INVESTIGATION REPORT ON

THE USE OF RESTRAINTS

ON INMATES CASE, SAYA, SEELYE AND STUTLEBERG

AT

MINNESOTA CORRECTIONAL FACILITY - OAK PARK HEIGHTS

Submitted by:

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INTRODUCTION

On October 6, 1982, Senator Linda Berglin's office contacted the Ombudsmans office concerning inmates Scott Seelye, Mark Stutleberg, Raymond Case and Anthony Saia, (all confined at Minnesota Correctional Facility - Oak Park Heights (MCF-OPH)). Senator Berglin's office had been contacted on behalf of the aforementioned inmates with allegations that the inmates were being abused by being in handcuffs and leg irons for extended periods of time. Senator Berglin requested an investigation of the allegations. On October 7, 1982, the offices of Senators Ronald Dicklich and Gerry Sikorski called with concerns similar to those of Senator Berglin and also requested an investigation of the allegations.

On October 12, 1982, the Ombudsman contacted Warden Frank Wood to advise him of the contacts from the three Senators and to inform him that the Ombudsman was undertaking an investigation of inmate allegations. The Senators also contacted the Warden who informed them that the Ombudsman would probably look into the inmates' allegations. Further, the Warden stated that the inmates had secured an attorney and advised him that legal action would be taken. The Warden defended his position in regards to the treatment of the inmates and stated a belief that any "fair" inquiry will substantiate the action he has taken.

On October 18, 1982, the Ombudsman met with Senator Dicklich. Originally, Corrections officials suggested that representatives from the prison and the Ombudsman's office meet to discuss and review action taken by MCF-OPH. The Ombudsman believed that a meeting involving his office, the Senator and Corrections officials would place the Corrections officials in a defensive posture before all of the facts had been gathered about what happened, and be unproductive. Therefore, the October 18 meeting was arranged as an alternative to the previous suggestion. At the meeting, Senator Dicklich was assured that the allegations were under investigation by the Ombudsman's staff who are monitoring the situation at MCF-OPH to ensure appropriate action is taken to protect the well-being of the inmates. Moreover, upon conclusion of the Ombudsman's investigation, a copy of the report will be made available to the Senator. This course of action was acceptable to Senator Dicklich.

This investigation was initiated on October 12, 1982, and focused on the inmates complaints of alleged excessive and abusive use of restraints. This report provides background information on MCF-OPH, findings, conclusions and recommendations.

BACKGROUND

MCF-OPH is a 400 bed facility, planned, designed and built as a "high (maximum) security" prison. Prisoners confined at MCF-OPH were to be the most difficult prisoners to manage.

Public information on the new facility (MCF-OPH) stressed the prison's design as a "state-of-the-arts" prison with the latest security features effective for managing the most difficult prisoners. Consequently, the focus has been on the physical attributes of the prison and their relationship to enabling the staff to control the prisoners. Staff was recruited and trained to work in a "high security" prison filled with hard to manage prisoners. The operating policies and procedures reflect the "high security" focus, e.g., prohibition of inter-unit contact and activities among the prisoners.

The facility opened in April, 1982, with 50 prisoners who were transferred from other State correctional facilities. None of the 50 prisoners were considered to be hard to manage and were to be part of the support services workers necessary to the operation of the prison. Most, if not all, of the 50 prisoners volunteered to transfer.

The prison has eight separate living units with a capacity of approximately 50 prisoners per unit. The units are designed to be self-contained, i.e., disturbance in one unit should not affect the functioning of the other units. They are expected to function as mini-prisons.

To date, five of the eight units are occupied with a total of 150 inmates. One of those units is the Control Unit (segregation) with a total capacity of 52 inmates. The Control Unit is the most secure of all units and is designed for inmates with disciplinary problems. Inmates who have been charged and/or found guilty of certain rules infractions are assigned to the Control Unit for specified periods of time. The time in the Control Unit is governed by the rules for infractions.

At the time of this investigation, twelve inmates were in the Control Unit. The complainants were four of the prisoners in the unit. In addition, there were 22 federal detainees being held for the federal authorities.

FINDINGS

The following information was obtained from the Ombudsman's files, inmate files, Control Unit daily log and interviews with inmates, the Warden and other staff.

