Use of Oleoresin Capsicum in Juvenile Detention Facilities in 2022

Overarching Report

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Executive Summary

The Board of Supervisors, through County ordinance, established the Office of Independent Review (OIR) to review systemic issues involving five County agencies including the Orange County Probation Department (the Department), and to serve as an independent resource to ensure accountability.[1]

In the spring of 2022, the OIR indicated that it would conduct a systemic review of all uses of force in juvenile facilities. By June of 2022, the then existing staff of the OIR had left County service with the project having no defined areas or types of force to be examined, no timeframe identifed, and minimal work completed.

In November of 2022, a new Executive Director joined the OIR. The Executive Director and members of the OIR met with the Chief Probation Officer and members of his staff. From that meeting the scope of the systemic review was focused to examine the use of Oleoresin Capsicum (OC) within juvenile detention facilities for calendar year 2022. The purpose of this review is to determine whether the Department was complying with relevant statutes, regulations, and department procedure.

The California Board of State and Community Corrections (BSCC) has set minimum standards for local detention facilities, including juvenile detention facilities. Title 15 of the California Code of Regulations provides definitions and standards related to uses of force in the juvenile detention setting and authorizes the use of chemical agents in those facilities.[2] The Penal Code provides peace officers with the authority to use force, including chemical agents, provided they have completed training required by the Commission on Peace Officers Standards and Training (POST).[3] Every law enforcement agency must maintain a policy which "provides a minimum standard on the use of force."[4] Because the Department is considered a law enforcement agency, and juvenile detention officers are sworn peace officers, each of the above statutes and regulations are applicable.

The Juvenile Operations Bureau of the Department consists of three facilities and in 2022 had an average daily population of 167 youths between the ages of 12 and 25 years old. The three facilities were staffed by a total of 238 Deputy Juvenile Correctional Officers (DJCOs).

In 2022, there were a total of 28 incidents across all three juvenile facilities. 26 different DJCOs deployed OC spray, with the majority doing so in only one incident.

OC spray was deployed in 27 (19%) of 142 incidents involving physical altercations, in response to an immediate, present, and ongoing threat of violence. The threats at issue were crimes of assault and battery. OC was also deployed in one incident not involving a physical altercation. The non-violent incident involved a youth who was engaged in conduct that had the potential for sudden and serious injury.

In all 28 incidents, the DJCOs had a genuine concern about an immediate threat to the safety of a youth prior to the first deployment of OC. The OIR determined that the initial deployment of OC spray in all 28

[1] Section 1-2-225(a) of Codified Ordinances of the County of Orange.
[2] Cal. Code Regs. tit. 15, §§ 1302, 1357.
[3] Pen. Code, §§ 835a, 12403.
[4] Government Code § 7286.

incidents was justified. However, due to a lack of adequate documentation, the OIR was unable to make a determination as to the appropriateness of the number of additional deployments in one incident and the length of deployments in two of the incidents.

In total, there were 58 bursts of OC spray affecting 71 youths either directly or indirectly. A single burst of OC spray resulted in the youths ceasing the conduct that threatened the safety of one or more youths and complying with the DJCO's instructions in only six of the 28 incidents. Additional bursts of OC spray, ranging from two to five times during an incident, were able to bring another eight incidents to an end without requiring the need for physical force. However, half of the incidents required DJCOs to physically intervene to overcome resistance and ensure the safety and security of youths and staff.

The deployment of OC spray was able to bring an incident to an end without requiring the need for physical force in 50% of the incidents. As a result, the risk, to both youths and DJCOs, of being injured due to a physical encounter was reduced to zero in those incidents. Additionally, no injuries were reported due to the deployment of OC spray. There was also nothing in the provided documentation that indicated that any of the youths experienced the exacerbation of an existing medical condition due to being sprayed with OC.

Department procedure related to OC spray complies with Title 15 and California Penal Code § 835a(b) by including state law requirements. As part of this systemic review, the OIR reviewed the 28 incidents for compliance with Department procedure.

The fact that there were only 28 incidents in which DJCOs resorted to the use of OC spray suggests that the DJCOs understand that the deployment of OC spray is a force option that is only to be used when there is an imminent threat to the safety of a DJCO or others.

The OIR was able to determine that DJCOs gave warnings of "OC Clear" in 27 out of 28 incidents prior to deploying OC spray. However, the OIR was unable to determine the efficacy of the "OC Clear" warning because the scope of this review did not include reviewing incidents where no OC spray was deployed.

In the majority of incidents where OC was deployed, staff ensured that the duration of spray did not exceed one second. However, three incidents were identified where a DJCO exceeded the authorized spray duration. The OIR also determined that no DJCO sprayed the same youth more than three times in any of the 28 incidents. However, there was one incident involving three DJCOs where a youth was sprayed a total of four times. OIR's review of this incident established that all four uses of OC spray were reasonable and appropriate given that the youth continued to fight with another youth after each of the deployments. The OIR did not find any incidents in which OC spray was used preemptively or after voluntary compliance was obtained.

The OIR identified 11 incidents in which 14 youths, who were not the target of OC spray, were exposed due to their proximity to the incident. Five staff members were also exposed to OC overspray in four different incidents. In each of those incidents, the youths were actively fighting when a DJCO deployed OC and another DJCO was inadvertently contacted by some amount of the spray.

Staff were generally very diligent in quickly commencing the decontamination process. Based upon a review of the available records, the average time from OC spray exposure to the commencement of decontamination was six minutes. In some instances, staff were not immediately aware that uninvolved

youth were exposed to OC spray and were only informed of the exposure after the youths had returned to their rooms, resulting in delayed commencement of decontamination.

In many incidents it was difficult for the OIR to determine whether the youths were placed in the shower fully clothed, pursuant to procedure. This information was generally not articulated in the narrative portion of an SIR, and the Use of Force/Restraint Report form does not have a field that can be marked off to document compliance.

Eight of the incidents contained reports that directly indicate that staff were with the youths throughout the entire decontamination process. The remaining 20 incidents contained reports with statements that imply, without specifically stating, that staff were with the youths throughout the entire decontamination process. The OIR believes that it is likely, based on the verbiage in these reports, that staff complied with the procedure, and that there was at least one staff member with the youth throughout the decontamination process.

As it relates to notifications, the records indicated that a supervisor was either on scene or notified about the deployment of OC spray in 27 out of the 28 incidents. Medical personnel were notified that youths were exposed to OC spray in all 28 incidents. However, in one incident there was no indication in any of the reports that an uninvolved youth who was oversprayed was seen by medical. The OIR also had concerns about the timeliness of notifications in two specific incidents. Mental health staff were also notified in all 28 incidents of youths who were intentionally exposed to OC spray. However, in three incidents there was no indication that mental health staff were notified about uninvolved youths who were oversprayed. The OIR also had concerns about the timeliness of notifications in two specific incidents where mental health staff were not notified immediately following decontamination. Parents and guardians of youths who were intentionally exposed to OC spray were also notified in all 28 incidents. However, in three of those incidents there were no records indicating that a parent or guardian was notified about an uninvolved youth who was oversprayed during the incident.

In the great majority of the incidents, Department reports documented a clear and factual justification for the use of OC, that OC spray was only used when de-escalation efforts were unsuccessful or not reasonably possible, the medical unit response, and that staff referred exposed youth to mental health staff in a timely manner. In incidents where additional bursts of OC were deployed, most reports made it clear that they were necessary because the fighting continued despite each deployment. The youth and staff involved in an incident, as well as the date, time, and location of the use of OC spray, and the fact that decontamination occurred were also properly documented.

However, documentation was also the area where the OIR noted the most concern and had the most recommendations. The OIR observed that some incident reports lacked clear detail that should have been clarified prior to the reports being approved. For example, in three incidents the DJCOs deploying the OC spray failed to clearly articulate the factual justification for bursts of OC. In another incident, a DJCO's SIR narrative did not include language describing verbal attempts to de-escalate despite the DJCO indicating that she did so in her UOF form. Several other reports contained inconsistencies primarily related to the decontamination process which made it difficult, if not sometimes impossible, to make certain determinations in evaluating compliance with Department procedures.

Documentation regarding how OC spray was used was also concerning. In at least four incidents the information contained in the reports appeared to be contradicted by video. These contradictions

included DJCOs indicating that the distance of deployment was greater than it appeared to be in the video and a DJCO indicating that he tried to grab a youth prior to deploying OC. The OIR also noted some instances in which pertinent information was absent from the reports, such as whether two youths were actually struck by a DJCO's deployments of OC, and a factual description that failed to mention a youth going to the ground and assuming the "duck and cover" position.

The OIR also observed that in many of the incidents, some DJCOs who only witnessed a use of force or assisted in the decontamination of the youths did not prepare a report documenting their involvement. There were also some internal inconsistencies in reports documenting how OC spray was used relating to the number and duration of OC bursts. These inconsistencies appeared to be inadvertent errors made when DJCOs completed both UOF forms and written narratives.

Reports related to youths that were oversprayed were sometimes missing as well. In three incidents, there was no documentation that mental health staff were notified about four uninvolved youths who were oversprayed. There was also one youth who was oversprayed and had no documentation of a referral to medical or any medical treatment.

Prior to the completion of this review, the Department updated its Use of Force and OC spray procedures. The changes primarily related to de-escalation, decontamination, documentation, supervisor responsibility, management responsibilities, notification, and documentation. The OIR believes that the changes made to the procedures are improvements that represent a positive step towards clearly articulating the Department's general policies regarding the deployment of OC.

The following pages contain the OIR's analysis, findings, and recommendations related to the Department's use of OC in juvenile detention facilities for the calendar year 2022, and its compliance with applicable statutory and regulatory authority. Appendix A consists of the 28 OIR reports that form the basis of this review.

Methodology

The findings and recommendations contained in this document were derived from several different sources.

The OIR began by conducting a review of the relevant state statutes and regulations governing the use of OC in juvenile detention facilities. This included a review of the Penal Code, Government Code, and California Code of Regulations.[5]

The OIR continued its review by examining the Department's policies and procedures related to the use of OC to make sure that they were consistent with federal and state law. Policies related to the Department's juvenile facility operations are located within the Juvenile Procedure Manual.[6] The OIR reviewed the Juvenile Procedure Manual focusing on areas related to Use of Force, OC, and Juvenile Facilities.

Next, the OIR submitted several requests to the Department for documents, videos, and related information pertaining to the 28 incidents that occurred in 2022 in which staff deployed OC spray. The Department responded by producing over 60 files which included documents and videos.

Documents

Documents provided by the Department consisted of Department procedures, use of force review board memorandums, and redacted special incident reports (SIR) related to each individual incident. An SIR contains the use of restraint/force information.

Videos

The Department produced video footage for 23 out of 28 incidents. As it relates to the five other incidents, three occurred at the Youth Guidance Center (YGC) which is a facility without cameras. One incident occurred at the Youth Leadership Academy (YLA), however according to the Department, "[t]here was no video of this incident, as it occurred outside the view of the cameras." The final incident occurred at Juvenile Hall (JH) in an area out of view of the camera.

Interviews

The OIR also had the opportunity to meet with and ask questions of the Department and Correctional Health Services (CHS) staff. The Department staff included both sworn and non-sworn command staff, custodial officers, supervising officers, and Division Directors. CHS staff included a senior comprehensive care nurse assigned to JH and a comprehensive care nurse assigned to the YGC.

During this review, the OIR found the Department and CHS staff to be open and forthcoming with information and willing to explain practices and procedures.

Outside Agencies

The OIR also sent public record requests to probation departments throughout the state, seeking statistical information, departmental policies, procedures, and manuals related to use of force and chemical restraint.

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[5] Cal. Code Regs. tit. 15, §§ 1302, 1357, 1362; Pen. Code §§ 835a, 12403; Gov. Code § 7286.

[6] The OC Probation Procedure Manual can be located at https://ocprobation.ocgov.com/communications/policy-procedure-training-manuals/procedures-facilities.

Overview

The Department

Facilities

The Department's Juvenile Operations Bureau is responsible for housing youths who are in custody. The Bureau operates three full time juvenile detention facilities: Juvenile Hall (JH), Youth Guidance Center (YGC), and Youth Leadership Academy (YLA).

Juvenile Hall

JH is located in the city of Orange and houses youths ranging in age from 12 to 25 years. It houses youths of all genders who are pending disposition, awaiting transfer to another facility or are serving a commitment as a serious offender or as a violation of their probation. Youths are typically assigned by age group and gender to living units that are designed to house between 20 to 60 youth.[7] JH has medical staff on-site 24/7.

Youth Guidance Center

YGC is a 5-unit, 125-bed facility offering substance abuse treatment and transitional services for male and female youths ranging from 12 to 25 years of age. Programs include Sobriety Through Education and Prevention (STEP) for female youths and Substance Abuse Education and Recognition Treatment (ASERT) for males.

YGC has medical staff on-site Monday through Friday 7:00 a.m. - 3:30 p.m. If YGC youth need to see medical outside of that time, the youths are transported to JH to see medical staff. In situations where a youth is exposed to OC spray at YGC, and medical is not on-site, the youth is transported to JH to be seen by medical staff.

Youth Leadership Academy

YLA is a semi-secured camp facility consisting of two, two-story modular living units that are designed to house up to 64 youths. YLA has two programs: the Progressive Rehabilitation in a Dynamic Environment (PRIDE) Program, and the Leadership Education Through Active Development (LEAD) Program. PRIDE is a comprehensive program designed for youths who receive extensive local commitments. This program is open to male youths who are 14 to 20 years of age. LEAD focuses on preparing youths to re-enter and transition back into the community. This program houses older male youths who are 17 to 20 years of age, however, to assist with population control at JH the program can also house younger youths. YLA has medical staff on-site 24/7.

