining to 35 of those individuals to the DSSH was considered. The cases of the remaining two individuals were to be transmitted to the Department only for informational purposes because those individuals could not be interviewed.

Of the 35 individuals whose cases were considered for referral, 27 were still employed at the OCCC or the HHSF; three were employed at either facility but were on extended leaves of absence; and five were no longer employed by the DSSH.

Letters were sent to each of the 35 individuals. The letters apprised them of the tentative findings and invited them to consult with the office before final decisions were made as to whether their cases should be referred to the DSSH. The CD, OCCC, and HHSF cooperated by distributing the letters to the 27 persons employed at the two facilities. Signatures of receipt were obtained from each of the 27 employees and returned to the office. Two copies of our letter were mailed to each of the remaining eight individuals, one copy by certified mail with return receipt requested and the other by regular postal delivery.

Twenty-eight of the individuals contacted the office and appointments for consultation were scheduled with each between July 6 and July 20, 1983. Seven individuals did not respond and, as stated in the letters, it was concluded that they chose not to consult with the office.

A total of 27 consultation sessions were held, in which either the individual or his representative appeared. In one case, an individual failed to appear for his scheduled appointment and did not contact us thereafter. In many instances, individuals were assisted by a union agent, a Deputy AG, or another person of their choice.

In each consultation session, a summary of the tentative findings and the reasons therefor was presented. The individuals were then provided the opportunity to respond. In many instances, the individual chose not to respond. As a result, no additional information was presented for our consideration, the tentative findings were therefore unaltered, and the cases were referred to the DSSH for appropriate action.

Of the individuals who chose to respond, a few provided us with pertinent information. However, in all but one case, such information did not exonerate the individuals. The additional information was transmitted to the DSSH.

In a single case, an ACO provided information which was considered credible and which reversed the tentative finding. After considering the information provided by the ACO, it was concluded that the force he used against a particular inmate was in self-defense and was reasonable. Because the tentative finding was reversed, his case was not referred to the DSSH.

After finalizing the tentative findings, each of the 27 individuals was informed by letter as to whether his case would be referred to the DSSH.

GEORGE R. ARIYOSHI
GOVERNOR

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DEPARTMENT OF THE ATTORNEY GENERAL
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TANY S. HONG
ATTORNEY GENERAL

MICHAEL A. LILLY
[redacted]
FIRST DEPUTY ATTORNEY GENERAL

May 18, 1983

MEMORANDUM

TO: Mr. H. Doi
Ombudsman

FROM: Hiromu Suzawa
Deputy Attorney General

SUBJECT: Interpretation of HRS sections 96-11 and 96-15

You have orally requested advice as to whether the Ombudsman is required under section 96-11, HRS, to consult with any agency or person before giving any opinion or recommendation that is critical of the agency or person, or whether the Ombudsman can under section 96-15, HRS, refer a matter directly to the appropriate authorities without consulting the agency or person involved, if he thinks there is a breach of duty or misconduct by any officer or employee of an agency.

Chapter 96, HRS, was originally enacted as Act 306, SLH 1967. It was patterned after a model statute prepared in 1965,[1/] and basically follows the provisions of the model statute. We note that the American Bar Association in 1974 also prepared a model ombudsman statute for state governments. This latter draft recognizes the problem under discussion and provides in section 15(c) that "[i]f the Ombudsman believes that any person has acted in a manner warranting criminal or disciplinary proceedings, he shall

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1/ Harvard Journal on Legislation, Vol. 2, No. 2 (June 1965) 221-138.

refer the matter to the appropriate authorities without notice to the person."[2/] The comments to this subsection states in part that the "Ombudsman has the duty of forwarding pertinent allegations to the appropriate agency, civil service office, or the attorney general. As such reporting might be construed under §14(a) to require informing the person of such allegations -- which, prematurely, might hinder adequate investigation -- he is empowered to do this without notice to the individual involved."

Inasmuch as the American Bar Association's draft of the ombudsman statute is not the model for the Hawaii statute, however, we do not believe that draft or the comment to said draft is controlling.

We now turn to the particular provisions of chapter 96, HRS, here in question. Section 96-11 reads:

> "Before giving any opinion or recommendation that is critical of an agency or person, the ombudsman shall consult with that agency or person."

Section 96-15 reads:

> "If the ombudsman thinks there is a breach of duty or misconduct by any officer or employee of an agency, he shall refer the matter to the appropriate authorities."

Both of the foregoing provisions are identical to the corresponding provisions of the model draft proposed by the Harvard Journal on Legislation. We also note that the term "agency" is defined in section 96-1, HRS, as well as in the Harvard draft, as "any permanent governmental entity, department, organization, or institution, and any officer, employee, or member thereof acting or purporting to act in the exercise of his official duties" with certain exceptions. The Harvard draft has no definition of "person."

2/ American Bar Association, Model Ombudsman Statute for State Governments, February 1974

Chapter 96, HRS, also does not define the term "person" but section 1-19, HRS, has a broad definition of "person" which would be applicable to the term as used in chapter 96.

