



The Cruel and Unusual Use of Restraint Chairs in California Jails **A Call to Action**



Disability Rights California opposes the use of California’s jails and prisons as de-facto housing for people with disabilities. Disability Rights California advocates to increase the quality and availability of housing, employment, education, and healthcare in order to reduce California’s reliance on the criminal legal system.

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This report, a Spanish-language version of the report, and an accessible electronic version of this report, are available at: <https://www.disabilityrightsca.org/restraint-chairs-in-california>

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Executive Summary

Disability Rights California (DRC) has long advocated for reducing and eliminating the use of physical restraints on people with disabilities. From hospitals to nursing homes to schools, we have advanced strict restraint standards through our legislative and public policy efforts.¹ We recently turned our attention to restraint practices in jails, with a specific focus on the restraint chair, upon learning from multiple media sources about the death of Andrew Holland, a young man with schizophrenia who was held in a restraint chair for nearly 46 hours at San Luis Obispo County Jail.² Andrew Holland's death highlights the lethal dangers posed by the use of restraint chairs and the need for clear, enforceable restraint standards in detention facilities.

Andrew Holland grew up in a tight-knit family on California's Central Coast. He is remembered as a friend who always took time to care for others and as a gifted athlete and avid surfer. By around age eighteen, Andrew started experiencing the symptoms of schizophrenia that ultimately resulted in conflicts with law enforcement and multiple arrests. During his final incarceration in San Luis Obispo County Jail, Andrew's family alleges he was kept in solitary confinement for close to 14 months.³

On January 20, 2017, San Luis Obispo County Jail deputies placed Andrew Holland in a restraint chair after removing him from solitary confinement to prevent self-injury as he had allegedly been punching himself in the face.⁴ Andrew was restrained in the chair for 46 straight hours, completely naked, except for a blanket that repeatedly fell off his lap. Prohibited from leaving the chair, he slept, urinated, and defecated on himself.⁵ At no point did he display violent behavior during his restraint in the chair. Andrew Holland died from an intrapulmonary embolism on January 22, 2017, 45 minutes after he was released from the restraint chair. He was only 36 years old.⁶

Because of our concerns about restraint chairs, DRC undertook a monitoring project to examine how restraint chairs are used in jails throughout California. Our review of current regulations, jail policies, academic research, interviews with county sheriffs and jail staff, and consultation with our expert, form the basis of our recommendations about how California can better protect incarcerated individuals from the dangers posed by restraint chairs.

State Regulations Governing Restraints in Jails

In California, the Board of State and Community Corrections (BSCC), an independent statutory agency formed in 2012, is responsible for promulgating regulations related to the operation of local detention facilities. The BSCC promulgates minimum standards regarding restraint, including the use of the restraint chair, in local jails, which are found in Section 1058 of Title 15 of the California Code of Regulations. In addition to these minimum standards, county sheriffs, tasked with the administration of the local jails in California, may develop county-specific policies that further define and regulate restraint use within their local jails. DRC reviewed the restraint policies from all 58 California counties.

In its current form, Section 1058 fails to protect incarcerated individuals from the dangers posed by restraints, and in particular, restraint chairs. The regulation asks that less restrictive alternatives to restraint be contemplated, but does not require they actually be attempted. It requires a medical assessment within an hour of restraint use, which can be far too late to prevent injury or death. Section 1058 also does not set time limits on the use of restraint chairs, even though the manufacturers of the restraint chair recommend a two-hour maximum time limit. Instead, the regulations only require that an individual be taken to a medical facility for further evaluation if the facility manager or designee, in consultation with health care staff, determines the individual cannot be safely removed after eight hours in the restraint chair. Furthermore, Section 1058 does not set standards for review or accountability if restraint is used inappropriately.

By contrast, some California counties have adopted stronger, stricter guidelines that more effectively govern the use of restraints, and, in particular, restraint chairs. Specifically, some counties limit the use of the restraint chair to two hours within a 24-hour period, others allow the restraint chair only for transportation, some but not all require medical assessment before its use, or require constant, direct observation and video-recording of its use.

Recommendations Regarding the Use of Restraint Chairs

While we remain concerned about the use of a range of physical restraints in jail, Andrew Holland's death prompted DRC to focus on the restraint chair. **Based on our monitoring of the use of restraint chairs in the jail setting, we recommend that counties adopt stronger measures to reduce their use in detention facilities.** Counties have great flexibility to create safeguards pertaining to restraint use and are not limited by the minimum standards set by the BSCC.

