



JI-WA-0002-0022

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5/2/01

The Honorable Robert J. Bryan

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

JAMES HORTON, JAMES BARNHART,
JEROME PAYTON, J.B., through his
next friend, LORRAINE WEST, and
K.M., through his mother DEBBIE
MOORE, on behalf of themselves
and all others similarly situated,

Plaintiffs,

vs.

BOB WILLIAMS, in his official
capacity as Superintendent of
Green Hill School; JEAN SOLIZ,
in her official capacity as
Secretary of the Department of
Social and Health Services; and
SID SIDOROWICZ, in his official
capacity as Assistant Secretary
of the Juvenile Rehabilitation
Administration; and the Chehalis
School District,

Defendants.

CLASS ACTION

NO. C94-5428 RJB

DECLARATION OF
ROBERT WILLIAMS, JR

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Robert Williams, Jr. declares

1. Experience. I have 15 years experience in the field of
corrections (Att. A). Since February 1990 I have been
superintendent of Green Hill School. In that capacity, I am
responsible for the day-to-day management of the institution,
which houses 170 to 190 juvenile offenders and has a staff of 200

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1 employees. Prior to coming to Green Hill, I was an associate
2 superintendent at the Washington State Penitentiary for one year.
3 Prior to that, I was an administrator in the Wisconsin adult
4 correctional system from 1979 to 1987. My experience has given me
5 broad managerial as well as hands-on experience in working with
6 offenders and in dealing with security issues.

7 2. Green Hill Demographics. In Washington, there are five
8 institutions for juveniles offenders. When sentenced, an offender
9 is assigned to one of the institutions, based on such things as
10 sex, age, nature of the crime, and prior offenses. By policy, the
11 older and most serious offenders are placed at Green Hill -- the
12 "end of the line" for juveniles, as some people call it.

13 This year Green Hill's population has fluctuated between 170
14 and 190 residents. The average age upon admission is 17.1, and the
15 average length of stay is 602 days. Commitment may be up to age
16 21. Residents have been committed for a variety of offenses, and
17 most of them are repeat offenders. On November 2, 1994, for
18 example, the breakdown of residents by offense was:

19 Murder 8, Robbery 21, Rape 24, Other Sex Offense 11, Arson 1,
20 Assault 59, Burglary 24, Motor Vehicle Theft 7; Theft 3;
21 Possession of Stolen Property 5; Malicious Mischief 3; Escape
22 1, Drug Offense 12, Other Offenses 7.

23 Of that population, 61 percent or 113 out of 186 had been
24 convicted of a "violent" crime, which is a typical percentage for
25 Green Hill, and higher than at the other institutions. Many of
26 the residents were committed initially to Green Hill, though some

1 transferred in from other institutions where they were too
2 difficult to handle.

3 3. Pepper Spray Background. When I became superintendent of
4 Green Hill in February 1989, my immediate challenge was to reduce
5 the number of assaults. Although the mission at Green Hill School
6 is to rehabilitate juvenile offenders, as superintendant, my first
7 concern must be the physical safety of staff and residents.

8 Prior to my arrival, the practice was for as many as 20 staff
9 from throughout the institution to respond to a dangerous
10 situation. The idea was to physically subdue the resident by
11 overwhelming him. The result was large numbers of injuries (some
12 very serious) to staff and residents alike. A resident probably
13 is more vulnerable because by necessity he is subdued by a number
14 of staff members. Because there was no tracking system, I do not
15 know the numbers of injuries prior to my arrival. The problem
16 created severe morale problems at Green Hill, however. It was so
17 serious that in 1988 the legislature created the crime of
18 "custodial assault" and made it a Class C Felony. RCW 9A.36.100.
19 Then, in 1989, the legislature required that residents who commit
20 such assaults be considered for transfer to an adult prison if
21 they posed too high a safety risk. RCW 13.40.280(3)-(4).

22 The problem with the then-existing method to control
23 threatening residents was that the large number of responding
24 staff created an excited environment in which residents felt
25 "challenged" to engage in physical confrontation. Many residents
26 viewed backing down as "loosing face" in the eyes of staff and

1 other residents. Pulling responding staff off their normal
2 assignments, moreover, created a lack of supervision elsewhere in
3 the institution, leading to further security problems. Under
4 the then-existing practice, when a resident was out-of-control or
5 failing to obey an instruction, staff had no alternative to
6 physically apprehending the resident in order to gain control.
7 The result too often was injury to staff or the resident.