In reviewing the legislative history of chapter 96 (Act 306, SLH 1967), we find nothing that touches upon the question under consideration here. However, the purpose of Act 306 (S.B. No. 19) is stated as follows:

> The purpose of this bill is to create within the state government a new office of the Ombudsman to represent citizens in their complaints against abuses by misfeasance or nonfeasance of governmental authority." Standing Committee Report No. 869, 1967 Hawaii House Journal, 817.

Insofar as the Harvard draft is concerned, the comment with reference to the section on consultation states that "the Ombudsman will have the views of an investigated agency before he issues any adverse report" and with reference to the section on misconduct by agency personnel states inter alia that "[u]nder this statute the Ombudsman can only refer the matter to the appropriate authority . . . . Giving the Ombudsman greater power has political disadvantages and interferes with the discretion traditionally lodged in prosecuting officials."

The possible ambiguity that arises here relates to the application of sections 96-11 and 96-15, HRS, when an investigation is made of an administrative act and the Ombudsman thinks there is a breach of duty or misconduct by agency personnel. Under those circumstances is the Ombudsman required to "consult" with the agency personnel involved or may the Ombudsman omit the "consultation" and refer the matter directly to the appropriate authority?

As a general rule, statutory language must be read in the context of the entire statute and construed in a manner consistent with the purposes of the statute. Waikiki Resort Hotel, Inc. v. City and County of Honolulu, 624 P.2d 1353, 63 Haw. 222 (1981); State v. Sylva, 605 P.2d 496, 61 Haw. 385 (1980); Pacific Ins. Co. v. Oregon Auto. Inc. Co., 53 Haw. 208 (1971). It is also fundamental in statutory construction that each part or section of a statute should

be construed in connection with every other part or section so as to produce a harmonious whole. State v. Davis, 624 P.2d 376, 63 Haw. 191 (1981). As indicated in Waikiki Resort Hotel, Inc. v. City and County of Honolulu, supra, uncertainty as to the meaning of a statute may arise from the fact that giving a literal interpretation to the words would lead to such unreasonable, unjust, impracticable or absurd consequences that they could not have been intended by the legislature. Departure from literal construction of a statute is justified when such construction would produce absurd and unjust result and literal construction in a particular action is clearly inconsistent with the purposes and policies of the act. Tangen v. State Ethics Commission, 550 P.2d 1275, 57 Haw. 87 (1976). However, where there is no ambiguity in the language of a statute, and the literal application of the language would not produce an absurd or unjust result clearly inconsistent with the purposes and policies of the statute, there is no room for judicial construction and interpretation, and the statute must be given effect according to its plain and obvious meaning. Matter of Palk, 542 P.2d 361, 56 Haw. 492 (1975).

In the instant case the ambiguity, if any, seems to be the applicability of sections 96-11 and 96-15 to a particular situation, rather than in the meaning of a particular word or phrase as used in said sections. Assuming that this is an appropriate situation to which the rules of statutory construction apply, would the literal application of section 96-11, HRS, produce an absurd or unjust result clearly inconsistent with the purposes and policies of the Ombudsman statute, so as to permit the disregarding of the consultation requirement, if the Ombudsman thinks there is a breach of duty of misconduct by an officer or employee of an agency? We realize that the consultation requirement might pose certain administrative problems but we are not convinced that literal application of section 96-11 would produce "an absurd or unjust result clearly inconsistent with the purposes and policies of the statute."

As above indicated, the purpose of chapter 96, HRS, is to create the office of the Ombudsman "to represent citizens in their complaints against abuses by misfeasance or nonfeasance of governmental authority." We believe

sections 96-11 and 96-15 can be construed so as to give effect to both sections without producing an absurd or unjust result that would be inconsistent with the purpose of chapter 96, HRS. The intent of section 96-11, as indicated by the comment to the Harvard draft, is to assure that the Ombudsman will have the views of the investigated agency before he issues any adverse report. If, after any explanation by the agency, the Ombudsman thinks there is a breach of duty or misconduct on the part of agency personnel, he is then authorized under section 96-15 to refer the matter to appropriate authorities for necessary action. Although this procedure may at times create problems in investigations, we do not think that compliance with section 96-11 will necessarily produce an absurd or unjust result that would be inconsistent or contrary to the purposes of the Ombudsman statute and, if giving effect to section 96-11 according to its plain and obvious meaning does not produce an absurd or unjust result inconsistent with the purpose of chapter 96, we have no alternative but to give effect to section 96-11, as worded. Accordingly, we believe that agency personnel should be informed of any allegation of wrongdoing and given a chance to explain or rebut such allegation under section 96-11, before the matter is referred to an appropriate agency under section 96-15.

If the contention is that the Ombudsman is not giving any "opinion or recommendation that is critical of an agency or person" but is simply referring a matter to the appropriate authority because he thinks there is a breach of duty or misconduct involved, we believe such referral would constitute in effect an adverse opinion or recommendation and, therefore, fall under section 96-11, HRS. Such referral must of necessity allege some wrongdoing on the part of agency personnel, supported by whatever findings the Ombudsman may have made. Under those circumstances, we believe the referral would constitute an "opinion or recommendation that is critical of an agency or person."