To set a strong baseline from which counties can develop their restraint policies, we recommend that the BSCC restrict restraint use to situations when all less restrictive methods have been attempted and failed. Further, we recommend that the BSCC promulgate a separate

set of regulations specifically pertaining to the use of the restraint chair that augments the existing Section 1058 restraint standards by incorporating the proposals listed below.

These improved minimum standards will enable counties to improve their practices and provide guidelines from which they can further explore ways to reduce restraint chair and restraint use.

Alternatives to the Use of Any Restraint

- Prior to using any form of physical restraint, including restraint chairs, county jails shall be required to attempt all less restrictive alternatives, including verbal de-escalation techniques, and only use physical restraint if those fail to control behavior that is imminently dangerous to the self or others. Specifically, Section 1058 should contain the following language: “physical restraints should be utilized only when all less restrictive alternatives, including verbal de-escalation techniques, have been attempted.”

Limits and Precautions on the Use of Restraint Chairs

- County jails shall conduct a medical and mental health assessment of an individual prior to the use of a restraint chair, or at the inception of its use.
- Deputies shall maintain direct, continuous observation of any restrained individual.
- County jails shall use the restraint chair only for as long as needed to secure an incarcerated individual for transport to outside medical attention and the use of the restraint chair shall not exceed two hours.

Accountability

- All restraint events shall be video-recorded.
 - County jails shall keep a separate logbook detailing all restraint incidents, including the following: the event(s) leading to the use of restraints; the duration of time spent per incident in a restraint; the number of serious injuries sustained by persons while subject to restraints.
 - Counties shall report to the BSCC all incidents of use of a restraint chair as part of its monthly jail report, including the following: number of times it was used; the duration of time spent per incident in a restraint chair; the number of individuals restrained; the number of serious injuries sustained by persons while subject to restraint in a restraint chair.
 - Counties shall report to the BSCC within ten days all deaths that occurred while individuals were in restraints, or where it is reasonable to assume that a death was proximately related to the use of restraint. The BSCC shall make this information publicly available.
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Overview of Requirements Regarding the Use of Restraints in Healthcare and Custodial Settings

Use of Restraints in Non-Custodial Healthcare Settings

In 1999, CMS, the federal Centers for Medicaid and Medicare Services (then called the Health Care Financing Administration) issued strict rules concerning the use of restraint and seclusion in hospital settings. Those rules have been modified several times, including as recently as November 2019.

Among its requirements, CMS currently mandates that:

- Restraints only be used in emergency situations to ensure the patient's physical safety and/or the physical safety of staff members or others and less restrictive interventions have been determined to be ineffective;
- Only the least restrictive method of restraint that is effective to protect the patient, staff members, and/or others should be used;
- Restraints require the written order of a physician or other licensed practitioner;
- A physician, other licensed practitioner, or trained staff must monitor the condition of a restrained patient; and
- A physician, other licensed practitioner, registered nurse, or physician assistant must see a restrained patient face-to-face within one hour of the initiation of restraint.⁷

CMS promulgated these guidelines in response to lethal hazards posed by the use of restraints.

The academic literature continues to support concerns about the serious health risks posed by restraint. In one survey on the risk factors for Deep Vein Thrombosis (DVT) in psychiatric settings, researchers found that DVT symptoms, typically felt in the legs, can be underreported by psychiatric patients. This under-reporting is due to their psychiatric symptoms and sedation interfering with sensation in their lower body, which results in pulmonary embolism as the first clinical manifestation of DVT in restrained patients. Additionally, sedation increases the likelihood of DVT.⁸

Further, the efficacy of restraints as therapeutic devices has not been empirically demonstrated in outcome studies. Restraints have been associated with death by asphyxia and aspiration, even when properly applied. Psychotropic medications might increase the likelihood of death while in restraint. Immobilization might be a risk factor for death because of its relationship to fatal pulmonary embolisms.⁹