.Inmate Scott Seelye was transferred from Minnesota Correctional Facility - Stillwater (MCF-STW) to Minnesota Correctional Facility - Oak Park Heights (MCF-OPH) - Control Unit (segregation) on June 22, 1982. Mr. Seelye is serving two consecutive 90 days segregation sentences and two 30 days concurrent sentences for Assault, Resisting Arrest, Disobeying a Direct Order and Threatening. He has 56 reports pending. Mr. Seelye was committed to prison on May 1, 1980, on a charge of robbery with a gun. His sentence expires on July 31, 1989, and he has a scheduled release date of December 19, 1984.

.Inmate Mark Stutleberg was transferred from MCF-STW to MCF-OPH on June 3, 1982. He entered segregation (Control Unit) on July 12, 1982, for Threatening. He received a 90 days sentence. His current segregation sentence expires on November 12, 1982. He pled no contest for a total of 123 days segregation time. He has 48 reports pending. Mr. Stutleberg has been in prison since October 7, 1981. He is serving a sentence of 14 years and eight months for second degree murder. His scheduled release date is August 15, 1995.

.Inmate Raymond Case was transferred from MCF-STW to MCF-OPH on May 11, 1982. He entered the Control Unit on August 19, 1982 for Disorderly Conduct and Verbal Abuse. He received 60 days and 30 days concurrent sentence with 30 days suspended. On November 2 and November 4, 1982, Case was granted a hearing on charges of Destruction of State Property and Disorderly Conduct. He was found guilty and sentenced to 120 days segregation. Mr. Case has 42 reports pending. Mr. Case was committed to prison on November 7, 1980, for Aggravated Assault. His scheduled release date is September 3, 1984.

.Inmate Anthony Saia was transferred from Connecticut to Minnesota as a serious management problem. Minnesota accepted him in exchange for three Minnesota prisoners transferred to Connecticut. On August 10, 1982, Mr. Saia was transferred from MCF-STW (Segregation) to MCF-OPH (Control Unit) because of his behavior. He was being held on predetention status on charges pending from MCF-STW. At the time of his transfer back to Connecticut on October 21, 1982, Mr. Saia had 46 reports pending. Mr. Saia was sentenced to prison June 14, 1973, in another state. He is serving a sentence of 99 years.

.All four inmates had previous contact with the Ombudsman office over an extended period of time covering a wide range of issues. The Ombudsman's contact with Mr. Seelye dates back to 1975.

.On July 13, 1982, complaints were received from Mr. Seelye concerning the disposition of personal property. The Ombudsman aided in resolving the complaint.

.On August 16, 1982, received the following complaints from Mr. Seelye: Guards do not wear gloves when serving inmates food; he was forced to have non-contact visits. The results of the case included: a commitment from food service staff to wear gloves and clarification of institutional policy which requires non-contact visits for prisoners in Control Unit.

.On September 8, 1982, Ombudsman received the first complaint from inmate Ray Case alleging excessive use of restraints (handcuffs and leg irons). Mr. Case's complaint alleged that his due process rights were being violated by the use of the restraints. He referred to it as "punishment without conviction". The staff interpretation of what happened was that Mr. Case was destroying State property and had to be restrained to prohibit any further destruction. Mr. Case requested that the Ombudsman notify the media so that people could be made aware of how he and other prisoners were being treated.

.On September 9, 1982, inmate Saia contacted the Ombudsman to complain that they were without lights and water in their cells. Consequently he and inmate Case kicked out the windows in their cell doors which resulted in their being handcuffed. The officer promised to remove the cuffs if they promised to be "good boys". The officer was told to "do his job". Mr. Saia claimed they remained in handcuffs for over ten hours. The record shows the handcuffs were put on at 7:30 p.m. on September 8, and does not show when they were removed. The record showed a check at 10:45 p.m.

CONTROL UNIT INCIDENT REPORTS

The insitutional records revealed the following information pertaining to the four inmates behavior:

.July 29, 1982, inmate Scott Seelye broke a metal stool in his cell, the window to his cell door, the outside window, the light fixtures, made several dents in his metal mirror and knocked several hunks of concrete out of the wall. Seelye was removed to another cell without resistance. Estimated damage was $1,000.

.August 29, 1982, staff discovered that the sprinklers in nine cells in segregation had been broken and partially or totally removed. A search failed to retrieve the sprinklers, but produced two knives, two spoons, a wrist watch and a butane lighter. It was conjectured damage occurred during the night-time exercise period.