8 4. Use of Pepper Spray. I first authorized the use of
9 pepper spray at Green Hill in October 1990. By that time, pepper
10 spray was being widely-used by police officers and correctional
11 staff throughout the country. It was viewed as a very effective
12 and safe way to subdue a threatening suspect or inmate without the
13 risk inherent in using physical or deadly force.

14 Since October 1990, I have authorized the use of pepper spray
15 about 320 times, and actual use has occurred about 105 times.
16 That is an average of about two times per month. During that
17 time, there have been about 1,200 residents at Green Hill, and
18 about 80 (six percent) of them have been exposed to pepper spray.

19 I believe that the use of pepper spray has reduced the risk
20 of injury at Green Hill. From September 1989 through October
21 1990, there were 56 staff injuries caused by controlling
22 residents, seven assaults of staff, and 18 injuries to residents.

23 From October 1990, when pepper spray was introduced, through the
24 present time, there have been 58 staff injuries, nine staff
25 assaults, and 11 injuries to residents. These figures demonstrate
26 a dramatic decrease in injuries. This decrease, in my judgment,

1 is at least in part due to the fact that staff no longer must
2 physically engage a resident in order to bring him under control.

3 Green Hill staff is dedicated to working with residents and
4 trying to rehabilitate them. Many residents, however, are very
5 strong and prone to violence, and so staff's paramount concern is
6 their own physical safety, especially in the two "intensive
7 management units" (IMU). That is why few issues are more
8 important to them than being able to use pepper spray, which they
9 regard as a safe and reliable method of avoiding physical
10 confrontation.

11 Of the four other juvenile institutions in Washington, two do
12 not use pepper spray, and the other two use it less frequently
13 than Green Hill. The reason for this difference, in my judgment,
14 is that Green Hill houses the older, most violent, and most
15 assaultive juveniles in the system.

16 5. New Policy. On October 1, 1994 Green Hill adopted a new
17 pepper spray policy (Att. B) which attempts to address all the
18 concerns raised by plaintiffs.

19 a. Criteria For Use. There are two criteria for using
20 pepper spray on a resident who fails to comply with a staff
21 directive (Att. B at 3). The first criteria is when staff
22 believes that use of other physical restraint measures to gain
23 compliance, without the use of pepper spray, likely would result
24 in injury to someone. In making this determination, staff must
25 consider the resident's demeanor, his verbal statements, and his
26 history of causing injury.

1 EXAMPLE - John Doe misbehaves by throwing things in the
2 cottage. Staff tells him to go to his room as a consequence,
3 but he refuses to go. He clenches his fists when staff
4 approach him to take him to his room. He tells staff he will
5 fight them rather than go voluntarily. Staff cannot talk
6 John into going voluntarily going to this room.

7 In this example, pepper spray may an appropriate response to
8 maintain institutional security. First, of course, staff
9 directives must be followed by residents. Thus, in the example,
10 when John misbehaved and refused to go to his room, staff must
11 require him to go. Otherwise, staff loses control, and the
12 residents are the ones in charge. Residents must know for certain
13 there are consequences for disobeying directives. Thus, John may
14 go to his room voluntarily, or be forced to go with the assistance
15 of staff either by physical apprehension or by use of pepper spray.
16 If John will not go voluntarily, then staff makes an assessment of
17 whether they can physically apprehend him, and take him to his
18 room without someone being injured. The fact that John's fists
19 are clenched, and he is threatening to fight, may lead staff to
20 conclude that injury would result if they attempted to physically
21 apprehend him. Thus, use of pepper spray may be justified.

22 The other criteria for using pepper spray is when a resident
23 in his room engages in disruptive behavior which creates a serious
24 disturbance that threatens institutional security.

25 EXAMPLE - After bedtime, John Doe in his room is banging and
26 yelling. This keeps other residents in the cottage awake,
27 and incites others to join in. Staff tells John to stop this
28 activity, but his refuses and threatens staff.