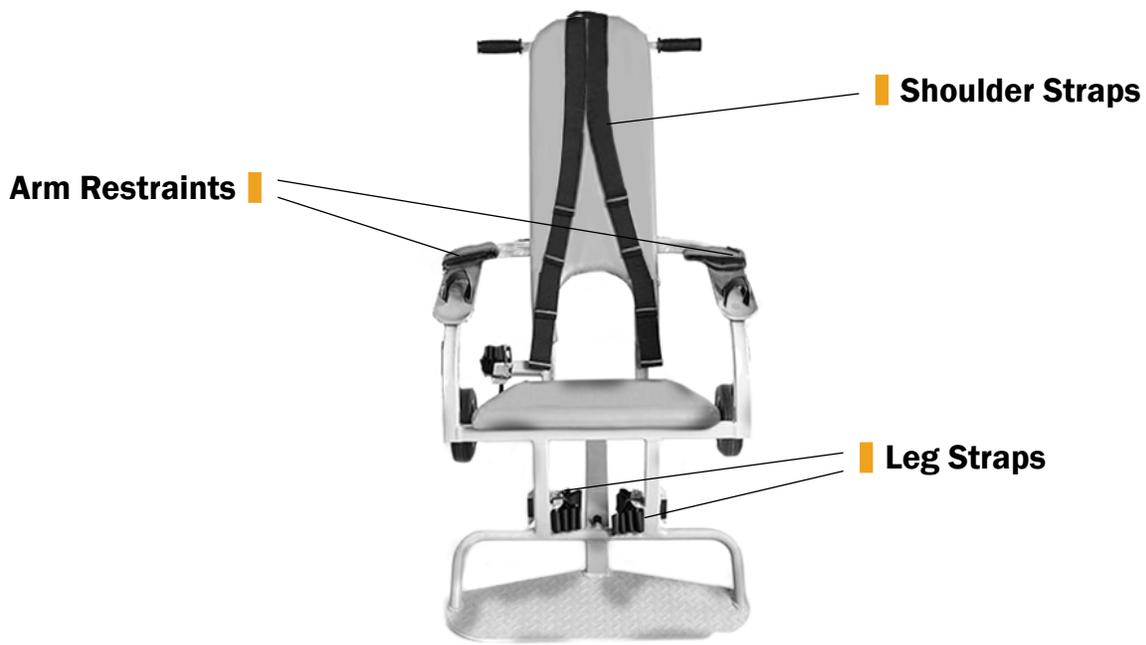
Use of Restraints and Restraint Chairs in California Jails

In California, the Board of State and Community Corrections (BSCC), an independent statutory agency, is responsible for promulgating the minimum standards which regulate the conditions within local jail facilities. The regulations governing restraint in local jails are contained in Section 1058 of Title 15 of the California Code of Regulations.

Currently, Section 1058 mandates that restraints in jail:

- Cannot be used for punishment or as a substitute for treatment;
 - Can only be used on incarcerated individuals who display behavior which results in property destruction or reveals an intent to cause physical harm to self or others;
 - Can only be used when it appears less restrictive alternatives would be ineffective in controlling the “disordered behavior;”
 - Require the approval of the:
 - Facility Manager;
 - Facility Watch Commander; or
 - Responsible Health Care Staff;
 - Must be reviewed a minimum of every hour;
 - Require medical opinion within one hour from the time of placement regarding placement and retention of restraints;
 - Require medical assessment within four hours of placement;
 - Require documented direct visual observation at least twice every thirty minutes;
 - Require an individual in restraint to be housed alone or in specified housing which protects the individual from abuse;
 - Require that an individual be taken to a medical facility for further evaluation if the facility manager or designee, in consultation with health care staff, determines the individual cannot be safely removed from restraint after eight hours.
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Compared to the aforementioned CMS rules defining the permitted use of restraints in healthcare settings, Section 1058 is much less stringent because it does not require the written order of a physician or licensed health practitioner; does not require monitoring by a physician, licensed health practitioner, or trained staff; and does not require that a physician or other qualified health staff conduct a face-to-face evaluation within an hour of placement in restraints. This is a troubling contrast, given the lack of oversight, training, and potential for abuse inherent in jail settings. Indeed, as noted by Dr. Kenneth Applebaum, a national expert on correctional mental health, **“endorsing restraint use in nonhospital correctional settings that is widely eschewed in nonhospital community settings stretches community standards and has risks. The prevailing lack of effective and meaningful oversight of correctional restraint use only compounds these risks.”**¹⁰



The Restraint Chair

The restraint chair keeps an individual strapped down, with locking mechanisms on the wrists, ankles, torso, and lap (refer to above). It can be moved easily to any area of a jail because it has wheels, which allows custodial staff to bring the device to a person they consider difficult or combative.