.August 30, 1982, at about 1:30 a.m., inmates Saia, Case, and Stutleberg began to destroy their cells. At 2:35 a.m., Mr. Saia was placed in restraints. Destruction continued: 3:45 a.m.,

Mr. Stutleborg was placed in restraints. No resistance was offered by the prisoners when they were restrained.

The four inmates were removed from their cells for a unit search and later returned and placed in handcuffs and leg irons. The black box* was used to secure the cuffs at the inmates' waists with their hands in front of them in order to prevent escape from the cuffs. Inmates thus restrained were Seelye, Saia, Stutleberg, Case, Staples, and Bennett.

At 11:45 p.m., staff observed that inmate Saia had broken his leg irons and the black box on his handcuffs and was missing his waist chain. The squad entered Mr. Saia's cell to subdue him and to place him in restraints. Another set of handcuffs and leg irons was put on Saia and he was restrained to the leg of his concrete desk. The leg of the desk is bolted to the concrete floor in his cell. From this position, Mr. Saia was unable to lie down.

Inmate Stutleberg had also broken his black box and removed his waist chain. He was subdued and restrained in a manner similar to Saia. Three other inmates: Seelye, Staples, and Case remained in restraints.

At 2:00 a.m., the nurse checked the handcuffs and leg irons on Mr. Saia and Mr. Stutleberg and pronounced the inmates well.

When meals were served all inmates were temporarily removed from restraints.

.August 31, 1982, restraints were removed from all inmates at 9:00 a.m. At 9:15 p.m., inmates Case, Stutleberg, Seelye, Saia Bennett, and Staples were placed in restraints. At 12:00 midnight, staff refused to remove Case's waist chain to allow him to use the bathroom. The stated reason for denial was because he could have used the facilities at 9:00 p.m.

.September 1, 1982, staff had problems with the doors, keys, switches, etc., which were not working properly. The tensions were high. Shakedowns produced contraband and threats from inmates.

.September 4, 1982, while out for exercise, inmate Saia placed his feces on the handle to the door leading to the Control Unit.

.September 8, 1982, staff observed cracks in the windows on the doors to Case's and Saia's cells at 7:30 p.m. Mr. Saia was placed in handcuffs, waist chain, black box and leg irons. At 7:50 p.m., Mr. Case was similarily restrained. Restraints were checked at 10:45 p.m. The inmates threw urine at staff and threats continued to be expressed toward staff.

*The black box is a device which is placed over the handcuff connection between the wrists to prevent the prisoner from tampering with the cuffs.

.On September 10, 1982, the Ombudsman visited inmates Case, Saia, Seelye, Stutleberg. They complained about use of restraints, cold meals, improper ventilation and removal of the sprinkler system from the Control Unit. Also complaints were stated about being in rooms without water and toilet fixtures.

The Ombudsman discussed the inmate complaints with staff and the Warden. The staff's response was that the fixtures which had been torn out by the inmates were in the process of being repaired. There were plans to move the inmates to cells with water and working toilet facilities.

The sprinkler system would not be replaced because the Warden believed the system to be too vulnerable whenever there is inmate unrest. The State Fire Marshall granted a variance at the Warden's request because staffing is provided to the Unit on a 24 hour basis.

.On September 12, 1982, at 12:30 a.m., Mr. Saia was placed in restraints. He allegedly had removed a strip of metal from between the two panes of glass in the bottom section of the courtyard window.

.On September 14, 1982, at 11:50 a.m., the switch controlling the doors to the Unit (where inmates Seelye, Case, Stutleberg and Saia were confined) was accidentally thrown, allowing all the inmates out of their cells. Seelye, Case, Stutleberg, and Saia refused to return voluntarily to their cells. Force was used to return them to their cells. Mr. Seelye was seen by the nurse, after the encounter with the staff. No injuries were observed.

.On September 16, 1982, at 1:20 p.m., Mr. Saia threw cups of urine, water, and milk out the book pass opening to his cell which splattered on the floor, walls and table.

.On September 21, 1982, at 9:50 a.m., a search of Mr. Saia's cell revealed a hole about 2½ inches by 3 inches going into an empty space connected to the air vent. Later, at 2:30 p.m., the room was reentered and the molding around the windows looking outside was stripped and a 1½ foot long rod and some matches were found.

At about the same time, search of Mr. Seelye's cell revealed carving around the vent had been occurring. Search of Mr. Case's cell revealed a hole 5 inches by 5 inches going into an empty space next to the air vent. The molding was stripped from the window looking outside and two screws were found.