29 In this example, if John's disruptive behavior continues for

1 a long period of time, use of pepper spray may be appropriate.
2 John's room behavior is creating in the cottage a serious
3 disturbance that possibly threatens institutional security. This
4 type of situation is discussed on pages 26 to 28.

5 These two criteria demonstrate that pepper spray is not used
6 as punishment, as plaintiffs contend, but instead as a means of of
7 prevent injury and maintaining institutional security. Moreover,
8 contrary to plaintiffs' contention, something more than a failure
9 to follow a staff directive is required; there also must be a
10 threat to institutional security.

11 b. Compliance with Staff Directive. The new policy assures
12 a resident ample opportunity to comply with the staff directive
13 before being sprayed. Generally, there is considerable time after
14 a disturbance starts until the time spray is even considered.
15 Staff must attempt verbal negotiation right up until the time
16 pepper spray actually is used. Moreover, they must wait at least
17 ten minutes from the time security arrives on scene with the
18 spray, except in cases of emergency (Att. B at 3-4). Normally,
19 there will be at least 30 minutes from the time pepper spray in
20 first threatened to the time it actually is used. Our objective
21 is to resolve the issue without having to use pepper spray.

22 Plaintiffs object that residents are sprayed even after they
23 comply with the staff directive. Invariably, near the time spray
24 is used, the resident will cease his threatening behavior, and
25 will assume a defensive posture to avoid the spray. This does not
26 necessarily mean the resident intends to comply voluntarily with

1 the staff directive. Moreover, there have been many instances
2 when a resident, just before pepper spray is to be used,
3 verbalizes that he will comply, and then returns to threatening
4 behavior when the threat of spray is retracted. A impasse is
5 created. The new policy attempts to resolve this issue by
6 prohibiting use of spray when the resident indicates compliance,
7 but allowing its use, without the normal waiting period, if the
8 resident soon resumes his threatening and non-compliant behavior
9 (Att. B at 4).

10 About two times in the past the name of a resident was placed
11 on a spray canister. The purpose simply was to warn the resident
12 that continued assaultive behavior may result in spraying, in
13 hopes of deterring that behavior in the future so that spray would
14 not be needed. This practice has not occurred in a long time, and
15 it is not our intent to use it in the future.

16 c. Pre-authorization. Plaintiffs complain that some sprays
17 are "pre-authorized" by the superintendent. The former policy
18 required the superintendent to approve each use. In practice,
19 however, I sometimes pre-authorized use on a resident who had
20 previously assaulted staff; in such cases, staff could use pepper
21 spray if the resident again engaged in the same threatening
22 behavior, without the need to contact me and explain the specific
23 facts. The new policy expressly prohibits pre-authorization (Att.
24 B at 2). In each case, staff requesting authorization must
25 explain to me the specific facts of the case. I am almost always
26 reachable in my office or at home, or by car phone or beeper, and

1 I will designate someone to act in my place on those limited times
2 when I am not reachable. I consider the use of pepper spray an
3 extremely serious matter, and I deny ever making any jokes or
4 light-hearted comments regarding its use, as alleged in
5 plaintiffs' submissions.

6 d. Administrative Review. Plaintiffs complain there is a
7 lack of administrative review of a pepper spray incident. In the
8 past, formal reviews were not always conducted. The new policy
9 requires a supervisory review of each incident, which then must be
10 reviewed by the superintendent, who is required to initiate a
11 "Major Incident Review" if there appears to be a injury or
12 procedural violation (Att. B at 6). If staff misuses pepper
13 spray, I will consider whether disciplinary action is appropriate,
14 and whether changes in the policy are necessary to prevent future
15 misuse.

16 e. Training. Plaintiffs complain there is a lack of staff
17 training. Prior to the filing of this lawsuit, all staff
18 authorized to use pepper spray were required to complete a
19 training course. (At Green Hill, there is a separate "counseling"
20 staff, and a separate "security" staff, and it is the former which
21 is called in to administer the sprayings.) The training course
22 generally lasts about a half-day, and is taught by local law
23 enforcement officials who are experts on the subject. The course
24 includes such things on how properly to use pepper spray and how
25 afterwards to "de-contaminate" the sprayed resident. Part of the
26 training includes staff themselves being sprayed; this is very

1 important because it gives staff first-hand experience in the
2 effectiveness of the spray, and helps them to empathize with a
3 person who has been sprayed.