However, experts have concluded that the restraint chair's mobility is at once its main advantage and its major disadvantage. Because the chair enables restraint to occur in many different settings, rather than in only a specifically designated restraint or seclusion room, it is often used on a housing unit where the environment is not supportive.¹¹ In such situations, the use of a restraint chair is less likely to follow the proper protocol and more likely to be used by staff who are not trained on the safe use of restraint, increasing the likelihood of an adverse outcome.¹²

Restraint Chair Manufacturers' Time Limits

The manufacturer of the SureGuard Correctional Safety Restraint Chair, used in many county jails, specifically cautions that "violent behavior may mask dangerous medical conditions; therefore, detainees must be monitored for and provided with medical treatment if needed."

The manufacturer states that detainees should not be left in the chair for longer than two hours.

Our review of county restraint chair policies shows that most county jail policies allowed for up to eight hours of confinement in the chair.¹³

Dangers of Restraint Chairs

Deaths Caused by Restraint Chairs

Andrew Holland is not the only incarcerated individual to have died or been injured while held in a restraint chair. Numerous other individuals have also perished in restraint chairs in county jails across the United States. Amnesty International has compiled a review of deaths in which the use of a restraint chair was a primary or contributing factor. Their review suggests that restraint chairs are routinely used in conjunction with inadequate supervision, inappropriate chemical or electrical restraints, and/or on intoxicated persons, leading to increased risk of death or injury.

While Andrew Holland’s death illustrates the danger posed by prolonged use of restraint chairs, even relatively short periods of unmonitored restraint in a chair can be deadly.

For example, Albert Lee Cothran was found unresponsive only 45 minutes after being placed in a restraint chair for the second time in 24 hours in Columbia County Detention Center in Florida. Mr. Cothran was left unsupervised while in the restraint chair.¹⁴

Similarly, Hazel Virginia Beyer was arrested in Tennessee for public intoxication and placed in a restraint chair in the Johnson City Jail after being assessed as a suicide risk. Due to her acute intoxication—her blood alcohol level was measured at three times the legal limit—she slipped down in the chair causing the restraining straps to tighten around her throat, choking her and ultimately resulting in her death several days later. Ms. Beyer was not monitored appropriately during her restraint and was only observed through the small window of the jail cell door intermittently.¹⁵

In addition to the increased risks to unsupervised and/or intoxicated restrained persons, persons who have been further immobilized by the use of electro-shock devices, such as tasers, or chemical restraints, like oleoresin capsicum pepper spray, are also particularly vulnerable to positional asphyxia in restraint chairs. In Louisiana, Kevin Coleman was forcibly removed from his jail cell after he refused to make a court appearance. Mr. Coleman was pepper sprayed and shocked with a shock shield before being placed in a restraint chair. Despite being periodically allowed out of restraint, Mr. Coleman was found not breathing and pronounced dead on his third day of restraint.¹⁶

The preceding examples of deaths attributable to the use of restraint chairs suggest that restraint chairs are inherently dangerous and should be used only when appropriate safeguards are in place.

The safeguards we recommend would only allow for the use of restraint chairs when:

1. all other less restrictive alternatives have failed to prevent self-injurious behavior or behavior that poses a danger to others;
 2. there are clear limits on the use of restraint chairs, including medical assessment prior to the use of restraint, direct observation during restraint, and time limits on the duration of restraint; and
 3. accountability measures are in place, including videotaping, documenting, and reporting to the BSCC information regarding the use of restraints.
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Limitations on Restraint Chair Use in California and Discontinuance in Other States

In 1997, four men were restrained in a Pro-Strait chair at the Ventura County Jail and brought a class-action lawsuit in federal court regarding its use. The lead plaintiff, Kurt Von Colln, had bipolar disorder, and many of the class members were people with mental illness. DRC submitted an amicus brief on behalf of the plaintiffs. In 1999, the court enjoined the Ventura County Sheriff from using the restraint chair in its jail facilities, finding that deputies used it to punish incarcerated individuals, leaving them to urinate and defecate on themselves, often while naked.¹⁷

In *Hernandez, et al. v. County of Monterey*, county jail inmates sought declaratory and injunctive relief against the county, the sheriff's office, and the private company managing the facility. The plaintiffs alleged state and federal constitutional violations due to poor jail conditions and violations of the Americans with Disabilities Act, the Rehabilitation Act, and a California statute prohibiting discrimination in state-run programs. The plaintiffs also alleged inadequate and poor care for mental health patients, particularly with the use of restraint chairs. The parties settled, and the defendants' implementation plan included more stringent policies for restraint chair usage, which placed limits on the amount of time a restraint chair could be used and required regular extremity exercise periods and monthly audits.¹⁸