To reiterate, based upon our review of chapter 96, HRS, and the comments to the model statute from which chapter 96 is derived, it is our opinion that the Ombudsman may not refer a matter to the appropriate authorities pursuant to section 96-15, HRS, without first complying with section 96-11, HRS, which requires the Ombudsman to

"consult" with an agency or person before giving an opinion or recommendation that is critical of that agency or person.

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Appendix E

These are examples of actual cases in which there was insufficient evidence of the use of unreasonable force. The names of staff members and inmates are omitted to protect the privacy of the individuals involved. Instead, the term "Inmate X" is used to designate the inmate against whom unreasonable force was allegedly used; and ACOs are designated as "ACO #1", "ACO #2", etc., when it is necessary to make a distinction between the ACOs mentioned in an example. The terms do not refer to the same inmate or ACO from one example to the next.

Example 1. Inmate X alleged that during his strip search in the Mauka-Ewa corner of the 4-way on Tuesday, December 15, 1981, he was struck with a baton by an HHSF ACO, that he fell to the ground, and was again hit with the baton and kicked. He began to scream and was kicked by a second HHSF ACO who told him to "shut up." The inmate claimed that his right ankle was injured and his left wrist was broken.

When interviewed a second time and shown ACO photographs, Inmate X identified two HHSF ACOs as the persons responsible for hitting and kicking him. He stated that ACO #1 hit him with a baton twice, once in the back and once on his right arm, and jabbed him with the baton in the back about three times. The inmate said that ACO #2 punched him four or five times in the stomach and attempted to "sic" a Doberman pinscher on him. The inmate failed to repeat, in the second interview, his earlier contention that he was kicked.

There was no evidence to support the inmate's allegation. The two identified HHSF ACOs were not assigned to the strip search team positioned in the Mauka-Ewa corner of the 4-way. The three ACOs of the team assigned to that corner each testified that they did not recall either ACO #1 or ACO #2 ever assisting them in searching any inmate in the Mauka-Ewa corner.

ACO #1 and ACO #2 both testified that they did not recall searching the inmate. Both denied striking the inmate and ACO #2 denied handling a dog in the 4-way at any time.

According to other testimony, the only dogs in the vicinity of the 4-way were the police dogs of the TOD, which were controlled exclusively by their police handlers. The officer who handled the only Doberman pinscher indicated that he alone handled the dog during the shakedown. The testimony from the HPD dog handlers indicated that others would not be able to handle their dogs safely.

There was no testimony from other inmates or staff members that force was used against Inmate X in the 4-way. There was no documentation that the inmate received any medical treatment for his alleged broken wrist, although numerous inmates with apparently less serious injuries received treatment.

Thus, the inmate's credibility was questioned. He made conflicting statements as to what allegedly happened to him in the 4-way, and his statement about the Doberman pinscher was not credible. In addition, Inmate X claimed that he witnessed the beating of another inmate in the 4-way; alleged that the other inmate was punched, kicked, and struck with a baton; and that ACO #2 also attempted to provoke the Doberman pinscher to attack that inmate. However, the inmate who was identified by

Inmate X testified that no force at all was used against him in the 4-way. Therefore, Inmate X's testimony as a witness served to further diminish his credibility.

It was concluded that there was insufficient evidence to support a finding that any force was used against Inmate X.

Example 2. Inmate X alleged that after he was strip searched in the 4-way on Tuesday, December 15, 1981, and as an HHSF ACO handed his clothes back to him, he snatched his clothes from the ACO because he was cold. The inmate alleged that another HHSF ACO then punched him once below his left eye. The inmate identified, from photographs, HHSF ACO #1 as the ACO who punched him.

Inmate X said that another inmate, who was also being searched in the 4-way at the time, may have seen ACO #1 punch him. He stated that HHSF ACO #2, whom he knew since they had attended the same school, may have also witnessed the punch. In addition, the inmate named an OCCC ACO whom he said was present in the 4-way and also may have witnessed the punch.

After viewing a photograph of the inmate, ACO #1 testified that his strip search team may have searched the inmate, as he looked familiar. However, he denied punching the inmate.

An HHSF sergeant, who supervised the strip search team of which ACO #1 was a member, stated that he did not recall his team searching the inmate. The sergeant testified that he did not, nor did he see ACO #1, punch the inmate.

ACO #2 testified that he knew the inmate because they both attended the same elementary school, but that he did not see the inmate in the 4-way.

The OCCC ACO named by the inmate as a possible witness stated that although he was present in the 4-way during many of the strip searches and knew Inmate X, he recalled no incident involving him. Another OCCC ACO, who was present in the 4-way but was not mentioned by Inmate X, stated that he saw Inmate X in the 4-way and that nothing happened to him.

The inmate witness identified by Inmate X initially stated that he saw an ACO punch the inmate near the area of his left eye. However, when re-interviewed, he described the blow as an open-handed slap. Contradicting Inmate X's allegation, the inmate witness identified ACO #2 as the ACO who struck the blow. That ACO was a schoolmate of Inmate X and was named only as a possible witness by Inmate X.

There was insufficient evidence to conclude that force was used against Inmate X.