Use of Force Review Board

In 2021, the Use of Force (UOF) Review Board was established to create a standardized procedure for reviewing use of force incidents. The UOF Review Board reviews OC Spray and physical force incidents causing injury. The purpose of the UOF Review Board is to assess whether a UOF was within department policy and procedure. According to the Department, recommendations from the UOF Review Board can include changes to training, policies/procedures, and equipment. The UOF Review

[7] OC Probation, Juvenile Hall, https://ocprobation.ocgov.com/bureaus/juvenile-operations/juvenile-facilities/juvenile-hall.

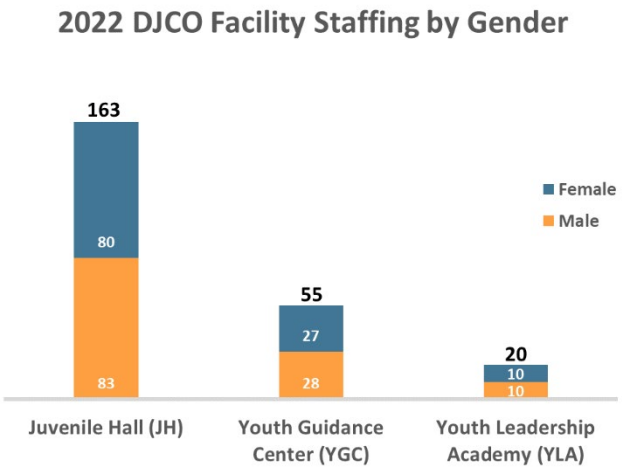
Board can also identify errors made during an incident and recommend corrective action to the administration.

The UOF Review Board Chair is a Division Director who is not assigned to any of the facilities. The UOF Review Board also consists of a Supervising Probation Correctional Officer, a Deputy Probation Correctional Officer, a subject matter expert based on the type of force under review, and any additional individuals whose expertise is required. The individuals assigned to the UOF Review Board are assigned by the Chief Probation Officer or designee and rotate every six months.

The UOF Review Board Chair can refer a matter to the Professional Standards Division (PSD) upon initial review, and prior to the entire board reviewing the incident, if they believe that misconduct may have occurred. In 2022, one incident was forwarded to PSD for further investigation by the UOF Review Board Chair.

Staffing

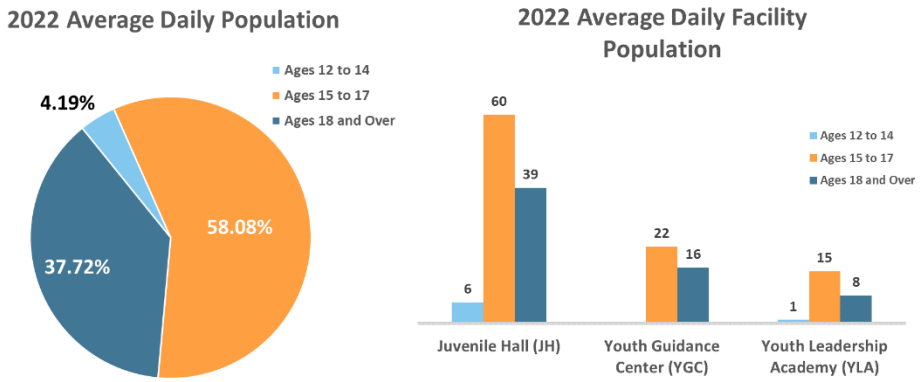
JH is staffed with 163 DJCOs and 19 Supervising Juvenile Correctional Officers (SJCO).[8] The gender of the DJCOs at each facility is almost evenly split. 83 (51%) of the DJCOs at JH are male and 80 (49%) are female. YGC is staffed with 55 DJCOs and 7 SJCOs. 28 (51%) of the DJCOs are male and 27 (49%) are female. YLA has 20 DJCOs and 2 SJCOs. 10 (50%) of the DJCOs are male and 10 (50%) are female.[9]



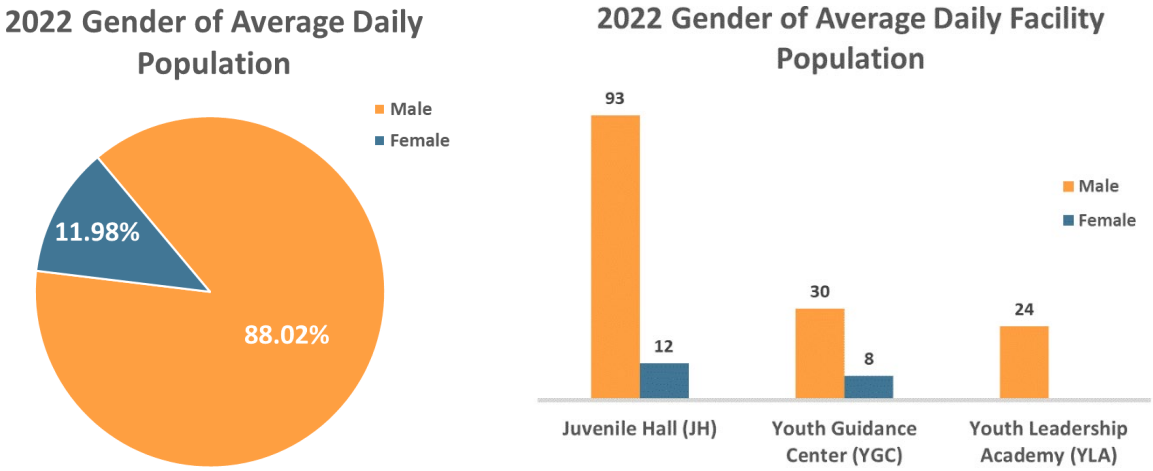
Juvenile Population

JH and YGC house both male and female youths, while YLA houses only males. All facilities house youths between the ages 12 to 25 years.

[8] Probation UOF and Staffing Statistics (January 26, 2024).
[9] Probation UOF and Staffing Statistics (January 26, 2024).



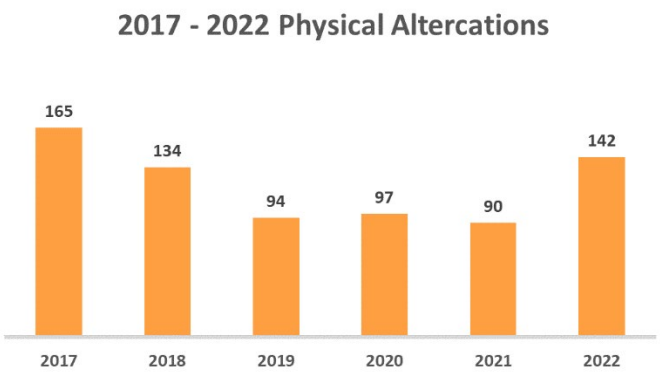
The average daily population among all three facilities for calendar year 2022 was approximately 167 youths.[10] In JH, there were an average of 6 youths that were between the ages of 12 and 14, an average of 60 youths that were between the ages of 15 and 17, and an average of 39 youths who were 18 years of age or older. At the YGC, there were an average of 22 youths between the ages of 15 and 17, and an average of 16 youths aged 18 years or older. At the YLA, there was an average of 1 youth between the ages of 12 and 14, an average of 15 youths between the ages of 15 and 17, and 8 youths aged 18 years of age or older.

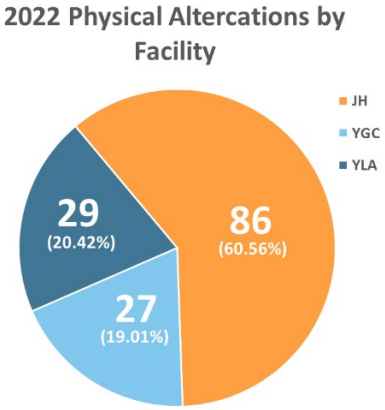


The gender breakdown of the average daily population among all three facilities for 2022 was 147 males and 20 females.[11] At JH, the average daily population of male youths was 93, and female youths 12. At the YGC, the average daily population of male youths was 30, and female youths 8. The YLA had an average daily population of 24 male youths.

[10] Probation Youth Population Data (Received February 27, 2024).
[11] Probation Youth Population Data (Received February 27, 2024).

Youth-on-Youth Physical Altercations





The OIR requested data related to the number of youth-on-youth physical altercations for 2017 through 2022. The information provided shows a downward trend beginning in 2018 and holding steady during the first two years of COVID-19. In 2022, there was a marked increase when youth-on-youth physical altercations rose to 142.[12] Approximately 60 percent of those physical altercations occurred in JH.

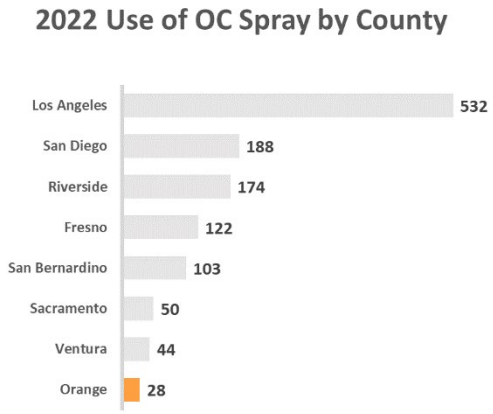
Oleoresin Capsicum

Oleoresin capsicum (OC) is the oil taken from the placenta near the stem of a pepper.[13] It can rapidly produce sensory irritation of disabling physical effects including inflammation to the eyes, skin, and nose, which disappear within a short time following termination of exposure.

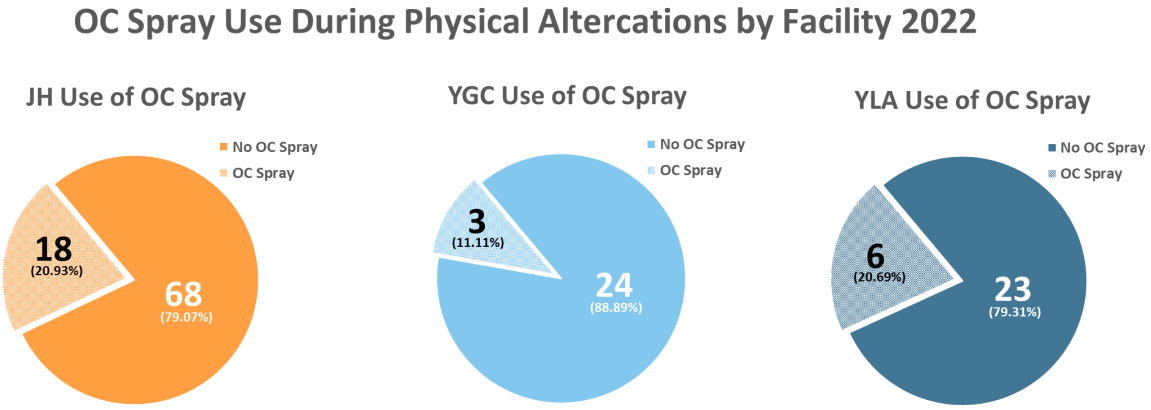
The Department issues SABRE Red OC spray canisters to DJCOs.[14] To deploy the OC spray, a DJCO must press the actuator to fire a burst of OC and release the actuator to stop firing.[15] The spray deploys in a powerful stream pattern. Department procedure instructs DJCOs to deploy the spray "ear to ear across subjects' eyes."[16]

[12] Probation Youth Population Data (Received February 27, 2024).
[13] SABRE, Pepper Spray, https://www.sabrered.com/pepper-spray-and-personal-safety-products.
[14] Procedure Manual Item 3-1-056 I(E) General Information.
[15] Procedure Manual Item 3-1-056 II(C)(4) Use of OC Spray.
[16] Procedure Manual Item 3-1-056 II(C)(4) Use of OC Spray.

OC Deployments



As of October 2023, 33 of 58 California counties authorized the use of OC spray in their juvenile facilities.[17] The OIR sent public records requests to several of those counties seeking the total number of incidents in which they deployed OC spray in their juvenile facilities in 2022. Several counties responded and provided information showing that the total number of incidents where OC spray was deployed exceeded that of Orange County. Los Angeles County reported 532 incidents. Riverside County reported 174 incidents where OC spray was deployed.[18] San Diego County reported 188 incidents of OC spray deployments,[19] and San Bernardino County reported 103 incidents of OC spray deployments across their juvenile facilities.[20] In 2022, the Orange County Probation Department deployed OC spray in juvenile facilities during 28 separate incidents.

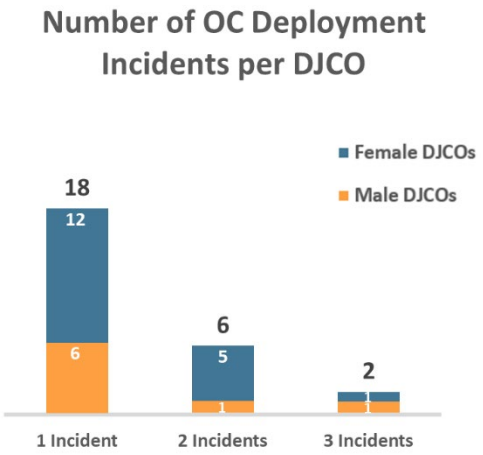


OC spray was deployed across all three Orange County juvenile detention facilities during 28 incidents. DJCOs deployed OC in 27 (19%) of the 142 incidents involving physical altercations. The deployments were in response to physically assaultive behavior, in the form of mutual combat or outright battery,

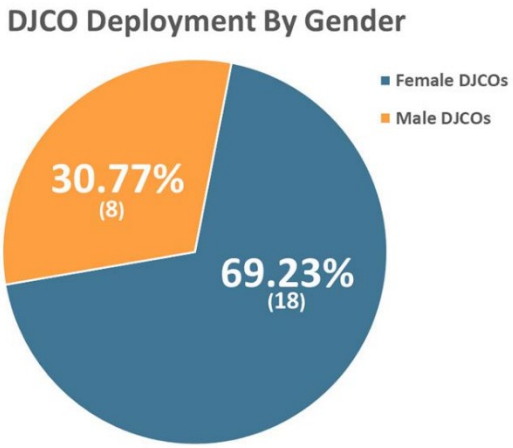
[17] Chief Probation Officers of California (November 9, 2023).
[18] Riverside County Probation Department (April 23, 2025).
[19] San Diego County Probation Department (April 9, 2024).
[20] San Bernardino County Probation Department (April 2, 2024).

that constituted an imminent threat to the safety of one or more youths. The remaining incident involved a DJCO deploying OC spray on a youth who was engaged in conduct that had the potential for sudden and serious injury to himself.