4 The new policy makes clear that only trained staff are
5 allowed to use pepper spray (Att. B at 4). The annual training
6 now will be expanded to cover six specific components (Att. B at
7 7).

8 6. De-escalation Skills. One of plaintiffs' main complaints
9 is that staff lacks verbal de-escalation skills to avoid the need
10 to spray. In response, under the new policy, such training is
11 made part of the annual pepper spray training (Att B. at 7). An
12 outside expert will be hired to make the presentation. An
13 emphasis on de-escalation skills was not lacking in the past,
14 however. First, staff must have a college degree in a social
15 science or criminology field, and are hired in part on the basis
16 of their ability to effectively communicate. Staff must attend
17 the week-long Criminal Justice Training Academy, where the
18 curriculum includes communication skills and techniques on
19 verbally defusing dangerous situations. They also must complete
20 day-long Nonviolent Crisis Intervention (CPI) training, which is
21 a nationally-recognized program (Att. C).

22 Lastly, in staff meetings and in informal discussion between
23 staff, there is an ongoing effort to improve abilities to
24 communicate both with residents generally and with certain
25 residents in particular. Establishing rapport with residents is
26 a primary goal of every counselor. Residents daily receive input

1 from counselors on the need to resolve their problems without
2 resorting to violent or threatening behavior. Indeed, staff
3 continually calm angry residents without even threatening use of
4 pepper spray. This is proven by the fact only six percent of our
5 residents are sprayed, and very few of them are sprayed more than
6 once. It also is proven by the fact that in cases where I have
7 approved the use of pepper spray, two-thirds of the time staff has
8 successfully resolved the problem without having to use spray. I
9 think the record shows that staff in fact is very adept at
10 defusing angry residents, many of whom have a demonstrated
11 propensity towards violence.

12 7. Spray Concentration. Formerly, staff used either a 5% or
13 a 10% spray concentration. Plaintiffs object that there is no
14 criteria for whether the 5% or 10% spray concentration is used in
15 a particular situation. According to the literature, a single
16 application of the 10% is not stronger, or at least not
17 perceptibly stronger, than the 5%. Nevertheless, I now have
18 directed that only the 5% be used by staff. This policy will
19 remain in effect unless it is later shown that the 5% is not
20 effective in bringing the resident under control, in which case
21 the policy will be re-examined.

22 8. Mental Health Services. Plaintiffs complain that mental
23 health services are not available to alleviate the need to use
24 pepper spray. This simply is not true.

25 When a resident enters Green Hill, he spends 60 days in an
26 "intake" unit during which he receives a complete assessment.

1 This assessment includes psychological testing, and a
2 psychological evaluation which is reviewed by a staff
3 psychologist. Each resident is assigned a counselor. At least
4 one formal one-hour counseling session is held each week, and the
5 counselor has daily contact with the resident. The counselor is
6 required to address any mental health concerns, personal problems,
7 and day-to-day living difficulties of the resident. A counselor
8 generally has only four residents on his or her caseload. Also
9 available at Green Hill is a contracted psychiatrist, who
10 administers medication and consults with residents who are
11 experiencing mental health problems,

12 Green Hill offers a variety of programs to enhance the mental
13 health of residents (Att. D at 6-19). For example, residents are
14 required to participate in group therapy for such things as
15 positive alternatives, anger management, and victim awareness.
16 There are special groups for sex offenders and for residents with
17 drug and alcohol problems. Green Hill uses state-of-the art
18 "biofeedback" technology, which measures the bodily responses of
19 residents to help them alter their responses in a socially-
20 desirable direction. Green Hill also has the "Help-Stress"
21 computer-assisted counseling program.

22 Furthermore, prior to this lawsuit being filed, I instituted
23 plans for a new day treatment mental health unit at Green Hill.
24 Staffed by three of our best counselors, this unit will provide
25 intensive treatment for 15 to 20 residents with the most serious
26 mental health problems for eight hours each day during the week.