Example 3. Inmate X alleged that as he proceeded through the corridor by Module 11 on his way to the 4-way on Tuesday, December 15, 1981, he saw two police officers, one holding a Doberman pinscher and the other a German shepherd. The German shepherd barked and lunged at him, and he told the dog, "shut up." He then received a hard slap to the right side of his head, then the left. The inmate said he suffered no injury which required medical treatment, but indicated that his right ear was sore for several days.

The inmate accused the police officer who held the Doberman pinscher as the officer who struck him. He identified that officer, from photographs, as TOD Officer #1.

The inmate stated that an OCCC captain witnessed the blows struck by the police officer and that after he was struck, the captain moved in, escorted him to the 4-way, and in this manner prevented the police officer from striking more blows.

TOD Officer #1 testified that he did not strike the inmate. Each of the six TOD police officers testified that TOD Officer #1 handled a German shepherd, not a Doberman pinscher, during the shakedown. They each testified that TOD Officer #1 was stationed outside the 4-way in the corridor leading to Module 5, a considerable distance from Module 11, during the first four to five hours in which inmates were brought in from the recreation field. Since the dormitory in which Inmate X was housed returned from the recreation field during the first one-and-a-half hours, TOD Officer #1 was not in the vicinity of Module 11 when Inmate X passed that module.

TOD Officer #2, who held the only Doberman pinscher, testified that he was in the vicinity of Module 11 during the first four to five hours of the inmates' return from the recreation field. He denied that he struck Inmate X.

TOD Officer #3, who handled a German shepherd, testified that he was present near Module 11 during the first few hours of the inmates' return from the recreation field. He testified that he did not strike Inmate X, nor did he see the officer who handled the Doberman pinscher strike Inmate X.

The OCCC captain, who was said by Inmate X to have intervened in the incident, testified that he recalled an incident between Inmate X and a police officer. He said that the inmate has a "fast mouth" and was "wising off" to the police officer. Since he felt that something was about to happen, he grabbed the inmate, pulled him away, and the inmate was not struck. The captain identified, from photographs, the police officer as TOD Officer #4. However, according to the testimony of the TOD officers, TOD Officer #4 was positioned with TOD Officer #1 outside the 4-way and away from Module 11 during the first few hours of the inmates' return from the recreation field.

Based on the testimony of the OCCC captain and Inmate X's statements, an incident did occur. However, there was insufficient evidence that force was used against Inmate X.

Example 4. An inmate stated that he witnessed OCCC ACO #1 punch Inmate X inside the Holding Unit and hold him to the ground. The inmate said that after ACO #1 allowed Inmate X to get up, Inmate X wanted to fight ACO #1. However, OCCC ACO #2 instructed Inmate X to leave the area and Inmate X complied. Although Inmate X was interviewed by the office and alleged he was beaten in the 4-way, he did not complain of having been struck by ACO #1 inside the Holding Unit.

ACO #1 testified that he struck Inmate X in the Holding Unit on Thursday, December 17, 1981. He stated that Inmate X had just returned to the Holding Unit from another part of the facility and that, pursuant to the procedures of the Holding Unit, he instructed Inmate X to strip for a search. However, Inmate X protested and accused ACO #1 of picking on him.

According to ACO #1, Inmate X then challenged him to fight "one on one" and approached him in a boxer's stance, with hands clenched. ACO #1 testified that he told Inmate X that he did not want to fight and gestured, with hands up and open with palms facing the inmate, indicating that he did not want to fight. However, Inmate X continued to "dance" while in a boxer's stance and approached him. ACO #1 stated that he unsuccessfully attempted to position himself so that other ACOs were between him and the inmate. He moved backward till his back was against a wall next to a stairway and was thus unable to back up any further.

When Inmate X did not desist and came close to him, ACO #1 concluded that Inmate X was about to hit him. Since the other ACOs did not come to his assistance, he felt either that he would be punched or he would have to punch the inmate. ACO #1 stated that he therefore punched the inmate once and then held him to the ground by grabbing his wrists. Apparently, no serious injury was sustained by Inmate X, since there is no entry in the medical records showing treatment received for any injury resulting from this incident.

ACO #2 testified that he was present when the altercation between Inmate X and ACO #1 occurred. He said that Inmate X wanted to fight ACO #1 "one on one" and told him not to interfere. He said that things then happened very quickly and, before he knew it, ACO #1 had Inmate X on the ground and was holding on to him. ACO #2 said that he saw neither the inmate nor the ACO deliver a blow, and he did not know what caused Inmate X to be on the ground. He said he ordered Inmate X to "go upstairs" and the inmate complied.

The standard discussed in Chapter IV was applied to the above-described circumstances, resulting in the following analysis:

(1) The initial objective was to strip search Inmate X. The threatening and aggressive behavior of Inmate X, exhibited by words and deeds, changed the objective to one of self-defense, which is a lawful objective.

(2) The resistance to the attainment of the lawful objective was evident by Inmate X's refusal to desist and in his continued threatening and aggressive behavior toward ACO #1. The inmate challenged ACO #1 to fight "one on one" and approached him while "dancing" in a boxer's stance even after the attempts of ACO #1 to dissuade him from fighting.