Shortly thereafter, search of Mr. Stutleberg's cell revealed a hole carved in the shape of a square above the door and in the ceiling.

At 5:30 p.m., in Mr. Saia's cell (103), the staff found four metal switch plates under his bed, with window putty, one metal switch plate in back of a book in the library card pocket, the "guts" of a reset switch and T.V. antenna, and wires under the desk on the floor. A three inch metal object was found in Mr. Saia's pocket - approximately 20 inches of window putty and an empty pop bottle were found in his closet. Also 20 matches were removed from legal papers in Mr. Saia's cell.

.On September 22, 1982, Mr. Stutleberg was overheard to say he would "keep a knife out of his food tray and kill a guard in order to get out of MCF-OTH and go back to MCF-STW or out of State".

At 11:00 a.m., staff conducted a strip search of Mr. Saia. Upon removal of his handcuffs, Mr. Saia hit Sgt. Hargate twice in the face with his fist. The security squad was immediately summoned to help control the situation. Mr. Saia was subdued and strip searched.

.On September 22, 1982, 2:15 p.m., key ring, 5-14 with two cuff keys, one R key and one master lock key were missing. It's conjectured that the keys were lost during the struggle between Mr. Saia and Sgt. Hargate. The area (101-106, was completely shaken down but there was no sign of the keys.

Thorough searches for the keys were made in the area on September 22 and September 23. The results were negative.

.On September 24, the entire area was searched again for the still missing keys with negative results. At about 8:30 a.m., inmates Seelye, Saia, Case and Stutleberg were placed in restraints and escorted individually to health services to x-ray their bodies for any signs of the missing keys. The results were negative.

Later, the staff located a key ring and ring number tab in Mr. Saia's cell. Staff also searched the outside grounds with a metal detector and came up with negative results.

.On September 26, inmate Saia threw his food tray out of his cell and almost hit an officer; he also tore the cover off his mattress. The Control Unit record does not show what action, if any, was taken by staff.

At this time, the institution began to repair and modify the cells which were torn apart by Saia, Seelye, Case and Stutleberg. The purpose of the modifications was to make the area more indestructible. The cell doors were equipped with different and a more durable type of glass.

.On September 27, Case scratched the new glass in his door. Staff were prevented from seeing inside through the glass and were required to open the slot to view the cell.

.On September 28, one of the inmates told staff that the keys would be returned if Stutleberg, Case and Seelye were returned to the general population of MCF-STW and Saia returned to Connecticut within seven days.

On September 30, Mr. Case called the Ombudsman's office to complain that during the previous week he was attacked by an officer while in restraints. The incident was investigated by prison officials and the responsible officer was disciplined. The incident occurred when Mr. Case initiated an exchange of racial slurs between himself and the officer. Mr. Case, allegedly spat on the officer.

.On September 30, 1982, at about 9:20 a.m., staff discovered that the locks on the doors to four cells had been tampered with - one of the locks was jammed.

.On October 1, 1982, at 4:15 p.m., Saia and Stutleberg kicked the windows out of the doors to their cell. Staff removed their shoes, placed them in leg irons and relocated Mr. Saia in another cell.

At 10:20 p.m., inmate Davis kicked out the window to his cell door. He was restrained in leg irons.

In a discussion with a member of the Ombudsman staff, the inmates stated that they were responding to the challenge to break them offered by the workmen and staff when the replacement glass was installed.

.On October 2, 1982, at 9:00 a.m., staff entered Mr. Saia's cell to remove the leg irons and found them missing from his legs. The irons were found later in the toilet, broken into small pieces. Mr. Saia was placed again in leg irons and handcuffs and later removed to another cell. A security check of Mr. Saia's cell revealed that two screws were missing from the light fixture and the vent was tampered with.

.On October 4, 1982, at 2:50 p.m., Case and Stutleberg were placed in restraints for kicking their doors. At 3:35 p.m., staff observed Mr. Stutleberg removing the last of his restraints and restrained him again in a different fashion (four point-arms to legs behind the back). The report states that Mr. Stutleberg was asked hourly if he wanted the restraints removed. The restraints were removed at 11:25 p.m.. The nurse checked his left hand which was swollen and told him to keep it elevated.

.On October 5, 1982, at 2:00 p.m., Mr. Case kicked out the window in his door. He was placed in restraints. A few minutes later, Mr. Stutleberg kicked out the window in his door and was placed in restraints. The records quote Stutleberg as saying:

"We are going to put this place on the map...We'll kill two or three guards at once."