Faced with similar lawsuits from detainees subject to restraint, many other jurisdictions have restricted or discontinued the use of restraint chairs in certain facilities.¹⁹ Utah and Florida have reportedly banned or partially banned the use of restraint chairs in their correctional facilities.²⁰ The states of Vermont, Oklahoma, Texas, Montana, and Iowa restrict the use of restraint chairs by regulation.²¹

Disability Rights California's Monitoring of Restraint Chairs

DRC's Review of California County Policies

Section 1058 sets the minimum standards, or the “floor,” for counties’ use of restraints in jails. It does not require a separate policy for the use of restraint chairs. Each county is further mandated to develop its own policies and procedures pertaining to the use of restraints. Specifically, Section 1058 requires that the “facility administrator, in cooperation with the responsible physician, shall develop written policies and procedures for the use of restraint devices and may delegate authority to place an inmate in restraints to a responsible health care staff.”

The policies must include:

- Acceptable restraint devices;
- Signs or symptoms prompting immediate medical/mental health referral;
- Availability of cardiopulmonary resuscitation equipment;
- Protective housing of restrained persons;
- Provision for hydration and sanitation needs; and
- Exercising of extremities.

In California, county sheriff departments operate local jail facilities and develop the written policies and procedures that govern their use, including the use of restraints and restraint chairs.

DRC issued a public records request to all 58 California county sheriffs, requesting their restraint policies, separate restraint chair policies (if available, as Section 1058 does not currently require a stand-alone restraint chair policy), number of jail facilities, number of restraint chairs, and average daily populations of their jails.²²

We toured jails and spoke to officials with the Alameda, Los Angeles, and San Francisco county jails, examined the literature concerning the use of restraint chairs, and reviewed restraint standards in healthcare and custodial settings. Additionally, we consulted with Dr. Terry Kupers of the Wright Institute,²³ one of the foremost experts on psychiatric healthcare in custodial settings. Dr. Kupers has written and testified extensively about best practices for psychiatric healthcare in community and custodial settings.

Analysis of County Policies on Restraint and Restraint Chairs

Do not use restraint chairs (9 counties)

Colusa, Glenn, Lassen, Modoc, San Luis Obispo, Siskiyou, Sutter, Tehama, and Yuba. San Luis Obispo County, where Andrew Holland died, has discontinued use of the restraint chair in its jail.

Stand-alone restraint chair policy (26 counties)

Contra Costa, Humboldt, Imperial, Kern, Kings, Lake, Los Angeles, Mariposa, Mendocino, Merced, Napa, Nevada, Orange, Plumas, Sacramento, San Diego, San Francisco, San Joaquin, San Mateo, Santa Barbara, Santa Clara, Shasta, Stanislaus, Tuolumne, Ventura, and Yolo

Rely on policy that mostly restates Section 1058 (13 counties)

Amador, Calaveras, Del Norte, El Dorado, Glenn, Inyo, Lassen, Madera, Marin, Mono, Monterey, Santa Cruz, and Trinity

Nine California counties do not use restraint chairs. Colusa County, which does not have a restraint chair, maintains that “restraints for the purpose of managing disordered behavior shall not be utilized in the Colusa County Jail,” and instead outlines a procedure in which restraint will only be used for the length of time necessary to transfer the incarcerated individual to the community hospital. Colusa County’s policy also delineates a strict timeline: “In no case shall an inmate be allowed to remain in the facility, in restraints, for more than thirty (30) minutes beyond the initial use of force.” Siskiyou County informed DRC that they do not use restraint chairs because they do not always have the medical staff on-site to make sure they are being used properly.

Several counties have stricter time limits than Section 1058 and contain safeguards such as direct, visual observation, shorter timelines by which a medical or mental health assessment must be conducted, and limitations on whom can be restrained. Some counties require detailed accounting of restraint use, including a notation of the events leading up to the restraint and duration of restraint. Other counties mention a preference, although not a requirement, for video-recording of all restraint events. Many of the policies and practices acknowledge that the primary purpose of the chair is to temporarily contain an individual for transportation to outside medical care.

