
**INVESTIGATION INTO THE
EVENTS OF MAY 1, 2020 AT THE
C. CARLOS CARREIRO IMMIGRATION
DETENTION CENTER, UNIT B,
BRISTOL COUNTY SHERIFF'S OFFICE**



**OFFICE OF THE MASSACHUSETTS ATTORNEY GENERAL
CIVIL RIGHTS DIVISION**

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I. EXECUTIVE SUMMARY

On May 5, 2020, the Civil Rights Division of the Massachusetts Attorney General's Office (the "AGO") opened an investigation into a disturbance that took place on May 1, 2020 at the Bristol County Jail and House of Correction (the "May 1 Incident"). The disturbance involved twenty-five immigration detainees housed in Unit B of the C. Carlos Carreiro Immigration Detention Center (the "ICE B detainees" or the "detainees") and multiple employees of the Bristol County Sheriff's Office (the "BCSO"), including Sheriff Thomas M. Hodgson himself. This report memorializes the AGO's findings and conclusions based on a thorough and comprehensive review of the available evidence.

To begin, we acknowledge that the May 1 Incident was deeply traumatic and upsetting for many of the ICE B detainees and BCSO employees who responded that day. And the result was not inevitable. Indeed, our central conclusion is that a series of institutional failures and poor decisions by BCSO leadership throughout the late afternoon and evening of May 1 culminated in a calculated—that is, planned and deliberate—use of force against the ICE B detainees that was disproportionate to the security needs at that time and that unnecessarily caused, or risked causing, harm to all involved.

In particular, our review of the available evidence supports the conclusion that the BCSO violated the civil rights of the ICE B detainees on May 1 in two distinct ways.

First, the evidence shows that the BCSO's use of force on May 1 was excessive and disproportionate based on the totality of the circumstances. The BCSO's calculated use of force included the use of a variety of less-lethal but dangerous weapons—including a flash bang grenade, pepper-ball launchers, pepper spray canisters, anti-riot shields, and canines—against detainees who had exhibited calm and nonviolent behavior for at least an hour before this operation. The BCSO deployed these weapons both indiscriminately upon entry and also specifically against particular detainees who were not combative, assaultive, or otherwise actively resisting staff. Informing our conclusion that the BCSO's use of force was excessive, we identified myriad violations of the BCSO's policies and procedures, as well as the Immigration and Customs Enforcement ("ICE") National Detention Standards. We are particularly troubled by the BCSO's unlawful use of canines, lack of attempt to de-escalate the situation or otherwise avoid further conflict, and failure to warn the detainees, including those who may not have understood verbal directives because of language barriers, before using substantial force against them.

Second, we found ample evidence that the BCSO acted with deliberate indifference to a substantial risk of serious harm to the health of the detainees. In particular, the BCSO used an excessive amount of pepper spray and pepper-ball, including against detainees with serious pulmonary or respiratory conditions, such as chronic obstructive pulmonary disease ("COPD") and asthma. In the end, so much pepper spray was used that two detainees were taken to the hospital with symptoms of

respiratory distress,¹ a third required the administration of emergency chest compressions to be revived, and many detainees reported breathing difficulties in the days and weeks after the May 1 Incident. Many of the detainees also were not given adequate medical attention following exposures to pepper spray, nor were they provided with a timely and sufficient opportunity to decontaminate. And perhaps most shocking, the detainee who required emergency chest compressions was not taken to the hospital for a medical evaluation or assessment, but was instead placed in solitary confinement.

There is no dispute that the May 1 Incident started with the non-violent refusal of ten ICE B detainees to consent to COVID-19 testing and isolation. We do not, and cannot, question the clinical and operational judgment of BCSO staff that these particular detainees required testing and isolation, even when those detainees may have sincerely feared the conditions that they would face during their period of isolation. There is also no question that some detainees engaged in destructive conduct that damaged the unit and threw plastic chairs at BCSO staff members earlier in the day. By focusing this report primarily on the BCSO's role in the May 1 Incident, we neither intend to suggest that the detainees' conduct in this regard was appropriate, nor do we intend to minimize the impact of this conduct on the BCSO security staff who were there at the time. On the contrary, the BCSO was entitled to take reasonable and proportional steps necessary to restore institutional order at the time that the detainees were engaging in that conduct. But because the detainees' conduct largely stopped in the intervening hour before the tactical and canine teams entered the unit, it simply did not justify the level of force that was ultimately applied, nor does it excuse the ultimate disregard for the health of the detainees.

During his press conference about the May 1 Incident, Sheriff Hodgson said, "if we're falling short, we need to know why and what we can do to fix it." We take this statement at face value and hope that the BCSO will implement the series of recommendations and suggested reforms included at the end of this report. We believe that, if implemented, these reforms will help protect the people who depend on the BCSO for a safe place to serve their sentences or await future court proceedings, and the employees and contractors who depend on BCSO leadership to provide a safe working environment.

We thank and acknowledge the BCSO staff members who cooperated with our investigation, including those who spent time meeting with AGO attorneys to share their candid observations about the events of May 1 and the impact that it also had on them. We also thank and acknowledge the ICE B detainees, and their lawyers, advocates, family members, and friends, who provided substantial assistance in our investigation. Finally, we thank the BCSO, which voluntarily produced several sources of evidence in connection with our investigation.

¹ A third detainee was also transported to the hospital for a shoulder injury.