Mr. Saia was quoted as saying:

"Minnesota is one of about four states in the country that hasn't had a guard killed yet...Being in a cell like this just makes me want to kill someone."

Mr. Case was reported to have said:

"Guards have been killed before...just not in uniform...you know what I mean?"

And the record states that Mr. Seelye said:

"I haven't stabbed me a pig in about five years."

During the shower period a routine shakedown was conducted and Mr. Case's cell window was observed to have been opened. It was concluded from the gourge marks on the window knob that some type of tool was used to open it. The same type of marks were on Mr. Stutleberg's window knob and again marks were found on some screws on the access plate under the sink in Mr. Seeyle's cell. A ½ inch piece of steel approximately 24 inches long was found in the mattress in Seelye's cell.

.On October 6, 1982, Saia had covered his door window grate with human excrements. Further, a pile of excrements was on the floor in front of his cell. At 3:50 p.m., Dr. Carlson (Mental Health Unit) was called in to talk with Saia. Saia refused to clean his cell.

.On October 7, 1982, at 12:30 p.m., Mr. Saia was offered an opportunity to clean his cell, which he refused.

.On October 8, 1982, at 10:20 a.m., Saia and Case were offered an opportunity to clean their cells and both refused. Staff cleaned the cells while they were being seen by the nurse.

.At 11:45 a.m., Case, Seelye, Saia, and Stutleberg refused lunch. This refusal began the first days of the hunger strike.

The record shows that all four inmates were offered food daily at each meal and meals were refused (data gathered through October 22). The record shows that Stutleberg and Seelye accepted

coffee at breakfast on October 14. The records also show that the nurse was in the Unit on a daily basis to check the vital signs of the inmates. Sometimes the inmates allowed the check, but most of the time they refused. The inmates stated that they were refusing a specific nurse because they didn't like her. They stated that they would be more inclined to cooperate with someone else.

The records show that the doctor was in the Control Unit on October 12, to see Washington and Case.

.On October 17, 1982, at 3:15 p.m., Mr. Case was placed in restraints for throwing a liquid in the face of an officer. At 8:10 p.m., the restraints were removed and Case and Stutleberg accepted milk.

The nurse viewed the inmates refusal to cooperate with her in the taking of their vital signs (weight and blood pressure) as refusing medical care.

.On October 13, 1982, the officer involved in the incident with Case resigned.

.On October 18, 1982, while on exercise, Mr. Seelye was denied a telephone call. He kicked the telephone and threw it against the wall until it broke into small pieces.

.On October 20, 1982, Stutleberg, Case, and Seelye accepted coffee.

.On October 21, 1982, the Ombudsman visited inmates Seelye, Stutleberg, and Case. Inmate Saia was in the process of being transferred to Connecticut. The inmates were still refusing food and they planned to continue their hunger strike until the Warden transferred them to another institution. Stutleberg and Case wanted to be returned to Stillwater. Mr. Seelye was willing to accept a transfer to another state. They wanted to see the doctor but would not cooperate with Nurse Hunt in order to see him. Mr. Seelye had made two requests to see the doctor for back problems and emphysema.

The inmates complained that their cells were cold (verified by Ombudsman) and the lighting was very poor. The windows on the exterior wall of the cell and the door had been altered. The window to the door had been replaced by a sheet of perforated steel with small openings which permitted one to see into the cell, but to block most of the light from entering. Likewise, the exterior wall window was covered with perforated steel which also blocked out most of the day light. A total of six cells had been modified in this manner.

The inmates believe that if they are not transferred out of MCF-OPH, someone will be hurt. They stated that they do not view themselves as vicious people, but feel that the Warden has a personal vendetta against them which makes MCF-OPH an unsafe place of confinement for them.

The inmates stated that they had made repeated requests to see the Warden, which he refused to grant.

The inmates accused the officers of harassment in getting them out of bed at all hours of the night and early morning for standing counts. If the inmates refused to get out of bed for count, they stated, the staff enters the room, handcuffs them and drags them out.

The Ombudsman discussed the inmates' complaints with the Warden and shared their specific requests for transfer and for a meeting with him. Further, the Ombudsman requested that the doctor see the inmates. The Warden denied receiving any request from the inmates to see him. He visited the unit several times and talked with staff about the inmates. At no time did any inmate request to meet with him. He stated that they did use a variety of abusive language in referring to him during the time he was present in the unit. The Warden stated that the lines of communication are always open to him, either directly or through his staff.