Notably, Santa Clara County sets a strict two-hour limit on the use of the restraint chair, including enough time to account for the removal from the restraint process. Santa Clara's policy only authorizes trained personnel to use the chair, and requires the facility to keep a record of custody staff trained in its use. The entire process must be video-recorded. "Without exception, all inmates placed in the Restraint Chair shall be expedited to their final destination." Further, Santa Clara County prohibits the use of the restraint chair on individuals who are housed on a Welfare and Institutions Code section 5150 (involuntary psychiatric) hold, severely mentally ill and/or under conservatorship, without the approval of a mental health clinician.

Los Angeles, San Benito, and Tuolumne counties also limit the use of the restraint chair to two hours, with exceptions for exigent circumstances. San Benito's restraint chair policy similarly states that "detainees should not be left in the Emergency Restraint Chair for more than two hours. This time limit was established for the detainee to calm down or sober up, and if needed, it allows for the correctional officer to seek medical or psychological help for the detainee." Even though they have a restraint chair policy, San Benito informed DRC that they have not used their chair because they have not had sufficient staffing to ensure its appropriate and safe use.

Although not in its written policy, San Francisco informed us that they use the restraint chairs in their San Bruno facility only for the time needed to transport a person for outside medical or psychiatric care, which rarely exceeds two hours.

Recommendations

Section 1058 and the county policies we reviewed prohibit the use of the restraint chair for punishment. However, that limitation alone is not sufficient to protect incarcerated individuals. Given the dangers posed by restraints and the lack of evidence to justify their application as a long-term method to control aggressive, dangerous, and violent behavior, county jails should limit the use of restraints and in particular the use of restraint chairs. Section 1058 is insufficient to protect incarcerated individuals from the dangers posed by the restraint chair.

The BSCC should not leave it up to individual counties to develop adequate policies regarding inherently dangerous practices. Custody standards should not be dependent on the county jail in which an individual is detained. The BSCC should adopt regulations that ensure restraint use in all jail facilities is thoughtfully and carefully applied, with consideration of alternatives, appropriate time and other limits, and accountability.

Alternatives to the Use of Any Restraint

The BSCC should strengthen Section 1058 to require de-escalation prior to the use of all physical restraints, including the restraint chair. Section 1058 currently states, “physical restraints should be utilized only when it appears less restrictive alternatives would be ineffective in controlling the disordered behavior.” The wording should be changed to, “physical restraints should be utilized only when all less restrictive alternatives, including verbal de-escalation techniques, have been attempted.”

This change would require county jails to show that all less restrictive alternatives, including verbal de-escalation techniques, have been attempted and failed to control behavior that is imminently dangerous to self or others. Dr. Kupers, our expert, recommends that correctional staff spend a significant amount of time trying to verbally engage the incarcerated person from his or her crisis before using any restraint. He also recommends that medical and mental health staff should be summoned to try and de-escalate the situation.

De-escalation is at the core of restraint reduction. The National Association of State Mental Health Program Directors (NASMHPD) created the “Six Core Strategies for Reducing Seclusion and Restraint Use.”²⁴ These strategies are

1. leadership towards organization change,
2. use of data to inform practice,
3. workforce (or staff) development,
4. use of seclusion and restraint prevention tools,
5. inclusion of all individuals in using seclusion and restraint prevention and
6. debriefing techniques.²⁵

The fourth strategy calls for “the use of de-escalation or safety surveys and contracts... and environmental changes to include comfort and sensory rooms and other meaningful clinical interventions that assist people in emotional self-management.”²⁶

Studies bolster the importance of de-escalation in the reduction of restraint. One study of adult patients with psychiatric disabilities found that “multimodal programs” in which the goal is to “decrease the occurrence of active aggression or the use of seclusion or restraint” consistent with the Six Core Strategies are likely the most effective in lowering aggressive behavior.²⁷ Another study that focuses on emergency medicine patients concluded that “verbal de-escalation is usually the key to engaging [a] patient and helping him become an active partner in his evaluation and treatment.”²⁸ Both of these studies are equally applicable to inmates in jails that are experiencing agitation.

Limits and Precautions on the Use of the Restraint Chair

The BSCC should promulgate a separate set of regulations pertaining to the use of the restraint chair that incorporates the existing Section 1058 restraint standards and adds the following requirements:

- County jails shall conduct a medical and mental health assessment of an individual prior to the use of a restraint chair, or at the inception of its use.