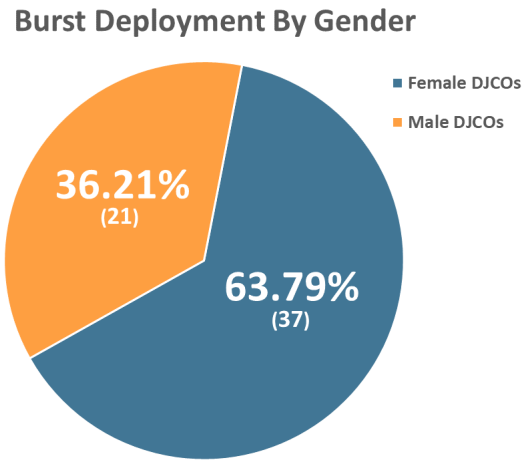
26 (93%) of the 28 incidents where OC spray was deployed involved male youths while only two incidents (7%) involved female youths. This is somewhat consistent with the overall youth population of 88% males and 12% females.



A total of 26 distinct DJCOs were involved in deploying OC spray during the 28 incidents. 18 of the 26 DJCOs only deployed OC spray in one incident. Eight DJCOs deployed OC spray in more than one incident. Six DJCOs deployed OC in two separate incidents, while two DJCOs deployed OC in three separate incidents.



The gender of DJCO facility staffing was almost evenly divided, with female DJCOs constituting 49.16% of the staff, and male DJCOs constituting 50.84%. Female DJCOs made up 69.23% of the DJCOs who deployed OC during the 28 incidents. Of the 26 DJCOs who deployed OC, 18 were female, and eight were male.



In the 28 incidents in which OC spray was deployed, there were a total of 58 bursts affecting 71 youths either directly or indirectly. Female DJCOs deployed a total of 37 bursts, while male DJCOs deployed a total of 21.

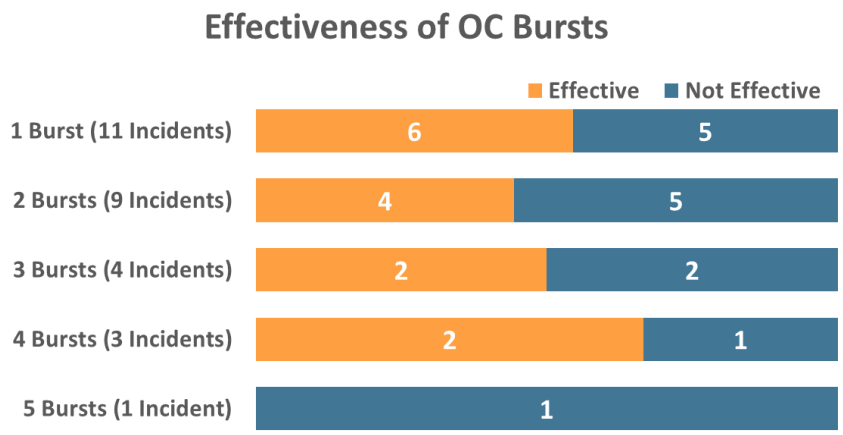
During a meeting with Department staff, the Department indicated that there are numerous factors that may have caused the approximate 2:1 gender disparity in the deployment of OC spray. According to the Department those factors could include anything from the size of the subjects being sprayed to the number of female officers assigned on the day of the incidents. None of the reports from the deploying DJCOs cited any of these factors as a reason that they deployed OC. Most of the reports indicated that the DJCOs relied upon the fact that the youths were harming another youth, or in one case was a threat to himself, as the basis for deploying OC. If the Department believes that there are factors that contribute to the gender disparity in the deployment of OC spray, it should further examine those factors to see if the disparity and overall number of OC deployments can be reduced.

Recommendation

Examine any factors that may have led to gender disparity in the deployment of OC spray to ascertain whether there are actions that could be taken to reduce the total overall number of OC deployments.

Effectiveness of OC Spray

During this review, the OIR sought to determine the effectiveness of OC spray in resolving the 28 incidents. The OIR defined effectiveness as whether the deployment of an OC burst resulted in the youths ceasing the conduct that threatened the safety of one or more youths and then complying with the DJCO's instructions. A total of 57 youths were intentionally exposed to 58 bursts of OC spray.



In 11 of the 28 incidents, OC was only sprayed once. A single burst of OC spray ended only six of those incidents. The other five incidents required the youths to be physically separated by the DJCOs to end the fighting.

In 9 of the 28 incidents, OC was sprayed only twice. Two bursts of OC spray ended four of those incidents. The other five incidents required the youths to be physically separated by the DJCOs to end the fighting.

In 4 of the 28 incidents, OC was sprayed only three times. Three bursts of OC spray ended two of those incidents. The other two incidents required the youths to be physically separated by the DJCOs to end the fighting.

In 3 of the 28 incidents, OC was sprayed only four times. Four bursts of OC spray ended two of those incidents. The other incident required the youths to be physically separated by the DJCOs to end the fighting.

The final incident involved five bursts of OC spray and was not effective at ending the incident. As a result, the DJCOs had to use physical force to end the fight.

In total, the deployment of OC spray caused the youths to cease the conduct that threatened the safety of one or more youths and comply with the DJCO's instructions in 14 of 28 incidents. These figures raise the question as to whether OC spray is effective as a force option to overcome resistance and ensure the safety and security of the youths and staff. If effectiveness is measured by obviating the need for physical hands-on intervention, then the fact that the deployment of OC was able to bring the incident to an end without requiring the need for physical force in 50% of the incidents raises an argument for its effectiveness. Because fifty percent of the incidents resulted in the youths complying with commands after being sprayed, the risk, to both youths and DJCOs, of being injured due to a physical encounter was reduced to zero in those incidents.

If effectiveness is measured by bringing the incident to an end as quickly as possible, the results are less clear. Eight out of the 14 incidents, that were resolved by the deployment of OC spray, required more than one burst to end the incident. Additionally, in the other 14 incidents, a "hands-on" approach was required to end the incident.

It is also worth noting that in some of these incidents, there were more youths in the room than DJCOs when a fight broke out. The presence of additional staff is often needed to safely separate and subdue the fighting youths as well as maintain control of the other youths present. In other words, OC spray may not have been the most effective tactic to end the incident but, with fewer DJCOs present than youths, it may have been the safest tactic.

Medical Considerations

Department procedure provides that whenever possible, staff should avoid deploying OC spray against youth who are known to have certain medical histories or profiles.[21] Among the medical conditions to be considered are a history of asthma, seizure disorder, and severe skin disorders. The procedure goes on to state that "[a]ll individuals who admit to any of the above medical histories or those who the arresting officer and/or a booking staff recognizes as being present should be identified upon booking and tagged with a colored medical alert ID bracelet. The purpose of this bracelet will be to alert staff of a 'no OC profile.' All reasonable efforts should be made to avoid spraying these youth with a OC spray. However, because staff and non-aggressive youth safety is our primary responsibility, there may be occasions where a OC spray may have to be used on medical alert youth to prevent serious injury."[22]

According to the Department, "all youth are issued ID bracelets upon intake, a probation issued one with the youth's identifiers and a medical bracelet if deemed necessary to identify medical issues." The medical bracelet is white with a green stripe.

None of the reports or documentation provided by the Department indicated whether any of the 71 youths who were exposed to OC spray were a "no OC profile" youth or whether they were wearing a medical bracelet when they were exposed. There was also nothing in the provided documentation that indicated whether any of the youths experienced the exacerbation of an existing medical condition due to being sprayed with OC.

DJCO reports documenting an incident should affirmatively state whether a youth was a "no OC profile" youth so that supervisors charged with reviewing the incident will be made aware and can take any necessary follow up action.

Recommendation

Update PMI 3-1-056 to require DJCOs to specifically indicate in their SIR or Restraint Report whether an exposed youth was a "no OC profile" youth, and if so, state what efforts were made to avoid spraying the youth.

[21] Procedure Manual Item 3-1-056 II(D)(1) Medical Considerations.
[22] Procedure Manual Item 3-1-056 II(D)(2) Medical Considerations.

Lawful Requirements for Use of OC

The OIR began by reviewing federal and state statutes and cases to determine a framework for evaluating the lawful requirements for the use of OC. The framework would then be used to determine whether it was appropriate to use this type of force when balancing the governmental interests of the Department.

In order to determine whether a particular use of force was appropriate, courts analyze the use of force "under the Fourth Amendment's prohibition against unreasonable seizures using the framework articulated in *Graham v. Connor*."[23] The reasonableness of a seizure turns on whether the use of force was "objectively reasonable in light of the facts and circumstances confronting [the user of force], without regard to their underlying intent or motivation."[24] Reasonableness is determined by balancing "the nature and quality of the intrusion on the individual's Fourth Amendment interests against the countervailing governmental interests at stake."[25]

There are three steps in conducting the balancing required by *Graham*. The first step is to assess the "the quantum of force used."[26] The second step is to measure "the governmental interests at stake by evaluating a range of factors."[27] Finally, the third step is to balance the quantum of force used on the individual against "the government's need for that intrusion to determine whether it was constitutionally reasonable."[28]

Quantum of Force

According to the Ninth Circuit, assessing the quantum of force used requires analyzing the nature and quality of the intrusion on the individual's Fourth Amendment interests, which, in turn, requires the fact finder to evaluate both the type of force inflicted, and the amount of force used.[29]

Type of Force Used

In all 28 incidents the type of force used was OC spray, commonly known as pepper spray.

The Ninth Circuit has clearly held that pepper spray is a form of "force capable of inflicting significant pain and causing serious injury."[30] "Pepper spray 'is designed to cause intense pain,' and inflicts 'a burning sensation that causes mucus to come out of the nose, an involuntary closing of the eyes, a gagging reflex, and temporary paralysis of the larynx,' as well as 'disorientation, anxiety, and panic.'"[31] As such, pepper spray is regarded as an "intermediate force" that, "while less severe than deadly force, nonetheless present[s] a significant intrusion upon an individual's liberty interests."[32]

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[23] *Young v. County of Los Angeles* (9th Cir. 2011) 655 F.3d 1156, 1161.
[24] *Graham v. Connor* (1989) 490 U.S. 386, 397; *Blankenhorn v. City of Orange* (9th Cir. 2007) 485 F.3d 463, 477.
[25] *Young v. County of Los Angeles* (9th Cir. 2011) 655 F.3d 1156, 1161.
[26] *Davis v. City of Las Vegas* (9th Cir. 2007) 478 F.3d 1048, 1054.
[27] *Davis v. City of Las Vegas* (9th Cir. 2007) 478 F.3d 1048, 1054.
[28] *Young v. County of Los Angeles* (9th Cir. 2011) 655 F.3d 1156.
[29] *Miller v. Clark County* (9th Cir. 2003) 340 F.3d 959, 964.
[30] *Young v. County of Los Angeles* (9th Cir. 2011) 655 F.3d 1156, 1161.
[31] *Young v. County of Los Angeles* (9th Cir. 2011) 655 F.3d 1156, 1162 citing *Headwaters Forest Defense* (9th Cir. 2000) 240 F.3d 1185, 1199-1200 (vacated and remanded on other grounds by *Humboldt County v. Headwaters Forest Defense* (2001) 534 U.S. 801).
[32] *Young v. County of Los Angeles* (9th Cir. 2011) 655 F.3d 1156, 1161.

Title 15 of the California Code of Regulations requires that facility administrators "develop and implement written policies and procedures for the use of force, which may include chemical agents."[33] Department procedure correctly authorizes the use of OC spray only when there is "an imminent threat to the youth's safety or the safety of others and only when de-escalation efforts have been unsuccessful or are not reasonably possible."[34]

However, Department procedure does not identify the use of OC spray as an intermediate level of force. While not required by Title 15, identifying OC spray as an intermediate level of force would put staff on notice that OC spray is more than just minor force. More specifically, it lets the DJCOs know that, in the Ninth Circuit, OC spray is a categorically higher level of force than a minor "hands-on" application of force. Most of all, a procedure change could assist staff in their decision-making process to determine whether OC spray is the appropriate level of force for a given situation.

Recommendation

Update PMI 3-1-056 to specifically state that OC spray is classified as an intermediate level of force.[35]

Amount of Force Used

OC Spray

Across the 28 incidents in which OC spray was deployed, there were a total of 58 bursts affecting 71 youths either directly or indirectly. A review of each individual incident revealed that OC spray was deployed anywhere from one time during an incident, up to five times during an incident. In 11 of the 28 incidents, one burst of OC spray was deployed before the youths were successfully detained. Nine incidents resulted in two bursts of OC spray being deployed before the youths were successfully detained. In four incidents three bursts of OC spray were deployed before the youths were successfully detained. In three incidents four bursts were required, and in one incident five bursts were required, before the youths were successfully detained.

During this review, the OIR classified all 28 incidents into minimal and moderate amounts of force. 20 of the incidents consisted of a minimal amount of force. Ten of those incidents were designated as minimal force because only one burst of OC spray was deployed and there was some indication that the duration of the spray was one second or less. Eight of the remaining 10 incidents involved two bursts of OC spray being deployed at two youths and contained reports that indicated that each spray was between one half to two seconds long. One incident involved three youths each receiving a half second spray. The final minimal force incident involved two youths each being sprayed twice with one second bursts for a total of four bursts.