The Warden had met earlier with Dr. Allen institutional physician, Howard Johnson, DOC, Health Care Administrator, Judy Menadue, Assistant Attorney General, and Nurse Punt. Dr. Allen took the position that he would not see the inmates until they cooperated with the nurse. He would see them on October 25, 1982, provided that they gave the nurse a blood and urine sample and allowed her to take their weight and blood pressure for three consecutive days. This position was acceptable to the Warden.

The Ombudsman accompanied the nurse back into the Control Unit. All three inmates refused to cooperate.

Later, the Ombudsman made an effort to contact the doctor to discuss his position but was unable to reach him but did contact the Commissioner of Correction's office with his concerns. The Ombudsman requested that the Commissioner arrange for the doctor to see the inmates.

On October 22, 1982, the Ombudsman received a handwritten statement titled "Open Statement To Senators In Care Of Ombudsman's Office From Oak Park Heights - Vanguard Four". That statement was critical of the Ombudsman office in its failure to gain the relief the inmates desired. The statement claimed that the Ombudsman's failure to take corrective action caused their decision to seek legal counsel and to petition the courts for redress.

.On October 25, 1982, the Ombudsman contacted Warden Wood. Dr. Allen had not yet seen the inmates but would see them on October 27, despite their continued refusal to cooperate with the nurse.

.On October 27, Dr. Allen visited the Unit and spoke with the inmates through the mail slot. He told them that he needed a blood sample before he would do any kind of assessment of their condition. Later the same day, the Deputy Ombudsman discussed the Doctor's request with the inmates. However, their refusal to cooperate continued. The inmates expressed a desire to be sent to Ramsey Hospital where they could undergo a thorough and "competent" medical evaluation.

During this visit with the inmates, Stutleberg, Case and Seelye, the Deputy Ombudsman also informed them of the information about their behavior obtained from the Control Unit records. They were offered an opportunity to challenge that information. All three inmates stated that they felt the Ombudsman knew what happened and they had told him all they planned to tell him. Their attorney, with whom they are now working to resolve the situation, has advised them not to give any further information to the Ombudsman.

.On October 25, 1982, the three inmates were transferred out of the cells which were modified to regular cells in the Control Unit.

.Corrections officials estimated the total damages in the Control Unit at $7,000 for materials, plus 250 hours overtime.

.On November 10, 1982, inmate Stutleberg ended his hunger strike and began to eat solid foods.

Inmates Case and Seeley continue to reject solid foods, but are consuming large quantities of liquids.

CONCLUSION AND RECOMMENDATIONS

Conclusions:

.Restraints (handcuffs, chains, leg irons) are used on inmates in the Control Unit at MCF-OPH when staff perceives the inmates to be out of control - unmanageable.

.Restraints were used on inmates Case, Saia, Seelye and Stutleberg for several hours at a time.

.The use of restraints followed inmate behavioral incidents, e.g., refusal to return to rooms, breaking furniture, etc.

.Restraints were not always effective. On several occasions the inmates were able to free themselves.

.Each time an inmate was able to free himself, the restraints were reapplied in a more secure manner.

.The application of restraints and the subsequent escape from them appeared to be a challenge to both staff and inmates.

.An examination of the records neither established nor refuted inmate claims that they were left in restraints for over ten hours. The records showed time and date of the application of restraints, but did not show an equal number of corresponding instances of releases from restraints.

.Case, Saia, Seelye and Stutleberg were not the only inmates placed in restraints: however, they were the only ones placed in four-point restraints and restrained for several hours at a time.

.The inmates appeared to be out to prove that the "high security" prison was destructible. Staff appeared to have a need to prove that the prison was indestructible.

Recommendation:

.That the MCF-OPH - Control Unit records reflect the following information for each instance restraints are used on inmates: kind of restraints, how they were applied, actual time the inmate was placed in restraints and the actual time the restraints were removed; also the name and rank of the officer authorizing the use of restraints.

Conclusion:

.There were instances of staff error which may have contributed to some of the problems involving the four inmates. For example, on September 14, 1982, a switch controlling the doors in the area where these four inmates were confined was inadvertently thrown, opening the cell doors. Force had to be used to return the men to their cells. Another example on September 22, 1982: during a strip search of inmate Saia, an officer with all of the keys to Mr. Saia's restraints entered Mr. Saia's cell. In the ensuing struggle the keys were dislodged and are still missing.