Section 1058 currently requires a medical opinion within one hour of restraint use, and a medical assessment within four hours of placement. We recommend that a medical and psychiatric assessment be conducted prior to the use of the restraint chair, or at the inception of its use. In his review of jail-related incidents, Dr. Kupers noted frequent instances where an individual might be admitted to jail with a subdural hematoma. According to Dr. Kupers, this is not uncommon because an incarcerated individual might have had a physical altercation prior to arrest, or

sustained an injury during the arrest process or might be disruptive. Disruptive and agitated behavior can be a sign of brain injury. Dr. Kupers has also found that arrested individuals might be under the influence of methamphetamine, crack cocaine, in a diabetic crisis, or another medical emergency, which appears to be disruptive behavior. All of these situations could lead to a death in custody if not detected immediately by a medical and psychiatric examination. In other words, disruptive behavior might be the first clue of a medical emergency.²⁹

Researchers who have examined the medical and legal literature on restraint chairs agree that “incorporating medical personnel into the protocol with carefully proscribed monitoring practices and documentation standards” is critical to ensure the safe use of the restraint chair.³⁰

Smaller jail facilities might not be able to comply with the requirement of first having a medical or psychiatric examination, which would preclude them from using restraints. In our review of county policies, smaller counties that do not have adequate medical and mental health resources have recognized this limitation on their own and do not employ restraint devices.

- Deputies shall maintain direct, continuous observation of any restrained individual.

Some counties currently require direct monitoring when an individual is restrained. That policy is superior to the intermittent monitoring that is permitted by Section 1058, which can result in a failure to see changes in a restrained person’s physical condition, which can lead to death. Requiring direct and continuous observation can also ensure that restraint is more prudently applied, as direct, continuous observation requires a commitment of staff time and resources, and therefore may prevent the misuse of restraint for staff convenience.

- County jails shall use the restraint chair only for as long as needed to secure an incarcerated individual for transport to outside medical attention, and the use of the restraint chair shall not exceed two hours.

Some counties have on their own recognized the risks and limitations posed by restraints, and particularly, the restraint chair, and have restricted its use to no more than two hours. Additionally, some counties only use the restraint chair for transport to an outside medical facility, in recognition that individuals whose behavior appear so agitated as to necessitate restraint require medical attention. Most strikingly, restraint chair manufacturers themselves recommend that their devices not be used for a period of time to exceed two hours.

Accountability

- All restraint events shall be video-recorded.
 - County jails shall keep a separate logbook detailing all restraint incidents, including the following: the event(s) leading to the use of restraints; the duration of time spent per incident in a restraint; the number of serious injuries sustained by persons while subject to restraints.
 - Counties shall report to the BSCC all incidents of use of a restraint chair as part of its monthly jail report, including the following: number of times it was used; the duration of time spent per incident in a restraint chair; the number of individuals restrained; the number of serious injuries sustained by persons while subject to restraint in a restraint chair.
 - Counties shall report to the BSCC within ten days all deaths that occurred while individuals were in restraints, or where it is reasonable to assume that a death was proximately related to the use of restraint. BSCC shall make this information publicly available.
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Many county policies discussed a preference for video-recording restraint use when possible. The BSCC should make this a mandatory requirement, as having a video-recording will help ensure that the restraint was justifiably applied and used consistent with the guidelines.

Similarly, the BSCC should require counties to document restraint use and report it as part of their monthly jail report to the BSCC. Restraint data reporting is commonplace in other hospitals and community settings. The BSCC should adopt reporting guidelines similar to those of psychiatric units of general acute care hospitals, acute psychiatric hospitals, psychiatric health facilities, crisis stabilization units, community treatment facilities, group homes, skilled nursing facilities, intermediate care facilities, community care facilities, and mental health rehabilitation centers.³¹

Data collection has always been essential to informing the practice and reducing the use of restraints. For example, since 2008, data collection is the second of the Six Core Strategies for the reduction of restraint use.³² There is no way to determine the status of restraints in a facility without documenting how many restraints occur, who is being restrained, who is restraining, and what the outcome of each restraint is. The purpose of data collection is to inform practice, improve the safety of incarcerated individuals and jail staff, and reduce the use of restraints.³³

The BSCC should recommend that all jails collect data to identify each facility's "baseline" when it comes to restraints. After baseline data are collected, the facility should set measurable improvement goals and comparatively monitor use over time in all units within the facility.³⁴

Currently, all facts about a death occurring while a person is in the custody of a law enforcement agency or while in custody in a local or state correctional facility must be reported in writing to the California Attorney General within ten days after the death. These writings are considered a public record.³⁵

Because local sheriffs are already required to do this reporting, it would not be unnecessarily burdensome to require that deaths in local jails, and specifically, restraint-related deaths, be cross-reported to the BSCC. Because this information is considered a public record, there is no restriction on the BSCC making this information publicly available.