The OIR also determined that a moderate amount of force was used in eight of the incidents. The moderate amount of force incidents included two incidents where the deployment of OC spray was at least three seconds or greater, three incidents where there were three or more bursts directed at a

[33] Cal. Code Regs. tit. 15, § 1357.
[34] Procedure Manual Item 3-1-056 I(C) General Information.
[35] Procedure Manual Item 3-1-056 has been replaced by Procedure Manual Item 3-6-003 as of August 18, 2023. This recommendation should alternatively be read to apply to Procedure Manual Item 3-6-003.

single youth, and three incidents where there were three or more deployments directed at multiple youths.

Continued Exposure

Unlike a physical restraint, OC can continue to harm the recipient following the termination of the spray. Some courts have held that not properly decontaminating a person exposed to OC can amount to a constitutional violation for failure to act.[36]

The OIR found that staff were generally very diligent in quickly commencing the decontamination process. Based upon a review of the available records, the average time from OC spray exposure to the commencement of decontamination was six minutes.

Governmental Interest

OC spray is an intermediate level of force "that must be justified by the governmental interest involved."[37] To evaluate the government's interest in the use of force, courts look to: (1) the severity of the crime at issue, (2) whether the suspect posed an immediate threat to the safety of the officers or others, and (3) whether the suspect was actively resisting arrest or attempting to evade arrest by flight.[38] The OIR reviewed these factors to determine whether deployment of OC spray was justified in each of the 2022 incidents.

Severity of the Crime at Issue

In all but one of the incidents, the crimes at issue were violent crimes of assault and battery. Under California law, assault and battery are generally misdemeanor offenses.[39] However, battery involving the infliction of serious bodily injury and assault by means of force likely to produce great bodily injury are both felony offenses.[40] The felony battery charge focuses on the actual injury inflicted, while the felony assault charge focuses on the force used and not whether the force produced great bodily injury. "The crime of assault by means of force likely to produce great bodily injury is completed before any injury is inflicted."[41] "It is enough that the force used is likely to cause serious bodily injury. No injury is necessary."[42] Courts have said that punching is "capable of inflicting significant pain and causing serious injury."[43]

In all 27 incidents involving violence, the reports prepared by staff indicated that the youths were actively engaged in assaultive behavior. The incident reports described repeated closed fist punching and kicking. Noticeably absent from one of the reports, however, is a description of the areas of the body targeted by the closed fist strikes. The OIR was able to view and confirm the reported assaultive conduct in the 22 incidents where video surveillance footage was provided.[44]

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[36] *Wilson v. Bucato* (E.D.Cal. Dec. 7, 2023, No. 1:23-cv-00023-HBK (PC)) 2023 U.S.Dist.LEXIS 218539.
[37] *Bryan v. MacPherson* (9th Cir. 2010) 630 F. 3d 805, 826.
[38] *Graham v. Connor* (1989) 490 U.S. 386, 396.
[39] Pen. Code, §§ 240, 242, 243(a).
[40] Pen. Code, §§ 242, 243(d), 245(a).
[41] *People v. Hopkins* (1978) 78 Cal.App.3d. 316, 320. [142 Cal.Rptr. 572].
[42] *People v. Hopkins* (1978) 78 Cal.App.3d. 316, 320. [142 Cal.Rptr. 572].
[43] *Reaza v. County of Riverside* (C.D.Cal. Oct. 26, 2022, No. 5:20-cv-01188-MEMF (SPx)) 2022 U.S.Dist.LEXIS 198653.
[44] Although there are a total of 23 videos of surveillance footage, one incident is not included in this total as the incident did not involve multiple youths with assaultive behavior.

Recommendation

Provide additional training reminding staff of the importance of providing clear details in reports, including areas of the body targeted by assaultive and/or violent physical behavior, to allow proper assessment of the likelihood of serious bodily injury when a supervisor is reviewing the incident.

The other incident did not involve assaultive behavior. During the incident, a youth climbed up to the top of a file cabinet and began to grab hold of a light fixture attached to the ceiling. Staff ordered the youth to come down due to concerns that he might fall. The youth refused to comply and staff deployed OC to stop him from continuing to engage in conduct that had a high likelihood of resulting in serious injury.

A review of all 27 incidents involving violent assaultive behavior led the OIR to find that the severity of the crimes between the youths was a factor justifying the use of OC spray. Conversely, the final incident did not involve a serious crime, so this factor would not support the application of OC spray in that incident.

Whether the Suspect Posed an Immediate Threat to the Safety of the Officers or Others

The Ninth Circuit has found that the most important single element of the governmental interest in a use of force analysis is whether the suspect poses an immediate threat to the safety of the officers or others.[45]

A review of the reports, and available video, in 27 incidents made clear that staff initially deployed OC spray in response to an immediate, present, and ongoing threat by one or more youths to the safety of another youth. All initial deployments of OC occurred while the youths were actively engaged in physically battering one another. Oftentimes the batteries included closed fist strikes to the face and head.

In some incidents, youths were also a threat to staff. At times staff members positioned themselves between combative youth as the youths continued to punch and kick. In one incident, a DJCO attempted to use physical force to separate two youths. While the DJCO was on the ground with one of the youths, another youth threw a punch and nearly struck the DJCO in the face. In another incident, a DJCO attempted to shield a youth with her body by blocking the assaultive youth's access, however, he continued his attempt to assault the youth until OC was deployed.

Additionally, many of the 27 incidents occurred in locations where uninvolved youths were congregating. As a result, there was a risk of injury to the youths who were in close proximity to the ongoing incidents.

The only incident of OC deployment not involving a mutual assault or battery was of a youth that had climbed onto a file cabinet. In deciding to use OC spray, probation staff reasoned that the youth's conduct constituted an immediate threat to his own safety.

Based on the above, the OIR determined that prior to the initial deployment of OC, the DJCOs had a genuine concern about an immediate threat to the safety of a youth in each of the incidents.

[45] *Chew v. Gates* (9th Cir. 1994) 27 F.3d 1432, 1441.

Whether the Suspect was Actively Resisting Arrest or Attempting to Evade Arrest by Flight

According to the Ninth Circuit, resistance "should not be understood as a binary state, with resistance being either completely passive or active. Rather, it runs the gamut from the purely passive protestor who simply refuses to stand, to the individual who is physically assaulting the officer."[46] None of the incidents that resulted in OC deployments in 2022 involved conduct that was purely passive.

In the 28 incidents reviewed, the youths were not attempting to evade arrest by flight. Instead, they were actively resisting the DJCOs' attempts to take control of them by refusing to comply with their commands and submit to their authority. In 25 of the incidents, verbal commands were given to the youth to either "stop" or "get down" prior to the first deployment of OC.[47] In those incidents, active resistance took the form of the youths continuing to fight and ignoring commands to stop and place themselves on the ground. It was only after each youth was targeted with OC spray that they either submitted to the DJCOs' authority or were physically restrained. In short, to place combative youths into custody, the DJCOs had to do more than simply place passive youths into handcuffs. As a result, this factor leans in favor of finding that the use of force was appropriate.

Balancing the Force Used Against the Need for Such Force

The Ninth Circuit "balance[s] the gravity of the intrusion on the individual against the government's need for that intrusion."[48] The Ninth Circuit has said that the law is clearly established "that police officers employ excessive force in violation of the Fourth Amendment when they use pepper spray upon an individual who is engaged in the commission of a non-violent misdemeanor and who is disobeying a police officer's order but otherwise poses no threat to the officer or others."[49]

As indicated above, OC spray was deployed by staff in 27 out of 142 physical altercations, which amounts to less than 20 percent of the youth-on-youth altercations. Additionally, after OC was deployed, the Department minimized its impacts on the affected youths by ensuring that the average time from OC spray exposure to the commencement of decontamination was six minutes.

In all 28 of the incidents in which staff deployed OC spray, the conduct of one or more of the youths constituted an immediate threat either to their safety or the safety of other youths. Because the youths were under the custody and care of the Department, the Department had an obligation to protect the youths from harm. In every incident, there was a significant likelihood of serious bodily harm if the conduct was not stopped immediately. All but one of the incidents involved punching or kicking.

The OIR concluded that all of the initial OC deployments were justified. However, the OIR was unable to make a determination as to the appropriateness of the length and number of OC deployments in three of those incidents.

The first incident began as justified and appropriate, however the OIR was unable to make a determination as to whether the use of OC spray continued past the point of where the youth was a

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[46] *Bryan v. MacPherson* (9th Cir. 2010) 630 F.3d 805, 830.

[47] Per Procedure Manual Item 3-1-056 II(C)(2), a verbal command or warning is not necessary before deploying OC spray if "it is reasonable to believe that even a momentary delay would result in injury to the youth or another."

[48] *Espinoza v. City & County of San Francisco* (9th Cir. 2010) 598 F.3d 528, 537.

[49] *Silva v. Chung* (9th Cir. 2018) 740 F. App'x 883.

threat. The DJCO's reporting of the incident contained internal inconsistencies related to spray duration which could not be resolved by reviewing the video of the incident.

The second incident involved deployments by two DJCOs. The documentation regarding the OC spray deployments failed to indicate whether the OC sprays occurred at the same time or separately. Additionally, while one DJCO's deployment of OC may have been initially justified, it is unclear from the documentation whether his extended five second burst of OC spray was appropriate, or unreasonably and unlawfully prolonged.

The final incident involved a situation where the first deployment of OC spray by the DJCO may have been justified because the youth had placed himself in a position where he posed an immediate threat to his own safety and was clearly refusing to follow commands. However, the OIR was unable to determine whether the second and third bursts of OC spray were justified under the law because the report prepared by the DJCO failed to provide a justification for these additional deployments.

After balancing the force used against the need for such force, the OIR determined that the initial deployment of OC spray during each of the incidents was justified when considering the governmental interest of the Department.

Procedure Review

The OIR requested all Department policies and procedures related to the use of OC spray in juvenile facilities. The Department has a Use of Force procedure,[50] and a more specific procedure addressing the use of OC spray in juvenile detention facilities.[51]

State Law

Facilities that are authorized to use chemical agents as a force option must include state law requirements in their policies and procedures.[52] Those requirements include, in part, that the policies mandate that chemical agents only be used when there is an imminent threat to the youth's safety or the safety of others and only when de-escalation efforts have been unsuccessful or are not reasonably possible;[53] that the policy outline the facility's approved methods and timelines for decontamination from chemical agents, including that youth who have been exposed to chemical agents shall not be left unattended until that youth is fully decontaminated or is no longer suffering the effects of the chemical agent;[54] that the policy define the role, notification, and follow-up procedures required after a use of force incident involving chemical agents for medical, mental health staff, and parents or legal guardians;[55] and that the policy provide for the documentation of each incident of use of chemical agents, including the reasons for which it was used, efforts to de-escalate prior to use, youth and staff involved, the date, time and location of use, decontamination procedures applied and identification of any injuries sustained as a result of such use.[56]

A review of the Department's OC Spray procedure determined that the procedure complies with Title 15 and California Penal Code § 835a(b) in that it includes state law requirements.

Compliance with Department Procedure

The OIR assessed compliance with Department procedure based on the Department's procedures as they existed in 2022.

Imminent Threat and De-escalation

The Department has two procedures that address the use of OC by DJCOs in the course and scope of their duties.[57] The OC procedure provides that OC spray may "only be used when there is an imminent threat to the youth's safety or the safety of others and only when de-escalation efforts have been unsuccessful or are not reasonably possible."[58] This verbiage is consistent with Title 15 of the California Code of Regulations.

There were only 28 incidents in 2022 in which staff resorted to the use of OC spray, which suggests that DJCOs understand that the deployment of OC spray is a use of force option that is to be used only when

[50] Procedure Manual Item 3-1-015 Use of Force – Facilities.
[51] Procedure Manual Item 3-1-056 Oleoresin Capsicum (OC) Spray – Facilities.
[52] Cal. Code Regs. tit. 15, § 1357.
[53] Cal. Code Regs. tit. 15, § 1357(b)(2).
[54] Cal. Code Regs. tit. 15, § 1357(b)(3).
[55] Cal. Code Regs. tit. 15, § 1357(b)(4).
[56] Cal. Code Regs. tit. 15, § 1357(b)(5).
[57] Procedure Manual Item 3-1-056 Oleoresin Capsicum (OC) Spray – Facilities; Procedure Manual Item 3-1-015 Use of Force – Facilities.
[58] Procedure Manual Item 3-1-056 I(C) General Information.

there is an immediate threat to the safety of a DJCO or others. 27 of the 28 OC deployments were in response to youths actively involved in assaultive behavior in the form of a fight, or an attack on a youth.[59] As discussed previously, these assaults carried the potential for serious injury to one or more youths, and clearly qualified as instances where there was an imminent threat to the safety of the youth or others.

In 26 out of the 27 incidents involving physical assaults, the OIR was able to determine that the DJCOs attempted to de-escalate the situation, prior to the initial deployment of OC, by using verbal commands, counseling, warnings, or attempting to physically separate the youths. In the 27th incident, a DJCO's SIR narrative failed to reference her attempts to de-escalate the situation using verbal commands despite indicating that she did so in her UOF form.[60] Due to this conflict, the OIR was unable to conclude that the DJCO attempted de-escalation prior to her deployment of OC.

OC Spray Warning

Department procedure provides that, "[w]hen possible, DJCOs shall provide a clear warning that OC Spray may be deployed if voluntary compliance is not accomplished."[61] The procedure is silent regarding what specific verbiage the warning should include. In practice, DJCOs typically provide this warning by stating "OC Clear."