Recommendation:

.That Control Unit staff be prohibited from entering a cell occupied by an inmate with any excess keys in his possession.

Conclusion:

.The four inmates were left in cells with broken toilet fixtures and no running water. The records do not show the length of time that they remained in such cells.

Recommendation:

.That the Control Unit records reflect the following information whenever an inmate is left in a cell with damaged fixtures: a description of the condition of the cell, e.g., broken toilet, no running water, etc., actual time the damage occurred, and how long the inmate occupied the damaged cell.

Conclusion:

.The decision not to replace the sprinkler system appears to be shortsighted and could prove to be a future source of trouble for MCF-OPH.

Recommendation:

.That the sprinkler system in the MCF-OPH - Control Unit be repaired and restored to working order.

Conclusions:

.Despite the Ombudsman's inability to gain the inmates the results they desired, they continued to contact the Ombudsman for assistance until (according to the inmates) their attorney advised against it.

.The Ombudsman pursued the facts on all complaints filed by the four inmates. The investigation did not provide information sufficient to support the actions demanded by the inmates. Further, the Ombudsman lacks the authority to require Corrections officials to respond in the manner suggested by the complainants.

Comment:

The Ombudsman will reemphasize the role of his office in investigating complaints and making recommendations for corrective action.

Conclusions:

.The inmates began their hunger strike to protest how they were being treated by the Warden and his staff.

.The hunger strike was seen by the inmates as an opportunity to dramatize their grievances against the institutional administration. They wanted the media to publicize what was happening to them at MCF-OPH in order to create pressure to gain the results they desired.

.The failure of the inmates to cooperate with the medical personnel (by giving blood and urine samples and having their weight and blood pressure checked on a daily basis) resulted in their not being seen and examined by the institutional physician when they requested it.

.The reasons for not returning Mr. Saia to Connecticut until October 21, 1982, was due, in part, to Connecticut's inability to find another prison willing to accept him because of his behavior. Minnesota had notified Connecticut of their desire to return him prior to his transfer to MCF-OPH. In the Ombudsman's discussions with Corrections officials, however, it was implied that MCF-OPH was a facility designed and built for prisoners like Mr. Saia.

.The Warden and his staff believe that their behavior toward these four prisoners was appropriate, justified by the circumstances and quite restrained.

.In one instance of obvious officer misconduct, the Warden took disciplinary action against the officer.

.The Ombudsman was unable to establish that staff used excessive force in responding to the behavior of the four inmates. The use of excessive force is difficult to determine, especially when its use appears to have been a legitimate response for the initial incident. Unfortunately, the use of excessive force is

more readily established in instances where the complainant has suffered grave bodily harm The institutional records do not show that either of the four inmates sustained any significant injuries.

Comment:

The Ombudsman recognizes that MCF-OPH has been operational for less than a year and that current policies and procedures require some time before they can be fully implemented. Therefore, the Ombudsman will carefully review and monitor the application and implementation of current policies and procedures with a focus on the Control Unit to assure that inmate rights are fully protected.

ADDENDUM:

In a meeting with Warden Frank Wood on December 1, 1982, the Ombudsman was advised that recommendation #1 had already been implemented. The Warden took the initiative when he observed that the Unit Records were incomplete. Likewise, action has been taken in relation to the other recommendations made by the Ombudsman.

In regard to recommendation #4, the Warden expects to have all sprinkler heads intact and operational, except for those outside of the recently modified cells.

Finally, Warden Wood offered the following statement:

> "The staff at Oak Park Heights have worked hard and diligently in attempting to finalize procedures relative to the operation of the institution and the segregation unit. Many of these documented procedures were in the process of taking place prior to the inmate disturbances in the segregation unit, which precipitated the investigation report by the Ombudsman's office. There was continual and regular contact with the Attorney General's office prior to the incidents in the segregation unit, and this has been an ongoing procedure. The staff have made every effort to improve documentation of incidences that occur in the unit, especially relating to the importance of documentation relating to procedural events. There have been memorandums and regular communication with the Attorney General's office, which have resulted in the formation of policies and procedures for the segregation unit with the support of legal opinion. The staff at MCF-OPH have made every effort prior to the incidents in segregation and after the incidences, to professionally establish the procedures in a fashion that will represent the effort toward appropriate sanctions and procedures within the institution and the segregation unit."