1 Operated out of the hospital building, this unit should be
2 operational in December.

3 Plaintiffs complain that mental health services are not
4 available before and after the use of pepper spray. When staff is
5 considering the need to use pepper spray, they must make every
6 attempt to talk the resident out of his threatening behavior.
7 Clearly, at that point, the focus must be on alleviating an
8 immediate security crisis, and not on dealing with long-term
9 mental health issues. If pepper spray is used, staff is trained to
10 assist the resident in a caring manner. The incident then is
11 taken up the next day in counseling. The counselor reviews with
12 the resident what caused the incident and ways to control his
13 behavior in the future. The counseling is "offense specific";
14 that is, the pepper spray incident is reviewed in context of the
15 behavior that caused the resident to be committed to Green Hill in
16 the first place. The behavior generally stems from a lack of
17 impulse control, which is the root problem to be addressed.

18 9. Behavior Control at Green Hill. Plaintiffs imply that
19 use of pepper spray is the primary method of controlling and
20 punishing residents. This is simply not the case.

21 Green Hill operates on the "Today-Tomorrow" program under
22 which each resident has a individualized behavior contract,
23 spelling out expectations for the resident. These include such
24 things as attending school, keeping the room clean, participating
25 in groups, and having positive peer and staff interactions. Each
26 day the resident receives points for meeting expectations. With

1 points the resident advances in "levels"; that is, he moves to a
2 living situation with greater privileges, such as television and
3 movies, phone calls, extra recreation, weight-lifting, later
4 bedtimes, and employment opportunity. The highest level is the
5 "honor program" where residents have the opportunity for off-
6 campus activity and for eventual transfer to a group home in the
7 community (Att. D at 8-9). The goal of the "Today-Tomorrow"
8 program is providing daily incentives for residents to obey the
9 rules and to participate in programs, which are the keys to
10 rehabilitation. The program is effective because good behavior is
11 encouraged and reinforced by continually rewarding it. This is
12 especially important for the many Green Hill residents who are
13 serving long sentences and need short-term incentives for good
14 behavior. Granting privileges is the centerpiece of Green Hill's
15 strategy to control the behavior of residents.

16 In addition, a misbehaving resident may be confined in their
17 room for up to one hour, or beyond one hour after an
18 administrative review for up to five hours. The theory of room
19 confinement is to sanction misbehavior, and in some cases to
20 remove temporarily a disruptive resident from the general
21 population. All confinement is in a resident's own room, as there
22 are no "isolation" cells at Green Hill.

23 Residents who continually misbehave may be assigned to one of
24 two cottages designated as "intensive management units" (IMU)
25 (Att. D at 10-11). In these units, residents when not in school
26 or at recreation are involved in special programming. The staff

1 ratio is higher. The idea is not to "punish" the resident, but
2 rather to provide a more structured program that hopefully will
3 change his behavior and attitudes, so that he can return to the
4 general population.

5 The fact is that many residents enter Green Hill with a
6 propensity towards violence. They often are angry and accustomed
7 to resisting and lashing out at authority. Staff are frequently
8 confronted by angry residents who would rather not do what they
9 are asked. Almost all situations are resolved through discussion
10 and through sanctions such as room confinement or taking away
11 privileges. The need to use pepper spray to maintain security
12 actually is very infrequent. Our objective always is to avoid the
13 need to use pepper spray.

14 10. Hostile Environment. Plaintiffs assert that the use of
15 pepper spray creates a violent and non-therapeutic environment.
16 I disagree.

17 In the perfect world, of course, taking physical control of
18 residents would not be necessary because they would do what is
19 asked of them and would never become threatening. In the real
20 world, however, this unfortunately is not the case. Thus, an
21 institution has the choice of either overtaking the resident with
22 physical force or by using a substance like pepper spray.

23 The most destructive features of an institution can be the
24 threat of physical injury. It promotes an "us verses them"
25 mentality which is very counter-productive to rehabilitation. It
26 causes "burn-out" which leads to undesirable high turnover of

1 staff. An actual injury destroys staff morale, and may excite
2 further dangerous behavior by residents. By greatly reducing the
3 risk of injury, pepper spray has helped in creating a more
4 positive environment at Green Hill.