The phrase "OC Clear" requires prior explanation and youths are informed during their orientation that the warning is given before the deployment of OC spray. According to the Department, "[y]outh are advised as to the expectation when fights occur and when staff provide an 'OC Clear' warning. Youth are directed to get down and to keep their heads down when the warning is given." The Department indicated that this expectation is also shared with youth during monthly drills and daily "structure" or instructions to youth at the beginning of each shift which often includes the topic of appropriate response to an "OC Clear" warning.

The OIR was tasked with reviewing the 28 incidents in which OC was deployed in 2022, not incidents where OC was not deployed. While the OIR was able to determine that the initial deployment of OC in all cases occurred in situations where the youths posed an imminent threat to their own safety or the safety of others, the OIR was unable to determine the efficacy of giving the "OC Clear" warning because it has no data showing how often the warning was successful in averting an incident that would have otherwise resulted in the deployment of OC.

The OIR was, however, able to determine that the "OC Clear" warning, in 27 out of the 28 incidents reviewed, was not effective in eliminating the need for the deployment of OC or physical intervention. In the 28th incident the DJCO's SIR narrative failed to describe any verbal commands despite a "Yes" indication on the DJCO's UOF Form that verbal commands were given. Due to the lack of information in

[59] The incident in which OC spray was deployed in the absence of a physical assault is the 12/6 incident that has been previously discussed. That incident, nevertheless, involved an imminent threat to the physical safety of the youth, and warnings were given.

[60] In this incident, there were multiple deployments of OC by three DJCOs. While the first DJCO failed to document a warning in her narrative, subsequent verbal warnings by two additional DJCOs were documented in their narratives.

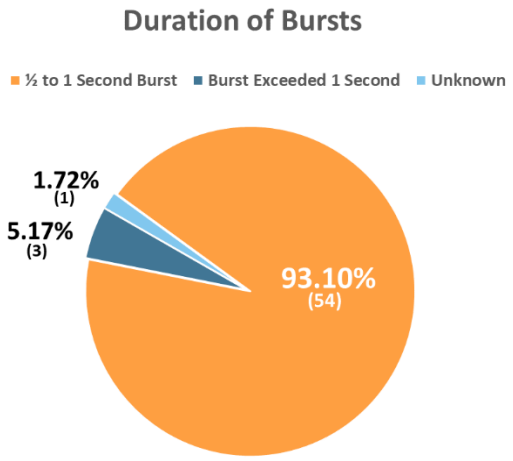
[61] Procedure Manual Item 3-1-056 II(C)(2) Use of OC Spray.

the DJCO's SIR narrative, the OIR was unable to determine whether the "OC Clear" command was actually given in this incident.

The OIR can only speculate as to whether the warnings given were simply ignored, or whether the youths were not given enough time to comply with the warnings. The OIR recognizes that staff responding to an ongoing fight or assault cannot delay intervention longer than necessary to protect the youths from serious bodily injury. While OC spray is typically deployed immediately after staff announces, "OC Clear," staff did not routinely document how long they waited to deploy OC spray after giving a warning, nor was there any requirement that they do so.

Spray Duration and Number of Spray Bursts

The Department's procedure sets limits on the amount of OC spray that may deployed at a single youth by limiting both the duration and number of sprays that each DJCO can deploy. According to the procedure, DJCOs are to "ensure that no greater amount of OC spray is used than is necessary to subdue the youth. OC sprays shall not be used on youth who are resistive, but not physically aggressive."[62] Additionally, OC spray shall be deployed "in ½ to 1 second bursts."[63]



In the majority of incidents where OC was deployed, staff ensured that the duration of spray did not exceed one second. However, three incidents were identified where a DJCO exceeded the authorized spray duration. The duration of OC spray in each of those incidents was two seconds, three seconds, and five seconds. There was also a fourth incident where the DJCO's SIR listed the spray duration as one second, but her Restraint Report listed the spray duration as two seconds. The OIR reviewed the video of the incident but was unable to resolve the discrepancy. As a result, the OIR was unable to determine whether the burst complied with the Department's procedure.

The OC procedure limits the number and length of spray bursts by directing a DJCO who is "unable to restrain the subject after 3, ½ to 1 second bursts," to "employ the next appropriate force option."[64]

[62] Procedure Manual Item 3-1-056 II(C)(4) Use of OC Spray.
[63] Procedure Manual Item 3-1-056 II(C)(4) Use of OC Spray.
[64] Procedure Manual Item 3-1-056 II(C)(4) Use of OC Spray.

In response to incidents identified by the OIR, the Department responded by indicating that "[t]he issue of reasonableness and circumstances plays a role in determining whether to continue with a force option or move to another one." According to the Department, "an officer's knowledge that a deployment did not land in the intended location would reasonably indicate that an additional attempt would be reasonable." Finally, the Department indicated that "the decision to not move to another force option can also be reasonable under the circumstances if other options are less reasonable or less safe."

However, the OC spray procedure as written does not provide the option for a DJCO to continue to deploy OC spray after three bursts or longer than one second. As a result, a DJCO who does so is in violation of the procedure as written. Additionally, the Department's Use of Force procedure provides that while a "DJCO must be entrusted with well-reasoned discretion," it must be "within the framework of this and related policies, in determining the appropriate use of force and tactics used."[65]

Recommendation
Provide additional training reminding staff that pursuant to the OC procedure, OC bursts may be no more than ½ to 1 second in duration.

The OIR also determined that, in all 28 incidents, no DJCO sprayed the same youth more than three times. However, there was one incident involving three DJCOs where a youth was sprayed a total of four times. During that incident DJCO 1, deployed a one second spray towards youth (Y1) while he was fighting with another youth (Y2). The youths continued to fight and DJCO 2 deployed two half-second bursts toward both Y1 and Y2. Finally, DJCO 3 deployed a one second burst to Y1's forehead as Y1 started to use his feet to kick and stomp on Y2. Eventually Y1 was pulled to down to the floor and taken into custody.

There was also another incident where a DJCO sprayed a youth three times and another youth twice for a total of five bursts. The OC deployment did not stop the youths from fighting, and the DJCOs eventually had to resort to physical force to separate the youths.

The Department should provide additional training to remind DJCOs of the importance of transitioning to the next appropriate force option when the number or length of OC spray bursts appear to be ineffective.

Recommendation
Provide additional training to staff reminding them of the importance of transitioning to the next appropriate force option when OC spray appears to be ineffective.

Most importantly, the OIR did not find any incidents in which OC spray was used preemptively or after voluntary compliance was obtained.

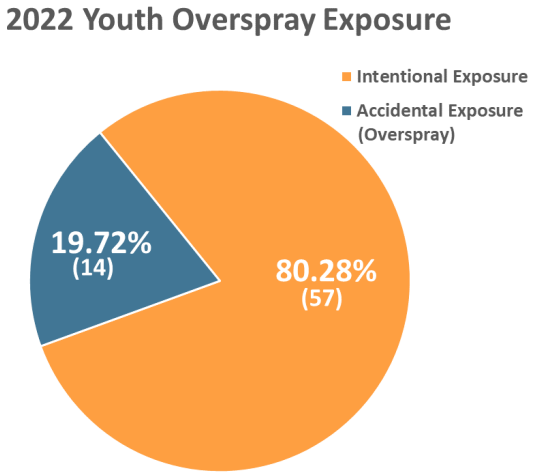
Overspray

Department procedure provides that staff members should, "[p]rior to the dispensing of OC sprays, whenever possible, allow an opportunity for non-involved persons to leave the area."[66] Both staff and youths were subjected to overspray throughout the 28 incidents. The term "overspray" refers to

[65] Procedure Manual Item 3-6-001 IV(A) Prohibited/Unauthorized Force Options.
[66] Procedure Manual Item 3-1-056 II(C)(3) Use of OC Spray.

someone that was exposed to OC who was not the intended target. Non-involved youths who are in the vicinity of a fight have been directed by staff to place themselves down on the floor in a prone position.

Due to the nature of an OC deployment, it is unrealistic to expect that only the intended targets will be affected by the OC spray. Most, if not all, of the fights involved youths that were in constant motion making it nearly impossible to ensure that OC spray contacted only the assaulting youth.



A total of 71 youths were exposed to OC in 2022. The OIR identified 11 incidents in which 14 youths, who were not the target of OC spray, were exposed due to their proximity to the incident. In 10 of those incidents, staff provided a warning that OC spray would be deployed.

11 of the 14 youths who experienced overspray, were uninvolved youths who were in the vicinity of a fight and were often down on the floor in a prone position when they were oversprayed. Two additional youths were victims of an assault and were oversprayed when the DJCOs attempted to spray their assailants. The final youth was struck by overspray when he intervened in a fight between two other youths as the DJCO deployed her OC spray.

Five staff members were also exposed to overspray in four different incidents. In each of these incidents, the youths were actively fighting when one DJCO deployed OC and another DJCO was inadvertently contacted by some amount of OC spray.

Prior to deploying OC, DJCOs should take into consideration the potential effects that deployment may have on uninvolved parties and staff. OC deployment may make it more difficult for staff to place youth into restraints. More importantly, inadvertently spraying staff can inhibit their ability to see, causing them to be unable to defend themselves if a youth were to attempt to assault them.

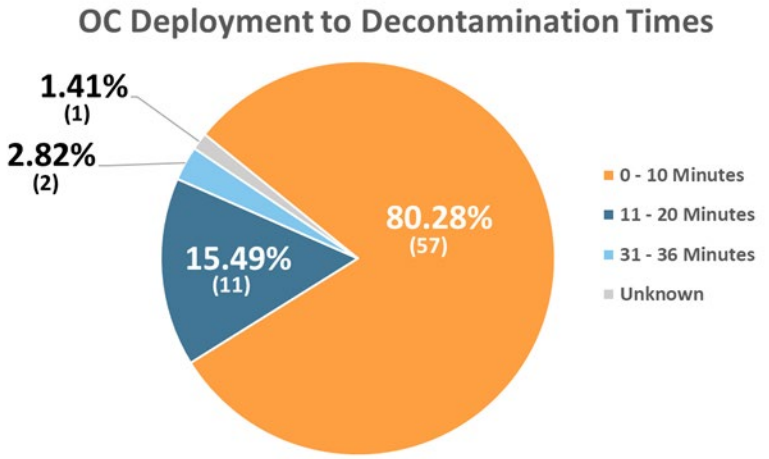
Recommendation

Provide additional training reminding staff that they should consider all available tactics and force options before deploying OC spray. While OC should not be considered a force option of "last resort," it also should not be employed in circumstances where a different tactic would be likely to lead to a better outcome, or where the use of OC may be counterproductive.

Decontamination

The Department's OC spray procedure also complies with Title 15 as it relates to decontamination. Specifically the procedure provides that "[d]econtamination measures must be undertaken as soon as practical after a youth is subdued and restrained,"[67] and that DJCOs must "[p]lace the youth, fully clothed, into a shower, at a sink, or on the patio with the garden hose, allowing cold water to freely fall onto the youth until the youth no longer feels the effects of the OC spray."[68] The decontamination procedures also mandate that DJCOs are to "be with the youth throughout the entire decontamination process," [69] and "have youth remove contaminated clothing and place in a marked plastic bag, and issue clean clothing."[70]

Commencement of Decontamination Measures



The OIR found that Department staff ensured that the length of time that youths felt the effects of OC spray was limited. The average time from OC spray exposure to the commencement of decontamination was six minutes.

Two youths in separate incidents began decontamination at least 30 minutes after OC was deployed. In the first incident, the youth tried to hide his involvement in an assault. Given the number of youths involved in the melee, staff were unaware that the youth had been sprayed. As a result, the youth was allowed to leave the dayroom with the other uninvolved youths and return to his room. Eventually, the youth notified staff that he too was sprayed with OC and was sent for decontamination approximately 30 minutes after the initial deployment.

The second incident involved an uninvolved youth who was affected by overspray during an incident between two other youths. The reports indicated that the youth began decontamination approximately 36 minutes after the deployment of OC. However, noticeably absent from the reports was any type of

[67] Procedure Manual Item 3-1-056 II(F)(3) Decontamination/Aftercare Procedures. (The Department's Use of Force Policy, Procedure Manual Item 3-1-015 VIII(E) Medical and Mental Health Considerations, has been renumbered and amended to include language that decontamination measures must be undertaken as soon as practical after a youth is subdued and restrained.)
[68] Procedure Manual Item 3-1-056 II(F)(4) Decontamination/Aftercare Procedures.
[69] Procedure Manual Item 3-1-056 II(F)(10) Decontamination/Aftercare Procedures.
[70] Procedure Manual Item 3-1-056 II(F)(7) Decontamination/Aftercare Procedures.

written narrative that explained how staff were made aware of the overspray or accounting for the delay in commencing decontamination procedures.

In the incident where the time to decontamination is unknown, the youth was affected by overspray when he attempted to separate two other youths. According to reports, staff offered the youth the opportunity to decontaminate in the showers. However, he declined and chose to decontaminate using the sink water in his room. Staff did not document when the youth began decontamination, or when he stopped decontamination, but reported that the youth "…began and ended decontamination by choice without a time limit." Due to a lack of detailed documentation, it is unclear when, or if, the youth decontaminated.

In some instances, staff were not immediately aware that uninvolved youth were exposed to OC spray and were only informed of the exposure after the youths had returned to their rooms, resulting in delayed commencement of decontamination. The OIR believes that the Department should assign a staff member to examine each uninvolved youth to determine whether they were actually sprayed. A procedure that requires staff take affirmative steps to determine whether youth, uninvolved or not, were exposed to OC should result in youths starting the decontamination process in a more expeditious manner.

Recommendation

Update PMI 3-1-056 to require that after OC spray is deployed, where uninvolved youths are present, that a staff member shall be assigned to examine each uninvolved youth to determine, and document, whether they were actually sprayed and whether they need to be decontaminated prior to returning to their room.