(3) The alternatives attempted by ACO #1 were to tell the inmate he did not want to fight, verbally and by gestures (raising his hands, with palms outward); attempting to position other ACOs between him and the inmate; and by moving back to the wall till he could move no further. Thus, reasonable alternatives were attempted and were unsuccessful.

(4) The force applied against Inmate X by ACO #1 was a single punch, which knocked Inmate X to the ground, and force used to restrain Inmate X by grabbing his wrists and holding him down. Under the circumstances, the amount of force used was just that amount sufficient to overcome resistance and subdue the inmate and did not result in serious injury. Thus, it was concluded that the force used under the circumstances was minimal.

(5) The minimal force used was directly related and limited to the lawful objective of self-defense. If ACO #1 had continued to strike the inmate after he was on the ground, rather than pinning him to the ground by grabbing his wrists, the force used would not have been minimal nor directly related and limited to self-defense.

Based on the above-described application of the standard to the circumstances of this case, it was concluded that the force used by ACO #1 against Inmate X was reasonable.

Appendix F

Examples follow of actual cases with <u>sufficient evidence</u> of the use of unreasonable force. The names of staff members and inmates are omitted to protect the privacy of the individuals involved. Instead, the term "Inmate X" is used to designate the inmate against whom unreasonable force was used; and ACOs are designated as "ACO #1", "ACO #2", etc., when it is necessary to make a distinction between the ACOs mentioned in an example. The terms do not refer to the same inmate or ACO from one example to the next.

Example 1. Inmate X stated on Tuesday, December 15, 1981, he was pulled aside by OCCC ACO #1 at Control Station 4 as he proceeded toward the 4-way. He alleged that ACO #1 and OCCC ACO #2, a sergeant, punched and kicked him, knocking him to the ground and that two other ACOs, whose identities he did not know, also hit him.

ACO #2 testified that he was not present but heard that Inmate X received "lickings" at Control Station 4. He accused two other OCCC ACOs of trying to "pin" him by saying that he was present when Inmate X was "licked" at Control Station 4. However, the two ACOs that he named did not even mention the incident when interviewed.

OCCC ACO #3 testified that he was present, along with ACO #1 and ACO #2, when Inmate X was stopped at Control Station 4. According to ACO #3, ACO #1 wanted to talk to the inmate because the inmate, while he was in the recreation field earlier during the shakedown, had verbally abused him. He stated that as ACO #1 spoke to the inmate, the inmate's hands came up and ACO #1, acting purely in self-defense, shoved the inmate and the inmate fell to the ground. Thereafter, ACO #1 told the inmate to crawl and the inmate crawled away.

ACO #1 first testified that he was positioned in the corridor by the kitchen and did not leave his post when he saw Inmate X approach and turn left into the corridor leading to the 4-way. However, when questioned specifically about the incident by Control Station 4 involving Inmate X, ACO #1 acknowledged that he saw Inmate X in the corridor past Control Station 4, left his post by the kitchen, and told the inmate to go to Control Station 4. He stated that he wanted to talk to the inmate about the abusive remarks the inmate had made to him while in the recreation field. ACO #1 acknowledged that he could have spoken to the inmate near his assigned post, but he could not explain why he told the inmate to return to Control Station 4. However, he denied that his purpose in ordering the inmate to Control Station 4 was to talk to the inmate out of the view of others because he anticipated trouble with the inmate.

ACO #1 stated that ACO #2 and ACO #3 were present when he spoke with the inmate by the Control Station. As he talked to the inmate, the inmate raised his hands and thinking that the inmate might hit him, he grabbed the inmate by the shirt with both hands and threw him against the wall. After hitting the wall, the inmate fell to the ground. While the inmate was on the ground, he then told the inmate, "Crawl, you fucker", and the inmate crawled for a short distance, got up, and walked away.

ACO #1 also testified that neither ACO #2 nor ACO #3 struck the inmate. However, ACO #1 said that after he threw the inmate against the wall, ACO #2, who was the ranking officer present, grabbed him, pulled him aside, and asked: "What you doing?" After the inmate left the area, he explained to ACO #2 that the inmate made abusive remarks directed at him and his family while the inmate was in the recreation field. ACO #2 then told him to talk to the inmate at some other time.

There was insufficient evidence to conclude that Inmate X had been punched and kicked by ACO #1, ACO #2, and two other ACOs. Despite suspicions that a greater degree of force was used, the evidence only supported a conclusion that ACO #1 threw the inmate against a wall, causing the inmate to fall to the ground.

An analysis of the facts of this case logically supports the following conclusions:

(1) The directive of ACO #1 to the inmate to crawl, delivered with an expletive, conveyed an intent that was not defensive.

(2) The testimony of ACO #1, that after he threw the inmate against the wall he was grabbed by ACO #2, indicated that ACO #2 did not perceive the inmate as posing an immediate physical threat to ACO #1. If ACO #2 perceived Inmate X as the aggressor and as an immediate threat to ACO #1, his logical response should have been to grab Inmate X, rather than ACO #1, after the ACO threw the inmate against the wall. That ACO #2 grabbed ACO #1 indicated that he viewed ACO #1, and not the inmate, as the aggressor in the incident.