As concluded by the Commission on Safety and Abuse in America's Prisons; "All public institutions, from hospitals to schools, need and benefit from strong oversight. Citizens demand it because they understand what is at stake if these institutions fail. Prisons and jails should be no exception. They are directly responsible for the health and safety of millions of people every year, and what happens in correctional facilities has a significant impact on the health and safety of our communities."³⁶

Transparency is key to improving oversight; indeed, as noted by Michael Gennaco, formerly with Los Angeles County's Office of Independent Review, "In order for the public to be adequately equipped to assess the way in which important issues such as violence, safety failures and employee misconduct allegations are addressed in our jails and prisons, more developed records of such incidents need to be maintained, and the ability to access those records expanded."³⁷

County boards of supervisors, grand juries, civilian oversight commissions, the media, and all concerned members of the public play a key role in oversight. The BSCC is in the best position to collect and make available information about restraint-related jail deaths so that these entities can continue to ensure that restraint use in local jails is monitored and reduced.

Summary of Recommendations:

Alternatives to the Use of Any Restraint

Section 1058 currently states, “physical restraints should be utilized only when it appears less restrictive alternatives would be ineffective in controlling the disordered behavior.” The wording should be changed to, “physical restraints should be utilized only when all less restrictive alternatives, including verbal de-escalation techniques, have been attempted.”

Limits and Precautions on the Use of Restraint Chairs

The BSCC should promulgate a separate set of regulations pertaining to the use of the restraint chair that incorporates the existing Section 1058 restraint standards and add the following requirements:

- County jails shall conduct a medical and mental health assessment of an individual prior to the use of a restraint chair, or at the inception of its use.
- Deputies shall maintain direct, continuous observation of any restrained individual.
- County jails shall use the restraint chair only for as long as needed to secure an incarcerated individual for transport to outside medical attention, and the use of the restraint chair shall not exceed two hours.

Accountability

- All restraint events shall be video-recorded.
- County jails shall keep a separate logbook detailing all restraint incidents, including the following: the event(s) leading to the use of restraints; the duration of time spent per incident in restraint; the number of serious injuries sustained by persons while subject to restraints.
- Counties shall report to BSCC all incidents of use of a restraint chair as part of its monthly jail report, including the following: number of times it was used; the duration of time spent per incident in a restraint chair; the number of individuals restrained; the number of serious injuries sustained by persons while subject to restraint in a restraint chair.
- Counties shall report to BSCC within ten days all deaths that occurred while individuals were in restraints, or where it is reasonable to assume that a death was proximately related to the use of restraint. BSCC shall make this information publicly available.

Endnotes

1. Disability Rights California. (n.d.). DRC has long advocated for reducing and eliminating behavioral restraint. Retrieved from <https://www.disabilityrightsca.org/stories/drc-has-long-advocated-for-reducing-and-eliminating-behavioral-restraint>
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22. County policies are continuously updated. Our analysis of the restraint and restraint chair policies pertains to the policies that we reviewed from our public records act request.
23. Any views or opinions expressed by Dr. Terry Kupers constitute his personal opinion and do not represent the views or opinions of the agency or organization with which he is affiliated. His opinions are based on the documents and evidence that he reviewed.
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31. Health and Safety Code 1108.2 (d)(3)(reporting requirements):
(3) Data collected pursuant to this section shall include all of the following:
(A) The number of deaths that occur while persons are in seclusion or behavioral restraints, or where it is reasonable to assume that a death was proximately related to the use of seclusion or behavioral restraints.
(B) The number of serious injuries sustained by persons while in seclusion or subject to behavioral restraints.
(C) The number of serious injuries sustained by staff that occur during the use of seclusion or behavioral restraints.
(D) The number of incidents of seclusion.
(E) The number of incidents of use of behavioral restraints.
(F) The duration of time spent per incident in seclusion.
(G) The duration of time spent per incident subject to behavioral restraints.
(H) The number of times an involuntary emergency medication is used to control behavior, as defined by the State Department of State Hospitals.
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Carty and Andrew Holland

Disability Rights California dedicates this paper to Andrew Holland. May we honor his memory by creating a society that respects and recognizes the importance and dignity of the lives of people with mental illness.



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