5 Using physical force that involves violent bodily contact,
6 moreover, breeds extreme hostility between the combatants.
7 Spraying, by comparison, is less personalized, and therefore less
8 likely to engender hostility. Being sprayed, unlike being
9 physically subdued, does not result in a resident's "loss of
10 face". Very few residents are sprayed more than once. This
11 shows that spraying, rather than breeding violence, actually
12 causes residents to behave better; we simply are not reinforcing
13 pathologies. While spray is used only to maintain security, a by-
14 product is that the threat of spray re-enforces the notion that
15 residents must comply with the structure and rules at Green Hill.
16 For many residents, this is the first time in their lives living
17 under those expectations. Learning to comply with rules is a
18 critical component of rehabilitation, because that, of course, is
19 what society demands.

20 Finally, there simply is no evidence supporting plaintiffs'
21 contention that spraying has produced a more hostile environment
22 at Green Hill. In fact, since 1990 when spray was introduced,
23 assaults are down. Many more residents are behaving to the point
24 they can be returned to the community to serve out their
25 sentences. We have expanded our programming (Att. D), and have
26 instituted new opportunities to work outside the institution.

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1 Green Hill's environment in the last four years, in my opinion,
2 has become decidedly more positive, even though society is sending
3 us generally more hardened offenders.

4 11. Previous Sprays. The policy is for all pepper spray
5 incidents to be video-taped. The reason for this requirement is
6 that the camera inhibits acting-out behavior by residents, and
7 thereby decreases the need to spray. It also provides a means to
8 review the conduct of staff to assure that spraying is carried out
9 in accordance with policy.

10 Plaintiffs' experts reviewed 27 tapes, and concluded that in
11 most of the cases use of pepper spray was not necessary. I do not
12 agree. Since plaintiffs' experts have worked very little inside
13 a facility housing violent juvenile offenders, I suspect they may
14 not fully appreciate the security needs of an institution like
15 Green Hill. In addition, many tapes do not show all events
16 leading up to the spraying, and so the conclusions of plaintiffs'
17 experts may not be based on full information. Finally, as stated
18 above, many times, just before a spraying, residents cease their
19 threatening behavior, and assume a defensive posture. This may
20 lead plaintiffs' experts wrongfully to conclude that spray is not
21 needed because the resident no longer is a threat.

22 Whether to use spray is a difficult judgment call which
23 depends on the circumstances of a particular case. With two
24 exceptions, past sprays, in my opinion, were based on a
25 reasonable belief they were needed to maintain security. In two
26 cases, residents improperly were sprayed while handcuffed; this is

1 | contrary to policy, and should never happen because a handcuffed
2 | resident can be controlled without the need to use pepper spray.
3 | In one of these cases, the offending staff was demoted and then
4 | retired two months later. In the other case, the offending staff
5 | was reprimanded. It is my firm policy to take disciplinary action
6 | against any staff who violate the policy. At a recent training,
7 | the associate superintendent reviewed the new policy line-by-line
8 | with staff, and there was an opportunity for discussion. Staff,
9 | therefore, is aware of the new requirements, and there is no
10 | excuse for not following them.

11 | Plaintiffs submit declarations from seven residents giving
12 | their versions of being sprayed. Except for the one involving
13 | Cyrus Plush, I located the incident reports (Att. E). Except in
14 | the case of Jeremy Bakke, staff was reasonably justified in using
15 | pepper spray. As noted above, since Mr. Bakke was handcuffed, his
16 | spraying was not justified, and the staff was reprimanded for his
17 | actions.

18 | 12. Post-Spray Practices. The practice is to get a resident
19 | to the shower within five or ten minutes of being sprayed. In
20 | some cases, it takes longer because something unusual has happened
21 | scene requiring staff to remain at the scene, or because the
22 | resident is agitated and cannot be safely transported. The
23 | practice is to guide the resident along as he walks to the shower
24 | to offer him comfort and to prevent him from falling. I am aware
25 | of only one case where a resident fell while going to the shower.
26 |

1 In that case, the resident fell when he tried to skip down two
2 stairs. He was immediately helped up. No injury was reported.

3 During a spray, uninvolved residents are sent to their rooms
4 so they are not impacted by the spray. Following a spray, the
5 impacted area is "de-contaminated" by turning on the exhaust fans
6 to draw out the air, or by opening the windows. If the spray
7 occurs in a room, the bedding is changed. Generally, an odor
8 completely dissipates within not more than 30 minutes.