(3) That ACO #2 asked ACO #1 what he was doing, after ACO #1 threw the inmate against the wall, indicates that ACO #2 did not perceive the inmate as posing an immediate threat to ACO #1. That ACO #2 asked the question, indicates that it was not apparent to him that ACO #1 had acted in self-defense.

(4) If ACO #3 perceived Inmate X as posing an immediate physical threat to ACO #1, his logical response should have been to restrain the inmate.

ACO #1 stated that he threw the inmate against the wall to defend himself. Self-defense is a lawful objective. However, the above analysis does not support the contention of ACO #1 that he acted in self-defense, but instead indicates that he acted as the aggressor in the incident. It was concluded that ACO #1 did not use force for the attainment of a lawful objective. Therefore, the application of the standard described in Chapter IV to the circumstances of this case results in a finding that the force used by ACO #1 against Inmate X was unreasonable. It was also concluded that ACO #1 used poor judgment in leaving his assigned post to confront the inmate at that time and place.

Example 2. Inmate X alleged that he was punched and kicked by an OCCC ACO on Wednesday, December 16, 1981, during a strip search outside the door of his module as he returned from the recreation field. The inmate stated that during the search, he was chewing on a blade of grass that he picked up while in the recreation field. The ACO asked him what was in his mouth, told him to open his mouth, and, before he could respond, punched him in the face. The ACO again asked what was in his mouth, and he answered "grass." He took the blade of grass out of his mouth to show it to the ACO, but the ACO punched him again, held his head to the ground, and kicked him. The inmate said that after he got up, the ACO punched him once more.

The inmate believed he was punched because the ACO thought he had marijuana in his mouth when he responded "grass." After reviewing photographs of OCCC ACOs, the inmate said that the ACO who punched him may have been OCCC ACO #1, but added that he was uncertain.

ACO #1 stated that he was not present outside of Inmate X's module during the time the inmates were returned to the module and were strip searched. He testified that he did not use force against any inmates during the shakedown.

A high-ranking officer of the HNG testified that he and other Guardsmen were present outside Inmate X's module where inmates were strip searched on their return from the recreation field. The officer recalled an incident in which an inmate had something in his mouth and did not respond when asked what it was. Therefore, an ACO slapped the inmate with a hard, open-handed blow across the cheek. The ACO then asked the inmate again what he had in his mouth and the inmate replied "grass." The officer stated that the ACO again slapped the inmate and grabbed the inmate's mouth and a piece of grass, not marijuana, was retrieved from the inmate's mouth. The officer said the inmate did not resist or strike back after he was struck by the ACO. However, he said he could not identify either the inmate or the ACO.

Another Guardsman testified that he saw an inmate slapped three times during the strip searches outside of the module. He said that the ACO conducting the search noticed the inmate chewing on something and asked the inmate what it was. When the inmate did not reply, the ACO slapped him. The Guardsman said that the ACO then repeated the question, the inmate responded "grass," and the ACO slapped him again. The ACO then repeated the question for the third time, slapped the inmate again for the third time, and grabbed the inmate to open his mouth. As it turned out, the inmate had a blade of grass in his mouth, not marijuana. The Guardsman said he could not identify the ACO or the inmate.

Interviews were conducted of 20 other inmates of that module against whom unreasonable force was allegedly used or who allegedly witnessed the use of such force. None reported having been struck under the same circumstances. Hence, it was concluded that the inmate referred to by the two Guardsmen was Inmate X. Based on the testimony of Inmate X and the Guardsmen, there was sufficient evidence to conclude that Inmate X was struck two or three times by an OCCC ACO during a strip search.

Strip searching an inmate is a lawful objective. Grabbing Inmate X's mouth to open it, as part of a strip search and for the purpose of retrieving suspected contraband after the inmate fails to respond to the ACO's question or to surrender the object to the ACO, would be considered the use of reasonable force. However, slapping Inmate X was not directly related nor limited to the lawful objective of strip searching him. Therefore, in applying the standard described in Chapter IV, it was concluded that unreasonable force was used against Inmate X. There was, however, insufficient evidence to identify the OCCC ACO responsible for using the unreasonable force.

Example 3. Inmate X alleged, when first interviewed, that OCCC ACO #1 punched him twice in the stomach during the strip searches in the 4-way on Wednesday, December 16, 1981 and that a second unidentified OCCC ACO punched him once on the jaw. However, when re-interviewed, the inmate stated that he was struck only by ACO #1; that the ACO twice tried to punch him on the ribs, but he blocked both punches; that the ACO also punched him once on the chest; and, after the search was completed, the same ACO punched him once on the face.

The inmate also stated that OCCC ACO #2, who was not a member of the team searching him, intervened by coming over to him and telling him to simply stand and "get yourself composed." According to the inmate, he was then required to turn and squat to complete the search and was then told by someone: "Get the hell out of here."

ACO #1 testified that he did not recall having strip searched Inmate X and denied punching him in the 4-way.