In another incident, a youth who was intentionally sprayed with OC spray did not receive decontamination immediately because the youth claimed that he did not feel the effects of the spray. As a result, he was returned directly to his room without decontaminating. Shortly thereafter, during room check, the youth told staff that he was feeling the effects of the OC spray, and staff began the decontamination process. The OIR believes that regardless of his initial statement to staff it is imperative that the exposure to OC spray concludes by decontamination. If a youth refuses to decontaminate, staff should document the refusal.

Recommendation

Update PMI 3-1-056 to require that any youth, who is the intended recipient of an OC deployment, be offered decontamination regardless of whether the youth is suffering the effects of the OC spray. The procedure should also require that any refusal to decontaminate be documented.

Youth Fully Clothed

As set forth above, Department procedure requires that youths be "placed fully clothed, into a shower, at a sink, or on the patio with the garden hose." In many incidents it was difficult for the OIR to determine whether the youths were placed in the shower fully clothed. This information was generally not articulated in the narrative portion of an SIR, and the Use of Force/Restraint Report form does not have a field that can be marked off to document compliance.

For example, in one incident, youths were placed in separate showers for the decontamination process. Most of the reports did not specifically state that the youths were placed in the shower "fully clothed." Some reports could be read to imply that a youth was "fully clothed" in the shower, such as a report which indicated that the youth was escorted into the shower stall, the water was turned on, and then the youth was directed to remove his clothes and set them outside the stall for collection. Similarly, the

report for another youth stated that the youth "was left handcuffed in the shower," and when he got to his room, he was uncuffed and given a clean pair of clothes "to change into" and his contaminated clothes were placed in a water-soluble bag. However, the reports for three other involved youths simply made no mention of whether the youths were "fully clothed" when they were placed in the shower.

Recommendation

Update the portion of the Use of Force/Restraint Special Incident Report (SIR) form relating to Pepper Spray and Decontamination to add an entry field that requires the report writer to specifically indicate whether the youth was placed into the shower fully clothed.

Continuous Staff Presence During Decontamination

State regulations require that the Department's policy include that "youth who have been exposed to chemical agents shall not be left unattended until that youth is fully decontaminated or is no longer suffering the effects of the chemical agent."[71] Per Department procedure, staff are required to "be with the youth throughout the entire decontamination process."[72]

Eight of the incidents contained reports that directly indicate that staff were with the youths throughout the entire decontamination process. The remaining 20 incidents contained reports with statements that imply, without specifically stating, that staff were with the youths throughout the entire decontamination process. For example, many of the reports indicated that the youth began the decontamination process while being "supervised" by a DJCO. However, those reports did not actually state that the DJCO remained with the youth during the entire time that the youth was decontaminating. Similarly, other reports also implied that there was someone present with the youth throughout the entire process by stating that the youth "turned off the water and informed us he was done," or that the youths "ended their decontaminations by their own request or choice."

The OIR believes that it is likely, based on the context of these reports, that staff complied with the procedure, and that there was at least one staff member with the youth throughout the decontamination process. However, a straightforward statement establishing that staff were with the youths throughout the entire decontamination process would be more helpful to supervisory staff charged with reviewing reports.

Notification

Notification to Supervisors by Staff

The Department's OC spray procedure specifies who is to be notified after the deployment of OC spray, who is responsible for making the notifications, and how soon the notifications must be made. For example, the procedure requires that a DJCO, who discharges an OC canister, must verbally notify his or her supervisor as soon as possible.[73]

In 27 out of the 28 incidents reviewed, the records indicated that a supervisor was either on scene or notified about the deployment of OC spray, pursuant to procedure. In one incident, however, there was no indication that the DJCO notified her supervisor of the deployment of OC. Additionally, none of the

[71] Cal. Code Regs. tit. 15, § 1357(b)(3).
[72] Procedure Manual Item 3-1-056 II(F)(10) Decontamination/Aftercare Procedures.
[73] Procedure Manual Item 3-1-056 II(E)(1) Notification and Documentation.

other reports for that incident indicated whether a supervisor was on scene or made aware of the deployment of OC.

Notifications to Medical Staff

As it relates to notifying medical personnel, the procedure provides that "[a]ll youth exposed to OC spray at Juvenile Hall or the Youth Leadership Academy must be seen by the Medical Unit immediately. The staff member who sprayed the individual is responsible for advising medical personnel or others of the decontamination procedures."[74]

Medical personnel were notified that youths were exposed to OC spray in all 28 incidents. However, in one incident where "[m]edical was called for all youth involved in the physical altercation," there was no indication in any of the reports that an uninvolved youth who was oversprayed was seen by medical. As a result, it is unclear whether a referral to medical for the uninvolved youth was made and not documented, or no referral was made at all.

Even though notifications were made in all 28 incidents, the OIR did have concerns about the timeliness of notifications in two specific incidents. In one incident, notification to the medical unit was not made for a youth until 55 minutes after the deployment of OC. While the delay was clearly documented in the SIR, no explanation was given for why the delay occurred.

In the second incident, the main SIR and Use of Force reports indicate that the medical unit was not informed of a physical altercation and deployment of OC until 37 minutes after the initial deployment. More specifically, the medical unit was not informed until 29 minutes after Y1 started decontamination and 26 minutes after Y2 started decontamination.

The OC procedure does not define what is meant by the phrase that youth "must be seen by the Medical Unit immediately." The OIR recognizes that there can be situations which may delay the notification to the Medical Unit. However, a notification delay of 37 minutes and 55 minutes respectively is unlikely to comply with the Department's expectation that a youth be seen by the Medical Unit "immediately."

Recommendation

Update PMI 3-1-056 to require that notification to the medical unit regarding the exposure of OC should occur no later than the start of the decontamination process.

Notifications to Mental Health Staff

Regarding notification of mental health staff, the procedure provides that "[i]mmediately following decontamination, the youth must be referred to Mental Health staff. A licensed clinician from the Health Care Agency (CEGU) will determine if the youth needs to be seen and if so, will see the youth within 72 hours and submit a report to the Director of the involved institution."[75] Children and Youth Services staff provide assessment and treatment services to youth during incarceration. This unit is known as the Clinical Evaluation and Guidance Unit (CEGU).

Mental health staff were notified that youths were exposed to OC spray in all 28 incidents. However, in three incidents there was no indication that mental health staff were notified about uninvolved youths

[74] Procedure Manual Item 3-1-056 II(F)(13) Decontamination/Aftercare Procedures.
[75] Procedure Manual Item 3-1-056 II(F)(17) Decontamination/Aftercare Procedures.

who were oversprayed. As a result, it is unclear whether referrals to mental health for the uninvolved youths were made, and not documented, or no referrals were made at all.

The OIR also has concerns about the timeliness of notifications in two specific incidents where mental health staff were not notified immediately following decontamination, pursuant to procedure. In the first incident, mental health staff were notified of one youth's OC exposure approximately four hours after completing decontamination and the other youth's exposure approximately seven hours after completing decontamination. Both youths were transported to JH after completing decontamination and one was taken to be examined at a hospital. However, none of these movements should have delayed notification to mental health staff for four or more hours. It should be noted that both youths were seen by mental health staff within 72 hours as set forth in Department procedure.

The second incident also involved two youths. In this incident, mental health staff were notified approximately five and a half hours after decontamination ended for both youths. Similarly, one of the youths was transported to JH and then taken to be examined at a hospital. No explanation was contained in the reports as to why notification to mental health staff was delayed for both youths for approximately five and a half hours.

Recommendation

Provide additional training to remind supervisors and staff that mental health notification procedures should be followed, not just with respect to youths who were the target of OC spray, but also for youths who encountered overspray.

Lastly, while procedure requires that the youth must be referred to Mental Health staff immediately following decontamination, it does not specifically identify whose responsibility it is to ensure that this section of the procedure is followed.

Recommendation

Update PMI 3-1-056 to clearly articulate who has the responsibility to refer youth to Mental Health Staff following decontamination. This change would put DJCOs on notice as to whose responsibility it is to ensure that Mental Health staff are contacted.

Parental Notifications

Finally, as it relates to parent or guardian notification, the Department's procedure states that "[t]he SJCO/Duty Officer or designee will contact the youth's parent or legal guardian. This call should be made at the earliest time possible and no longer than 24 hours from the incident."[76]

Parents or guardians were notified that youths were exposed to OC spray in all 28 incidents. However, in three of those incidents there were no records indicating that a parent or guardian was notified about an uninvolved youth who was oversprayed during the incident. As a result, it is unclear whether notifications were made to the parents or guardians of the uninvolved youths, and simply not documented, or whether notifications were not made at all.

[76] Procedure Manual Item 3-1-056 II(F)(18) Decontamination/Aftercare Procedures.

Recommendation

Provide additional training to remind supervisors and staff that parental notification procedures should be followed, not just with respect to youths who were the target of OC spray, but also for youths who encountered overspray.

Documentation

The Department's Use of Force Procedure provides that "[a]ny DJCO involved in or a witness to a use of force … shall write and submit a Special Incident Report (SIR) including all relevant facts related to the circumstances leading up to the incident, the DJCO's perceptions at the time of the incident, level of resistance, tactics attempted prior to the use of force, and why force appeared necessary."[77] The majority of concerns, and recommendations, identified by the OIR relate to documentation.

Report Language

In reviewing the reports provided by the Department, the OIR observed that some incident reports lacked clear detail that should have been clarified prior to the reports being approved.

For example, in one incident, a DJCO wrote in an SIR that a youth "had to be assisted to the ground…" The term "assisted" is vague and ambiguous and could represent anything from simple arm guidance to a foot-block shoulder-drag, or full-on tackle. It is important that staff reports provide a clear and accurate picture of the actions taken by all individuals involved.

Recommendation

Provide additional training to address report writing as it relates to using the non-descriptive phrase "assisted to the ground." DJCOs should clearly articulate in their reports the means and type of force that they used to "assist" a juvenile to the ground.

In another incident, a DJCO stated that he quickly ran in the direction of two youths with the intent to stop them. When he arrived at their location, his "forward momentum bumped them and caused both youths to fall to the ground and stop fighting." The DJCO's description of his physical interaction with the youths did not accurately paint a picture of how he encountered the two youths. As described by the Use of Force Review Board, and clearly seen in the video, the DJCO "broadened his arms and dropped his body, in what appears to be a tackling motion." The DJCO then ran straight into the youths, driving both youths to the ground and landing on top of them. The Use of Force Board described the encounter best by stating that "[t]he video shows DJCO [] tackling both youth to the ground…" Clearly, the DJCO's report fails to put the reader on notice as to the nature and extent of his "bump" into the two youths.

Recommendation

Provide additional training reminding DJCOs of the importance of making sure that their reports are accurate and complete.

Report Inconsistencies

The OIR also observed that several incident reports contained inconsistencies. While these inconsistencies, or discrepancies between reports, were relatively minor, they still made it difficult, if not sometimes impossible, to make certain determinations in evaluating compliance with the

[77] Procedure Manual Item 3-1-015 VIII(F) DJCO Responsibilities.

Department's procedures. The discrepancies were primarily related to the decontamination process, including who supervised the decontamination process. There were also discrepancies in timing related to the start and end times of a youth's decontamination, as well as when a youth was seen by medical, or when notifications were made. There were also some inconsistencies in reports related to spray duration and number of bursts.

SIRs are supposed to be reviewed by SJCOs. Supervisors are responsible for making sure that the DJCOs' reports are accurate and complete. Complete and accurate reports need to include the reasons for any delays in commencing decontamination procedures and obtaining medical attention. More importantly, supervisors have the responsibility of making sure that inconsistencies between reports, including those written by different DJCOs, are addressed before reports are approved.

Department Procedure

According to the Department's OC spray procedure, an SIR and Use of Force Report must include a clear and factual justification for the use of OC spray, efforts to de-escalate prior to use or reasons why de-escalation was not reasonably possible, youth and staff involved, the date, time and location of use, a description of how OC Spray was used and the results obtained, decontamination procedures applied, and identification of any injuries and medical treatment.[78] The Department's OC spray procedure complies with Title 15 as it relates to documentation.

Clear and Factual Justification

In 25 out of the 28 incidents reviewed, the records documented a clear and factual justification for the use of OC. In these incidents, the documented justification for the use of OC spray was that the youths were engaged in ongoing physical assaults. In the three remaining incidents some, if not all, of the OC bursts may have been justified. However, documentation of the factual justification for each burst, by the DJCO deploying OC spray, was lacking.

In the first incident, a DJCO prepared a Use of Force report to document the deployment of OC directed at a youth. The DJCO's report indicated that three one-second bursts of OC spray were deployed, but did not offer a justification for each burst, instead offering a singular justification for all three bursts. As a result, the DJCO's report was lacking sufficient details to explain why the second and third bursts were necessary and why they were deployed in quick succession totaling a span of 14 seconds. While the DJCO clearly articulated justification for the initial deployment of OC spray, his report lacked the factual justification for the additional bursts.

In the next incident, a DJCO was presented with a quickly evolving and rapidly escalating incident. The DJCO stated in his report that he deployed three bursts of OC at one youth, and two bursts at another youth. It is clear from the video that none of the bursts of OC spray had the desired effect of causing the youths to cease fighting. As a result, each of the DJCO's bursts of OC spray was justified because of the imminent and continuing threat that the youths posed to each other and because each of the previous bursts failed to end the fight. However, the DJCO failed to articulate this justification in his report. Instead, the DJCO simply stated the number of OC bursts that were deployed at each of the youths without explaining why the additional bursts were necessary. As such, the justification for each use of force should have been included in the reports.

[78] Procedure Manual Item 3-1-056 II(E)(2) Notification and Documentation.