9 13. Sprays Under New Policy. The new policy was adopted on
10 October 1, 1994. Since that date, there have been two incidents,
11 involving a total of three residents, when pepper spray was used.

12 a. First Incident. The first incident occurred November 13 on
13 Joshua Howell. It started about 9:50 p.m. in Poplar Cottage (IMU)
14 when Howell received a "time-out" for banging on the office
15 window, and calling a staff "cocksucker". Staff tried talking to
16 Howell, but he refused either to talk or to go to his room.
17 Instead, he began lining up chairs against the two doors leading
18 out to the floor in a barricade fashion. Staff removed the
19 chairs, and Howell ran into the restroom. Security was called.
20 When security arrived, Howell and two other residents (Kevin Moore
21 and Brian Emmons) were in the restroom, refusing to leave. The
22 restroom was being flooded with five or six inches of water that
23 had begun running under the door. Howell was located by security
24 standing on top of the commode, flooding the floor by pushing down
25 excessively on the commode handle. When staff attempted to
26 escort the residents to their room, they refused to go. Emmons

1 had to be pulled out and taken to the ground. Moore followed him
2 out. Howell also refused to go to his room. He started swinging
3 at staff, and picked up a chair in the dayroom and tried to throw
4 it. Staff eventually cornered Howell, and tried unsuccessfully to
5 handcuff him. He eventually was pulled into his room. While this
6 was happening, Emmons also started fighting with staff with use of
7 a plexiglass shield that staff had dropped and he had picked up.
8 Moore also started swinging at staff. Staff eventually moved the
9 three residents to their rooms.

10 Prior to that point, staff had not requested from me
11 authorization to spray. Staff had responded to the incident
12 thinking Howell could be controlled without pepper spray. When
13 they did respond, the situation quickly got out of control.

14 At 10:30 p.m. Moore again was let out of his room to use the
15 restroom, but instead of using the restroom, he started drawing
16 graffiti on the walls, and running to the rooms of other
17 residents. He eventually ran to Howell's door, and refused to
18 leave. Security again had to be called. At that point, I was
19 called, and authorized the use of spray on the acting-out
20 residents based on the current situation and on the earlier
21 assaults. Staff did not use spray on Moore because they were able
22 to escort him was escorted back to his room. In his room, he
23 started banging and yelling. When warned he might be sprayed, he
24 stopped.

25 Howell, however, continued to furiously pound and kick his
26 door. He too was warned that he would be pepper sprayed if he

1 continued doing so. When he chose to continue, he was sprayed.
2 This spray had little effect on him because his had wrapped his
3 face in bedding. When about one minute later he resumed his
4 pounding, he was again sprayed.

5 The spraying was justified under the new policy. Howell's
6 behavior in his cell was inciting four or five other residents to
7 yell and bang in their cells. It is possible to kick open a door,
8 in which case staff might have faced the same dangerous situation
9 that had happened earlier in the evening. Moreover, in light of
10 Howell's behavior earlier in the evening, staff would have been at
11 risk if they had tried to move him. Finally, it was nearing
12 midnight, and Howell's behavior was keeping the cottage in an
13 uproar, was diverting limited nighttime staff from their regular
14 duties, and was preventing other residents from sleeping on a
15 school night when they had to get up early the next morning. This
16 type of situation is intolerable, and cannot be allowed to
17 continue indefinitely. Prior to the spraying, Howell was given
18 every opportunity to conform his behavior.

19 Furthermore, staff certainly would have been justified in
20 using pepper spray on the three residents when they were in the
21 flooded restroom. Their failure to use it necessitated a
22 dangerous physical confrontation that easily could have resulted
23 in injury. Fortunately, staff reported only soreness and bruises,
24 and there were no serious injury to the residents. This incident
25 demonstrates the type of situation in which pepper spray is a far
26 better alternative than physical confrontation.

1 b. Second Incident. The second incident occurred on
2 November 17, 1994 on Jason Kennedy and Chris Walters. It started
3 after bedtime, at 10:10 p.m., in Fir Cottage when security was
4 called because three residents were pounding and banging on their
5 doors. At 10:45 Kennedy was let out of his room to use the
6 restroom. While out, he filled a water jug, and sprayed it over
7 the office counter. He also turned over a chair in the dayroom,
8 and with encouragement from another resident, attempted to throw
9 it through the office window. He encouraged other residents to
10 join him, and then ran to his room and closed the door. Kennedy
11 and several other residents kept periodically pounding on their
12 doors.