ACO #2 testified that he witnessed ACO #1 strike the inmate twice on the arm with a closed fist. He said Inmate X resisted the search in that he had difficulty in complying with the order to squat because he was scared and shaking. The ACO stated that the inmate squatted halfway, straightened up, and did not want to squat again. The ACO said that he pushed aside ACO #1, who was conducting the search, and told the inmate to turn around and squat. He said the inmate complied, so he then told ACO #1 to finish up the search. After the search was completed, ACO #2 said he told the inmate, "All right, out", and walked away.

The independent testimony of ACO #2 strongly supported the allegation of the inmate in several details: (1) the inmate stated that ACO #2 intervened during his strip search, as did the ACO; (2) the inmate stated that when ACO #2 intervened, he told him to "get yourself composed," indicating that he was flustered, and the ACO testified that the inmate was so scared he was shaking; (3) the inmate indicated that he was searched by ACO #1 and ACO #2 also testified to that effect; and (4) the inmate stated that after ACO #2 intervened, he was required to turn and squat and the ACO testified that when he intervened, he told the inmate to turn around and squat. Most importantly, with respect to the blows struck, ACO #2 testified that he witnessed ACO #1 twice strike Inmate X with a closed fist on the arm. The inmate said that ACO #1 threw two punches at his ribs, but that he was able to block both blows.

Based on the foregoing, the testimony of ACO #2 and most of the testimony of Inmate X was found to be credible. Based on their testimony, it was concluded that ACO #1 punched Inmate X at least twice with a closed fist.

Strip searching inmates is a lawful objective. However, punching an inmate to force compliance with a strip search is not directly related nor limited to the attainment of such lawful objective. It was thus concluded that ACO #1, by punching Inmate X, used unreasonable force.

Example 4. It was alleged that Inmate X was struck during the strip searches in the 4-way on Wednesday, December 16, 1981. When called for an interview at the OCCC, the inmate chose not to be interviewed. However, when subsequently contacted, the inmate responded to a question by stating that he was struck by an OCCC ACO in the 4-way, but that he was not interested in pursuing the matter.

Prior to his refusal to be interviewed, Inmate X made a statement to the former CDAA. According to the former CDAA's report, the inmate stated that he was struck on the face by OCCC ACO #1, that the same ACO pounded his head against the 4-way wall, and that OCCC ACO #2 and OCCC ACO #3 intervened and stopped ACO #1.

ACO #1 testified that he did not hit the inmate, nor did he pound the inmate's head against the 4-way wall. He believed he did not work at the OCCC on Wednesday, December 16, 1981 and said that on the days he worked, during the week of the shakedown, he was assigned to and remained in the cellblock.

However, CD personnel records showed that ACO #1 worked on the day in question, and he was on duty during the period in which Inmate X was strip searched in the 4-way.

ACO #2 testified that ACO #1 slapped the inmate and "sent him flying," and that he and ACO #3 stopped ACO #1 and took the inmate out of the 4-way. However, testimony regarding the incident was not obtained from ACO #3.

OCCC ACO #4 testified that he saw ACO #1 grab the inmate, slam him into the stone or metal portion of the 4-way wall, strike the inmate twice, and thereafter let him go.

OCCC ACO #5 testified that he saw ACO #1 deliver, for no reason, a very hard slap to the inmate's mouth which caused the inmate's false teeth to fly out of his mouth.

OCCC ACO #6 testified that a slap by ACO #1 knocked the inmate to the ground. The ACO also said that the inmate complied with the strip search instructions, but spat on ACO #1.

OCCC ACO #7 testified that an ACO slapped the inmate and the inmate's dentures flew out of his mouth, but that he did not know whether ACO #1 was that ACO. He said the inmate was not resistive, but was "mouthing off to the max."

OCCC ACO #8 testified that the inmate was struck by a forearm or with an open hand by a big OCCC ACO who was terminated about three weeks after the shakedown. According to CD records, ACO #1 was terminated about three months after the shakedown. ACO #8 also said that the inmate wore a bridge and, during the altercation, the bridge fell out of his mouth.

The inmate's medical records indicated that he was treated at the OCCC Medical Unit after the strip searches were completed for a small laceration to the back of his head. On inquiry, the medical staff also reported that the inmate has worn dentures since 1979.

Based on the foregoing, it was concluded that Inmate X was slapped by ACO #1 with such force that his dentures flew out of his mouth and that ACO #1 slammed him into the 4-way wall, resulting in a laceration to the back of his head. The testimony of ACO #1 that he was not present during the incident is negated by the testimony of other ACOs identifying him as the person responsible for the use of force against Inmate X.

The facts of the case do not reveal any justification for the force used against Inmate X. Even if the testimony of the ACOs who alleged that Inmate X "mouthed off to the max" or spat on ACO #1 is accepted as being true, the type of force used by ACO #1 was not directly related or limited to the attainment of the lawful objectives of controlling the inmate or continuing the strip search. The facts also do not reveal any unsuccessful attempt of an alternative to the use of force, nor that force was used as a last resort. Thus, the application of the standard described in Chapter IV results in a finding that the force used against Inmate X by ACO #1 was unreasonable.

Appendix G

These are examples of actual cases involving breaches of duty or misconduct by supervisory personnel. The names of staff members and inmates are omitted to protect the privacy of the individuals involved.