In the final incident, the main SIR indicated that DJCO 1 deployed her OC spray. However, both the main SIR and DJCO 2's narrative failed to mention critical facts that justified DJCO 1's deployment of her OC spray. Specifically, after DJCO 2 took Y1 to the ground, Y2 continued to try to assault Y1. DJCO 2 attempted to protect Y1 by pushing Y2 away, and Y2 pushed DJCO 2's hands away to get at Y1. This interference, which immediately preceded the deployment of OC spray, appears to have been a key reason for DJCO 1's deployment and should have been included in the reports.

De-escalation

In 27 out of 28 incidents, the records document that OC spray was only used when de-escalation efforts were unsuccessful or not reasonably possible. In one incident, two youths were engaged in a fight, involving closed-fist punches aimed at each other's head and upper torso, resulting in an imminent threat to the safety of the youths. A DJCO submitted a UOF Report form indicating "Yes" to the prompt "Verbal Commands (eg. Get down/OC clear)." However, the main SIR narrative written by the DJCO did not contain any reference to her attempts to de-escalate the situation by providing any verbal commands. Instead, the DJCO 1's narrative stated that she "was about 10 feet away when the incident began so [she] immediately responded and motioned towards the youth as they were engaging in a physical altercation." The DJCO's narrative did not elaborate or explain how she "motioned towards the youth," and it did not indicate that any verbal commands were given. The DJCO's narrative went on to state, that "[o]nce I got closer to the youth who were fighting, I dispersed a one second spray of Oleoresin Capsicum (OC pepper spray) towards [the youth] and made successful contact…" If the DJCO's narrative is accurate and complete, it conflicts with her UOF form, and the DJCO did not give a warning or attempt to deescalate before deploying the OC spray burst.

Recommendation

Provide additional training that reminds line staff, and supervisors, that all SIRs, where OC spray was deployed, should include a discussion of whether de-escalation was attempted and whether warnings were given. Additionally, if efforts to de-escalate, and warnings, were not given prior to the deployment of OC spray, then the SIR should articulate why.

Youth and Staff Involved

Based on a review of the video and reports provided to the OIR, it appears that all youth and staff involved in the 28 incidents were documented.

Date, Time, and Location of Use

All of the reports clearly identified the date, time, and location of the use of OC spray.

How OC Spray was Used

Pursuant to Department procedure a DJCO deploying OC spray is required to complete an SIR including facts related to how the OC spray was used. The OIR identified some concerns related to documentation of the deployment of OC spray. In some incidents the concerns related to information contained in the reports that appear to be contradicted by the video reviewed by the OIR.

In one incident, a DJCO prepared a Use of Force report and indicated that the distance from which she deployed the OC spray was "5 to 6 feet." The video footage, reviewed by the OIR, did not support the DJCO's Use of Force report. The distance between the DJCO's outstretched arm and the youth's face, at what appears to be the moment of deployment, is much closer to two feet.

Similarly, in another incident, a DJCO's report indicated that she "deployed a one second bust of oc pepper about five feet away." This was also inconsistent with the video. The second burst of spray, deployed by the DJCO was deployed at a much closer distance than the five feet that the DJCO indicated in her SIR. The DJCO can be seen on the video walking directly up to two youths who are on, or close to, the floor and continuing to fight while two other DJCOs are attempting to separate them. The DJCO can then be seen bending down and extending her arm towards the face of one of the youths before deploying a burst of OC spray. A precise distance between the spray canister and the youth's face is impossible to determine, but it appears from the video footage that the distance is likely less than two feet.

During a review of another incident, the OIR observed that a DJCO's factual description of the events leading up to his deployment of OC was inconsistent with the video. In his report, the DJCO stated that prior to deploying OC, he attempted to grab a youth's arm but failed and the youth continued to hit another youth in the head. The DJCO then subsequently deployed his OC. However, a review of the video showed that as the fight began, the DJCO stood up from a desk and started to run towards the fight. While the DJCO was running, he removed his cannister of OC spray from his waist. As he approached the youths, he shook his cannister of OC spray and then deployed a one second burst of OC targeted at a youth's forehead. At no time prior to deploying the OC spray is the DJCO observed "attempting to grab" the youth's arm.

The OIR also noted some internal inconsistencies in reports documenting how OC spray was used. For example, in one incident, a DJCO's SIR narrative indicated that she deployed a one second burst of OC, however, her Use of Force report indicated that she deployed a two second burst of OC. In another incident, a DJCO indicated that he deployed OC spray twice in his Use of Force report, however, his narrative stated that he deployed OC spray only once and directed it at two youths. In a third incident, a DJCO also prepared a Use of Force report to document the deployment of OC spray at two youths. It was clear from the DJCO's narrative report that she deployed one burst of OC directed at one youth, and one burst of OC directed at the other youth. However, the DJCO entered the number "2" for the "number of times spray was used" in the Use of Force report for each youth.

There were also some instances in which pertinent information was absent from reports. For example, in one incident, a DJCO prepared Use of Force reports to document her intentional deployments of OC directed at two youths. However, her narrative did not make clear whether the youths were struck by either of her deployments of OC. After her first deployment of OC, the DJCO indicated that she "was unable to get a clear shot," but doesn't mention if she actually struck either youth. After her second deployment, the DJCO does not mention anything other than the fact that she "discharged a one second burst again." In three other incidents, while the DJCOs who deployed OC completed individual reports, the main SIRs failed to mention all of the DJCOs that deployed OC during the incident.

Recommendation

Provide additional training to give DJCOs guidance on the necessary level of detail to accurately describe the use of force and the results obtained. At a minimum, use of force reports should provide a description of how and where the force was applied on the youth, whether the youth was contacted by the force, and the reaction that the youth had to encountering the force.

Results Obtained from the Use of OC Spray

In many of the incidents, the DJCOs documented that the youths continued to fight after the initial burst of OC spray was deployed. Most of those reports made clear that additional bursts of OC were necessary because the fighting continued despite each deployment. These reports were easily corroborated by the video provided to the OIR.

However, the OIR did identify an incident where the documentation of the result of the deployment of OC was inconsistent with the video provided. The reports by three involved DJCOs essentially stated that when two youths "came into contact with the chemical restraint, they ignored the staff directives and continued to fight." These statements were clearly contradicted by the video which showed that immediately after being sprayed, one of the youths moved away from the other, and laid face down on the ground and placed his hands behind his head in the "duck and cover" position. None of the three DJCOs' reports mentioned anything about the youth going to the ground and assuming the "duck and cover" position.

Decontamination

Staff documented that decontamination occurred in all 28 incidents. However, there were some issues related to the documentation of the decontamination process.

Per Department procedure, staff are required to "be with the youth throughout the entire decontamination process." However, many incidents contained reports that did not actually state that someone remained with the youth during the entire time that the youth was decontaminating. Instead, the reports implied that there was someone present with the youth throughout the entire process by simply stating that the decontamination process was supervised by a DJCO or that the youth notified a DJCO that they were done decontaminating.

For example, in one incident, DJCO 1's report indicated that DJCO 3 and DJCO 4 "supervised the decontamination process." However, DJCO 3's report indicated that DJCO 4 "took charge of the decontamination procedure at which time I left the unit and proceeded to attend to my blood stained clothing." Similarly, DJCO 1's report indicated that SRJCO 1 and DJCO 7 "supervised the decontamination process for youth" Y2 in Unit I. However, DJCO 7's report indicated that when Y2 stepped into the shower stall to decontaminate, "[he] was then relieved by" DJCO 8 and returned to Unit O.

In another incident, the DJCO's main SIR narrative indicated that he "removed the handcuffs from [a youth]'s wrists," and that "the decontamination procedure for [the youth] ended at the request of the youth." It also indicated that the DJCO "issued clean clothing to" the youth, and then "collected the contaminated clothing, and placed it in a bag," and labeled it. This was the only verbiage that could be read to indicate that the DJCO was "with the youth throughout the entire decontamination process."

To allow supervisors to ensure that someone was physically present with a youth during the entire decontamination process, the OIR recommends updating the Use of Force/Restraint Report to explicitly solicit this information.

Recommendation

Update the portion of the Use of Force/Restraint SIR form relating to Pepper Spray and Decontamination to add an entry field that requires the report writer to specifically indicate which DJCO(s) stayed with each youth during the entire decontamination process.

In some incidents, staff members, who assisted with the decontamination process, did not prepare a report documenting their involvement. When a chemical restraint such as OC spray is used, procedure requires only staff members who "use or witness the use of OC spray" to submit a written SIR and Use of Force Report.

In one incident, the main SIR mentioned that the youth was affected by overspray and was sent to the showers to decontaminate. A DJCO completed a Use of Force Report/OC spray checklist. However, there was no SIR narrative prepared by anyone who escorted, or supervised, the youth during his decontamination. Due to the lack of reporting, it is unclear whether staff followed the proper decontamination procedures for the youth, or which staff members participated in the decontamination process. Additionally, the youth began decontamination 20 minutes after the first deployment of OC and none of the reports provided an explanation as to why decontamination was delayed.

In another incident, the reports stated that approximately 17 minutes after the deployment of OC, a youth complained "that he had some burning from 'overspray' of the OC Pepper Spray." The youth "was brought out and permitted to shower for the decontamination procedure." It appears from the reports that staff was not aware that the youth was exposed to overspray until after the incident was over and all uninvolved youths were returned to their rooms. No supplemental narrative was written related to the youth's decontamination indicating who participated and how the decontamination process was carried out.

In yet another incident, two uninvolved youths were affected by overspray and taken to the showers to decontaminate. One youth began decontamination within seven minutes of the OC deployment, and the other youth began decontamination approximately 12 minutes after the OC deployment. The main SIR states that a DJCO supervised the decontamination of the two uninvolved youths, however, the DJCO did not prepare a narrative report to document his participation or how the decontamination process was carried out.

Finally, a report documented an incident where the decontamination process was detailed extensively in the main SIR narrative, including the fact that two DJCOs escorting the youth were switched out for two other DJCOs during the decontamination process. The DJCO who prepared the main narrative was not present for the decontamination, and no report was provided by the two DJCOs who were supposedly present during the decontamination process. As a result, the events recited in the main SIR narrative were secondhand.

Noticeably absent from Department procedure is a requirement that staff members tasked with supervising youth during decontamination prepare a written report. A report regarding the decontamination process should be authored by someone with personal knowledge of the events. Staff who supervise, or are involved in supervising, youths during the decontamination process should prepare a report documenting their involvement with each step of the decontamination process.

Recommendation

Update PMI 3-1-056 to require that all staff members assisting with decontamination, even of uninvolved youth affected by overspray, prepare reports documenting their role in the decontamination process.

Medical Treatment and Identification of Injuries

The Department's OC procedure states that an SIR must include information related to medical treatment and identification of injuries.[79] Staff consistently complied with Department procedure regarding the documentation of the Medical Unit response.

There were 28 incidents involving 71 youths who were exposed to OC, either directly or through overspray. The OIR reviewed all 28 incidents and located only one youth who had no documentation of a referral or any medical treatment. The youth was not involved in the incident and subsequently identified himself as having been exposed to overspray. While the records indicate that medical staff saw the two involved youths within 25 minutes of the incident, there was no indication in any of the reports that the oversprayed youth was seen by medical.

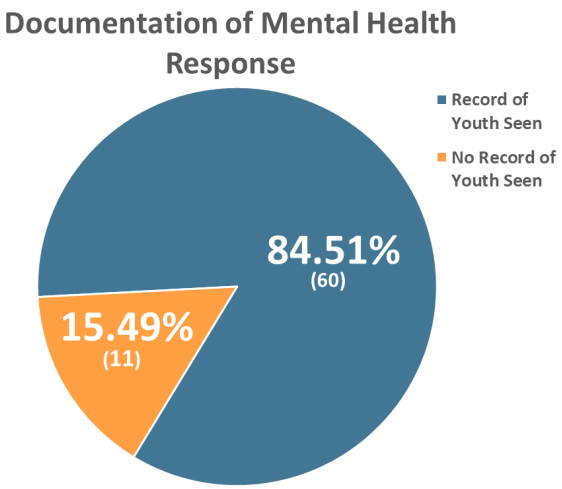
No injuries were reported as a result of the deployment of OC spray. There was also nothing in the provided documentation that indicated that any of the youths experienced the exacerbation of an existing medical condition due to being sprayed with OC.

Mental Health Response

Department procedure requires that a youth must be referred to Mental Health staff immediately following decontamination, and that "a licensed clinician from the Health Care Agency (CEGU) will determine if the youth needs to be seen, and if so, will see the youth within 72 hours."[80]

The reports related to all 28 incidents confirmed that the Department consistently referred intentionally exposed youth to mental health staff in a timely manner in compliance with Department procedure. However, in three incidents, there was no documentation that mental health staff were notified about four uninvolved youths who were oversprayed.

[79] Procedure Manual Item 3-1-056 II(E)(2) Notification and Documentation.
[80] Procedure Manual Item 3-1-056 II(F)(17) Decontamination/Aftercare Procedures.



As it relates to the 71 youths who were exposed to OC spray, records were provided establishing that referrals were made by the Department to mental health staff for 67 of the youths. Records indicate that 60 of the youths were then seen by a licensed clinician within 72 hours following exposure. No Department records were provided establishing whether the remaining 11 youths were seen by a licensed clinician. The youth may have been seen by mental health staff; however, health records are maintained by the Health Care Agency, not the Department.

According to the Department, SIRs are usually completed at, or near, the time of the incident, while Department procedure allows CEGU up to 72 hours to see a youth. As a result, it is likely that a youth may be seen after the incident reports have been completed. Therefore, there is no specific directive in the Procedure Manual that requires an SIR to indicate whether a mental health clinician actually saw a youth exposed to OC. Instead, the Department procedure focuses on ensuring that a referral is made immediately following decontamination.