13 At 12:04 a.m. Walters was let out of his room to use the
14 restroom. He refused to go back into his room. Staff attempted
15 to talk him into going. This refusal continued for the next 90
16 minutes, during which time Walters paced the floor, and Kennedy
17 and others kept periodically banging on their doors.

18 At 1:15 staff decided this situation could no longer
19 continue. I was called, and authorized the use of pepper spray on
20 both Kennedy and Walters. Warnings were given. At 1:30 staff
21 confronted Kennedy. Residents began yelling encouragement for him
22 not to go back to his room. Walters may have been influenced by
23 this yelling not to return to his room. Walters did not return to
24 his room, and told staff that they would have to physically take
25 him. At that point, Walters was sprayed. Kennedy, meanwhile,
26 continued banging on his door, and was getting at least three

1 other residents to join in. After spraying Walters, staff entered
2 Kennedy's room. He cursed and threatened them, at which point
3 Kennedy also was sprayed. The cottage then became quiet.

4 I believe these sprays were justified. Between midnight and
5 1:45 Kennedy had refused instructions to return to his room. His
6 actions resulted in a situation that caused other residents to
7 bang their doors, making it impossible for other residents, as
8 normal, to be let out of their room to use the restroom. When
9 staff went to take him to his room, he refused to go voluntarily,
10 and made comments indicating he would resist. This threat,
11 coupled with the fact Kennedy was convicted of assault and
12 recently had assaulted another resident, led staff reasonably to
13 conclude that there would be a fight if they tried to apprehend
14 him.

15 Kennedy, on the other hand, had been banging on his door for
16 90 minutes, and inciting others to do the same. He refused staff
17 directives to stop. His pounding was keeping up the entire 16-
18 member cottage on a school night. When staff entered his room, he
19 cursed and threatened them. Earlier in the evening he had engaged
20 in very threatening behavior.

21 The situation that night in Fir Cottage was unacceptable for
22 institutional security, and could not be allowed to continue
23 indefinitely. I simply cannot tolerate a situation where a
24 resident engages in threatening and non-compliant behavior that
25 keeps an entire cottage awake and in turmoil in the middle of the
26 night. Walters and Kennedy were given very ample opportunity to

1 comply. Pepper spray absolutely was needed to restore security
2 and to prevent injury.
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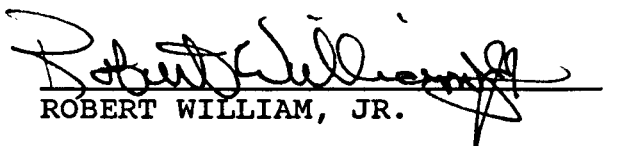
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1 Moving a disruptive resident to a room away from other
2 residents is not an option. First, a disruptive resident, like
3 Kennedy, may be dangerous to move. Moreover, all rooms at Green
4 Hill are in a cottage; there are no isolation rooms. Nor is
5 creating isolation rooms an option. I believe such rooms are
6 counter-therapeutic; the theory at Green Hill is to work with
7 residents, not isolate them. Furthermore, moving any resident who
8 acts out at night to isolation, would encourage some residents to
9 act out just for the attention, and would burden the short-handed
10 night-time staff. Finally, if we made going to isolation at night
11 an option, there sometimes would not be enough rooms to handle the
12 demand. In short, having isolation rooms is not an option, and
13 residents must be expected to behave at night in their own rooms.

14 Conclusion. Based on the foregoing, it is my professional
15 opinion that the use of pepper spray at Green Hill School,
16 pursuant to the new policy, is necessary to prevent physical
17 injuries and maintain security, is safe and humane, and enhances
18 rather harms the rehabilitative environment by reducing the risk
19 of injury.

20 I CERTIFY UNDER PENALTY OF PURJURY THAT I HAVE READ THE
21 FOREGOING DECLARATION, AND TO THE BEST OF MY KNOWLEDGE IT IS
22 TRUE AND CORRECT.

23 DATED this 21st day of November, 1994.

24 
25 ROBERT WILLIAM, JR.
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