Example 1. Inmates alleged that an OCCC ACO supervisor witnessed the use of unreasonable force against several inmates in the corridor between Modules 3 and 4. They stated that the supervisor was stationed outside the corridor and was in a position to see incidents that occurred in the corridor.

The supervisor acknowledged that he was positioned outside the corridor near Module 2 and that he was able to see through the corridor to the 4-way. He testified he saw HHSF ACOs take a different inmate on three separate occasions into the Module 4 alcove, a small recess in the corridor fronting the module door. The supervisor said that the inmates, whom he named, disappeared from his line of sight. Therefore, he did not know what happened to them in the alcove.

The ACO supervisor testified that he thought that the HHSF ACOs were perhaps telling the inmates whom they took in the alcove to "wise up," because he heard that some inmates were verbally abusive toward staff members while in the recreation field. The supervisor acknowledged that the thought that HHSF ACOs might be punching the inmates in the alcove occurred to him while he was positioned outside the corridor, rather than at a later time. However, he stated he did not wish to think of such things. The supervisor said he knew something was going on in the alcove, but he did not investigate because the inmates appeared to be physically all right since they were able to walk past him on their way to the cellblock. He said he might have investigated if he saw inmates who could not walk or who fell in the corridor.

It was concluded that it was the ACO supervisor's responsibility to investigate his suspicions that the HHSF ACOs might be punching inmates in the alcove. There was evidence that unreasonable force was used in the corridor against four inmates, including two inmates who were identified by the supervisor. An immediate investigation may have prevented the occurrence of some of the incidents. Regardless of whether, in fact, those inmates were punched, it was the supervisor's responsibility to investigate his suspicions.

Example 2. There was sufficient evidence to conclude that unreasonable force was used against Inmate X as he was strip searched inside his module before being sent out to the recreation field. Six staff members testified that the inmate was punched, slapped, or shoved to the ground. An OCCC ACO supervisor and an OCCC administrator were present in the module at the time.

The ACO supervisor testified that the inmate was not punched or slapped and that no force was used against him during the strip search. However, another ACO testified that when the inmate was repeatedly shoved to the ground during the search by

other ACOs, he called this to the attention of the supervisor and questioned whether it was permissible. The ACO testified that the ACO supervisor told him that the ACOs were "only doing their job."

When questioned about strip searches conducted by the HHSF, the administrator stated that it was not proper to slap an inmate for refusing to comply with a search. Later, the administrator testified that he saw an OCCC ACO slap Inmate X's mouth. He stated that the inmate was verbally abusive toward the ACOs and refused to strip for the search. The administrator said that while the slap did not constitute "reasonable use of force," it was not unreasonable. When questioned further, he said that the slap did not bother him and he personally would condone it. When questioned even further regarding the conflict between his latest statement and his earlier statement about the HHSF strip searches, the administrator stated, "I changed my mind," and said that slapping Inmate X was justified.

It was concluded that the administrator breached his duty to intervene and stop the use of unreasonable force and to subsequently report the incident. Similarly, it was concluded that the ACO supervisor breached his duty to intervene and stop the use of unreasonable force and to subsequently report the incident. The supervisor's breach was clear since the use of unreasonable force against the inmate was called to his attention by a subordinate ACO, and because the ACOs who used such force were under his immediate supervision.

Example 3. An ACO supervisor received a list of OCCC ACOs from a subordinate ACO. The subordinate ACO, who compiled the list, testified that it named ACOs who were present in the 4-way, rather than ACOs who used unreasonable force. The supervisor stated that the list named ACOs who had teamed up to subdue recalcitrant inmates during the strip searches, rather than ACOs who used unreasonable force. However, the former CDAA testified that both the supervisor and the ACO informed her that the ACOs whose names were listed used excessive force against inmates in the 4-way. Confirmation that the list contained names of ACOs who used excessive force was obtained from confidential sources.

The ACO supervisor stated that the list did not prompt him to investigate anything. He indicated that he did not speak individually with the ACOs whose names were listed. He stated that an investigation was not required because most of the facility's ACOs could not singly subdue an inmate and three or four ACOs were necessary. He indicated that he did not speak individually with the ACOs whose names were listed, but rather addressed a group of ACOs and told them not to take out their past grudges as they would someday have to return to work in the cellblock where they would be greatly outnumbered by the inmates. He told them not to retaliate and not to think about the past.

The ACO supervisor failed to inform any of his superiors of his receipt of the list. The OCCC Administrator testified that he learned of the list by chance. He stated that he was in the ACO supervisor's office when he received a telephone call from the former CDAA, who asked him about the list that the supervisor had received. He testified that when the ACO supervisor learned that the former CDAA was inquiring about the list, the ACO supervisor's reaction was: "Shit, who told her?"

It was concluded that the list received by the ACO supervisor named ACOs whom the subordinate ACO thought used unreasonable force against inmates in the 4-way. Regardless of the validity of the evaluation made by the subordinate ACO, it was the responsibility of the ACO supervisor to investigate whether the ACOs did, in fact, employ unreasonable force and to report his receipt of the list to his superiors. It was, therefore, concluded that the ACO supervisor breached his duty.

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