Missing Reports

The OIR reviewed all incident reports, use of force reports, and available video footage for each of the 28 incidents. In many of the incidents, there were missing reports. The missing reports included all three types of reports: SIRs, Use of Force/Restraint Reports, and OC spray checklists. The subject matter of the missing reports also covered a range of information. The primary areas where reports were missing typically revolved around DJCOs who witnessed a use of force or assisted in the decontamination of youths.

Following a use of force incident, DJCOs who are a witness, or involved in the incident, at a minimum must complete an SIR. An SIR is a narrative to document their observations and involvement in the incident. DJCOs who are directly involved in a use of force must also complete a Restraint Report in addition to the SIR. Finally, DJCOs who deploy OC spray must complete an OC spray checklist for each exposed youth to document whether the exposure was intentional or accidental, the spray duration, spray distance, number of sprays, and timing of medical, mental health, and parental notification.

Recommendation

Provide additional training reminding DJCOs of the importance of making sure that they complete an SIR including a narrative in compliance with the Department's use of force procedure.

Reports related to youths that were oversprayed were sometimes missing as well. For example, in one incident, a DJCO prepared a Use of Force report to document the intentional deployments of OC directed at two youths. Noticeably absent was a Use of Force report prepared by the DJCO to document a third youth's exposure to overspray. A staff member who assisted in escorting the oversprayed youth for decontamination prepared a Use of Force report to document his securing of the youth's elbow. He also noted that a chemical restraint was used. However, the page used to document the details of an accidental exposure to OC was not prepared to record the specifics related to youth's exposure to overspray.

Recommendation

Provide additional training reminding DJCOs who deploy OC to complete a Use of Force form for each affected youth, whether intentional or the result of overspray.

Failures in documentation can be problematic, especially when undocumented conduct involves a use of force. Reports of staff members who witness a use of force event help to provide an additional layer of transparency and thoroughness. Use of force incidents often rapidly evolve and rarely last longer than a few minutes. As such DJCOs who witness, but are not directly involved, may be in a better position to recall, and document, specific details that are relevant to supervisory review.

Supervisors rely on documentation to determine the reasonableness of a specific use of force incident and accompanying staff conduct. As a result, it is incumbent on supervisors to ensure that all DJCOs who witnessed, or were involved in, an event document their involvement. This includes ensuring that a Use of Force report is completed for each youth that is a target of an OC deployment, clearly documenting efforts at de-escalation, documenting when youths are seen by medical staff and explaining when delays in notifications occur.

Recommendation

Provide additional training reminding supervisors of the importance of making sure that DJCOs' reports are accurate and complete. Supervisors should also be reminded of their role in making sure that inconsistencies in, or between, reports are addressed before reports are approved.

Procedure Revisions

In August of 2023, after the 28 incidents in this systemic review occurred, the Department renumbered and made changes to both PMI 3-1-015 (Use of Force – Facilities) and PMI 3-1-056 (OC Spray- Facilities).[81] Both sections are applicable to uses of force involving the deployment of OC spray.

PMI 3-1-015 Use of Force

De-escalation

The Department expanded on its definition of "de-escalation" by clearly articulating that the goal of de-escalation "is to stabilize the situation, reduce the threat's immediacy, and gain the subject's voluntary compliance so that more time, options, and resources can be called upon to resolve the situation without force or with a reduction in the force necessary."

The Department also added language to the de-escalation section of the Use of Force procedure related to verbal management of aggressive behavior. This change added language directing DJCOs to listen, empathize, ask questions, paraphrase, and summarize as part of the verbal de-escalation process. The section also discussed the T.A.C.T. method which stands for time, atmosphere, communication and tone.

Changes to the Department's procedure related to de-escalation clearly outline the goal of de-escalation for staff and provide guidance for when to use de-escalation tactics. Additionally, the inclusion of a clear admonition mandating that OC spray shall only be used "when there is an imminent threat to the youth's safety … and only when de-escalation efforts have been unsuccessful or are not reasonably possible," could result in a decrease of OC spray incidents.

Decontamination

The Department's Use of Force procedure was also updated to indicate that "youth exposed to OC spray, through a direct spray or overspray, decontamination measures must be undertaken as soon as practical after a youth is subdued and restrained." This change does provide some expectation as to how soon decontamination measures should be undertaken.

Documentation

The Department updated the Use of Force procedure to articulate that an SIR must now include information pertaining to de-escalation attempts. Additionally, if no de-escalation attempts were made, the SIR must contain "the reason why they were not attempted." While it is appropriate to add this requirement to the Use of Force procedure, it should be noted that this requirement was already contained in the Department's OC Spray procedure. As recommended above, the OIR believes that additional training on documentation that includes the requirement that an SIR must contain the efforts to de-escalate prior to the discharge of OC spray, or reasons why de-escalation tactics were not reasonably possible, would be beneficial.

The updated Use of Force procedure now requires the SJCO, Duty Officer (DO), or designee to document the fact that they notified a youth's parent or legal guardian of the incident. The addition of this requirement is appropriate and should help to alleviate instances where parental notifications are not

[81] PMI 3-1-015 (Use of Force – Facilities) was renumbered as PMI 3-6-001; and PMI 3-1-056 (OC Spray- Facilities), was renumbered as PMI 3-6-003.

made. However, as recommended above, the OIR believes that additional training should also be provided to remind supervisors and staff that parental notification procedures should be followed, not just with respect to youths who were the target of OC spray, but also for youths who encountered overspray.

Supervisor/Duty Officer Responsibility

Further updates to the Use of Force procedure clarified the responsibilities of the SCJO/DO in terms of notification of a youth's parent or guardian. The procedure now requires that notification be made "at the earliest time possible, no longer than 24 hours from the incident." The inclusion of this direction will likely help ensure that a youth's parent or legal guardian is notified of the incident in a timely manner.

Another update to the Use of Force procedure expanded the responsibility of an SJCO/DO to review for certain items in SIRs and Restraint Reports. The Use of Force procedure now specifically requires the SJCO/DO to review reports to determine whether a "use of force was objectively reasonable, consistent with the law, and within policy." The procedure also puts supervisors on notice that the determination should be made "from the perspective of a reasonable officer in the same situation, based on the totality of the circumstances known to or perceived by the officer at the time rather than with the benefit of hindsight." SJCOs and DOs are also now required to look for potential training issues when they review SIRs and Restraint Reports.

The updated Use of Force procedure also requires that all SIRs and Restraint Reports shall be forwarded to the appropriate Assistant Division Director (ADD) within 24 hours of the incident.

Management Responsibilities and Review

Similar to SJCOs and DOs, the update to the Use of Force procedure now clarifies that an ADD is to review Use of Force Reports to determine if the use of force was objectively reasonable. ADDs are also required to review the reports for training issues.

PMI 3-1-056 OC Spray

Notification and Documentation

The Department also updated the OC Spray procedure to require that SIR and Restraint Reports include documentation of a mental health evaluation, parental notification, and if applicable, attorney notification. While referrals to mental health and parental notifications were required under the previous OC Spray procedure, this change now adds attorney notifications when applicable and ensures that the completion of all three tasks is also documented. It is appropriate to add this requirement to the OC Spray procedure to ensure additional documentation. However, as recommended above, the OIR believes that the procedure should require an SIR to include information pertaining to whether the youths were actually seen by CEGU and, if so, whether they were seen within 72 hours as required by procedure.

The OIR believes that the changes made to the above procedures are improvements. Further, the changes represent a positive step towards clearly articulating the Department's general policies regarding the deployment of OC. The above changes will also help facilitate more effective internal, and external, oversight of incidents involving the use of OC spray.

Conclusion

The OIR's review showed that the Department's procedures comply with Title 15 and the California Penal Code. Some of the Department's procedures have been updated since this review began. The most recent versions of the Use of Force and OC procedures reflect the current state of the law in California as it relates to the use of chemical restraints in a juvenile detention facility.

There are, however, areas where improvement can be made. As a result, the OIR made 23 recommendations primarily addressing the type and amount of force used, decontamination, procedures after the use of force, notification, and documentation. Many of these recommendations are suggestions that can be appropriately addressed through procedure changes and training. These recommendations are meant to improve upon the good work that the Department is doing.

Most of the reports that were provided, when coupled with video surveillance recordings, allowed for a thorough review of the incidents. However, there were several times the OIR found that questions were left unanswered due to a lack of detailed reporting. In some cases, the lack of reporting appeared to be attributable to isolated mistakes in reporting as well as supervisory oversight. As a result, the OIR believes that the Department could benefit from changes in procedure to ensure accurate and complete reporting of OC deployments. Changes to procedure requiring more robust reporting will ensure appropriate supervisory review and provide a mechanism for supervisory staff to readily identify and address any issues. The recommended changes will also give supervisors an opportunity to provide necessary support to staff members in order to avoid similar issues in the future.

A few of the OIR's recommendations ask the Department to document additional information. The OIR recognizes that the Department collects and maintains an overwhelming number of documents and information on force incidents involving a large youth population. However, the documentation recommendations are meant to ensure that the obligations set forth under state law and Department procedure are accomplished and to allow a supervisor the ability to easily determine compliance.

Many positive areas were also observed, starting with the fact that OC spray was deployed in less than 20 percent of the 142 physical altercations that occurred in 2022. This relatively low number of deployments indicates that DJCOs understand that the deployment of OC spray is a use of force option that is only to be used when there is an immediate threat to the safety of a DJCO or others.

Other positive areas noted by the OIR included the fact that there were no systemic issues related to the justification for the initial deployment of OC spray and no incidents of OC spray being used preemptively or after voluntary compliance was obtained. There were also no injuries reported as a result of the deployment of OC spray.

Finally, while there may have been specific individualized issues related to the number or duration of OC spray deployments, ultimately the initial deployment of OC spray during each of the incidents was justified given the immediate threat to the safety of the youths in the care of the Department.

Recommendations

1. Examine any factors that may have led to gender disparity in the deployment of OC spray to ascertain whether there are actions that could be taken to reduce the total overall number of OC deployments.

2. Update PMI 3-1-056 to require DJCOs to specifically indicate in their SIR or Restraint Report whether an exposed youth was a "no OC profile" youth, and if so, state what efforts were made to avoid spraying the youth.

3. Update PMI 3-1-056 to specifically state that OC spray is classified as an intermediate level of force.

4. Provide additional training reminding staff of the importance of providing clear details in reports, including areas of the body targeted by assaultive and/or violent physical behavior, to allow proper assessment of the likelihood of serious bodily injury when a supervisor is reviewing the incident.

5. Provide additional training reminding staff that pursuant to the OC procedure, OC bursts may be no more than ½ to 1 second in duration.

6. Provide additional training to staff reminding them of the importance of transitioning to the next appropriate force option when OC spray appears to be ineffective.

7. Provide additional training reminding staff that they should consider all available tactics and force options before deploying OC spray. While OC should not be considered a force option of "last resort," it also should not be employed in circumstances where a different tactic would be likely to lead to a better outcome, or where the use of OC may be counterproductive.

8. Update PMI 3-1-056 to require that after OC spray is deployed, where uninvolved youths are present, that a staff member shall be assigned to examine each uninvolved youth to determine, and document, whether they were actually sprayed and whether they need to be decontaminated prior to returning to their room.

9. Update PMI 3-1-056 to require that any youth, who is the intended recipient of an OC deployment, be offered decontamination regardless of whether the youth is suffering the effects of the OC spray. The procedure should also require that any refusal to decontaminate be documented.

10. Update the portion of the Use of Force/Restraint Special Incident Report (SIR) form relating to Pepper Spray and Decontamination to add an entry field that requires the report writer to specifically indicate whether the youth was placed into the shower fully clothed.

11. Update PMI 3-1-056 to require that notification to the medical unit regarding the exposure of OC should occur no later than the start of the decontamination process.

12. Provide additional training to remind supervisors and staff that mental health notification procedures should be followed, not just with respect to youths who were the target of OC spray, but also for youths who encountered overspray.

13. Update PMI 3-1-056 to clearly articulate who has the responsibility to refer youth to Mental Health Staff following decontamination. This change would put DJCOs on notice as to whose responsibility it is to ensure that Mental Health staff are contacted.

14. Provide additional training to remind supervisors and staff that parental notification procedures should be followed, not just with respect to youths who were the target of OC spray, but also for youths who encountered overspray.

15. Provide additional training to address report writing as it relates to using the non-descriptive phrase "assisted to the ground." DJCOs should clearly articulate in their reports the means and type of force that they used to "assist" a juvenile to the ground.

16. Provide additional training reminding DJCOs of the importance of making sure that their reports are accurate and complete.

17. Provide additional training that reminds line staff, and supervisors, that all SIRs, where OC spray was deployed, should include a discussion of whether de-escalation was attempted and whether warnings were given. Additionally, if efforts to de-escalate, and warnings, were not given prior to the deployment of OC spray, then the SIR should articulate why.

18. Provide additional training to give DJCOs guidance on the necessary level of detail to accurately describe the use of force and the results obtained. At a minimum, use of force reports should provide a description of how and where the force was applied on the youth, whether the youth was contacted by the force, and the reaction that the youth had to encountering the force.

19. Update the portion of the Use of Force/Restraint SIR form relating to Pepper Spray and Decontamination to add an entry field that requires the report writer to specifically indicate which DJCO(s) stayed with each youth during the entire decontamination process.

20. Update PMI 3-1-056 to require that all staff members assisting with decontamination, even of uninvolved youth affected by overspray, prepare reports documenting their role in the decontamination process.

21. Provide additional training reminding DJCOs of the importance of making sure that they complete an SIR including a narrative in compliance with the Department's use of force procedure.

22. Provide additional training reminding DJCOs who deploy OC to complete a Use of Force form for each affected youth, whether intentional or the result of overspray.

23. Provide additional training reminding supervisors of the importance of making sure that DJCOs' reports are accurate and complete. Supervisors should also be reminded of their role in making sure that inconsistencies in, or between, reports are addressed before reports are approved.