II. METHODOLOGY

The AGO’s investigation of the May 1 Incident commenced on May 5, 2020 after we received multiple complaints that BCSO personnel, including Sheriff Hodgson, used excessive and disproportionate force against the ICE B detainees and denied them access to appropriate medical care for injuries and other medical conditions resulting from this use of force. Our investigation was focused on the May 1 Incident and sought to determine whether the BCSO violated the detainees’ civil rights that day.

Our findings and conclusions (at pp. 24-53 of this report) are based on several sources of evidence. We relied, in substantial part, on the available video footage of the May 1 Incident. This footage included the available surveillance video from Unit B, short video clips taken on a BCSO employee’s cell phone from inside the ICE B control room bubble,² and footage from three camcorders that began recording shortly before 6 pm from three different locations—the ICE B control room bubble, the recreation pen area, and with the Sheriff’s Response Team (“SRT”) as it made entry into Unit B later that evening.

We also relied extensively on over a thousand pages of documentary evidence, including without limitation: (1) incident reports by BCSO staff who responded to or were otherwise involved in the May 1 Incident (including Sheriff Hodgson, SRT officers, canine officers, and nursing or other clinical staff); (2) logbooks; (3) documentation relating to the placement of the detainees in the Restrictive Housing Unit (*e.g.*, segregated housing units/solitary confinement); (4) selected BCSO policies and procedures; (5) a collection of BCSO email communications; and (5) medical records and other documentation provided by the detainees and/or their families and advocates. We also reviewed audio recordings and transcriptions of non-legal phone calls placed by certain detainees on May 1, and over 300 photographs taken by BCSO personnel.

In addition to these sources of evidence, we also interviewed thirteen BCSO employees who responded to or otherwise participated in the May 1 Incident, including Superintendent Steven J. Souza, the commanding officers of SRT and the Canine Division (the “K9 Division”), the Watch Commander, the Director of Medical Services, and several corrections officers, including SRT and K9 officers. As to the ICE B detainees, fifteen participated in the AGO’s investigation through interviews and/or the submission of written statements through their counsel, family members, and/or other advocates, which we carefully reviewed and considered. We also spoke with several lawyers, family members, community advocates, and other stakeholders who were in regular contact with detainees before, during, and/or after the May 1 Incident.

² The “ICE B control room bubble” is a secure area in the detention center where, among other things, BCSO security staff can observe and monitor portions of ICE Unit B through a large window. The ICE B control room bubble is located next to the only interior point of egress/ingress for Unit B.

In addition to these sources of evidence, we also considered statements and other evidence provided to the federal district court by the parties in *Savino v. Souza*,³ a class action lawsuit brought by immigration detainees in custody at the BCSO related to the COVID-19 pandemic, as well as Sheriff Hodgson's public statements, including his press conference about the May 1 Incident, and other publicly available information, including recent audit and inspection reports by various regulators. We also relied on the relevant ICE National Detention Standards and other best practices related to the use of force and the provision of medical care in correctional settings.

Although our investigation into the May 1 Incident was thorough and robust, there are two notable limitations on its scope. First, we did not interview every witness. We determined that extensive witness interviews were unnecessary in this case due to the availability of other substantial sources of evidence including video footage, contemporaneous audio recordings, and numerous written statements by the detainees and BCSO personnel. This limitation, therefore, has no meaningful impact on our findings and conclusions, each of which is independently supported by the evidence that we reviewed.

Second, while we very much appreciated the BCSO's voluntary cooperation and production of several sources of evidence, the BCSO did not provide documents in response to all of our requests for information. In particular, the BCSO did not provide information related to the BCSO's participation in the 287(g) program⁴ (which the BCSO asserted was irrelevant) and the investigations and disciplinary files for the SRT and K9 officers who responded to the May 1 Incident (which the BCSO asserted were irrelevant because no disciplinary action had been taken against any of these officers related to the May 1 Incident). We also requested, but did not receive, video footage from Sheriff Hodgson's cell phone.

III. BACKGROUND

a. Overview of the Bristol County Sheriff's Office

Each county in Massachusetts has a sheriff's office that is responsible for operating jails and correctional facilities within the county.⁵ County jails and correctional facilities generally house pretrial detainees and convicted offenders who are serving a sentence of 2 ½ years or less.⁶

³ No. 1:20-cv-10617 (D. Mass., filed March 27, 2020).

⁴ The BCSO's participation in federal immigration enforcement, including its participation in the 287(g) program is discussed on pp. 10-11 of this report.

⁵ See Mass. Gen. Laws ch. 37, §§ 1-26 (duties and obligations of county sheriffs).

⁶ The BCSO was established as an independent state agency on August 6, 2009; however, the Sheriff has retained administrative and operational control over the BCSO. See

The BCSO operates a large detention complex in North Dartmouth, Massachusetts, which includes the Bristol County Jail and House of Correction (the “BHOC”), the Women’s Center, and the C. Carlos Carreiro Immigration Detention Center (the “Detention Center”), which houses federal immigration detainees at all levels of custody classification.⁷ The BHOC is comprised of several decentralized housing units, including three special management units where prisoners may be segregated and isolated from the general population for administrative, disciplinary, or protective reasons. Most immigration detainees at the BCSO are held in the Detention Center, but some are housed in other parts of the BHOC, including the modular housing and the special management units. These facilities are headed by Superintendent Souza.

In addition to the housing units, the BCSO also maintains specialty units that support the operations of BCSO facilities. In relevant part, these units include SRT, the K9 Division, and the Health Services Unit.

The Sheriff’s Response Team

SRT is a paramilitary-style tactical response team that is tasked with “address[ing] security situations within the correctional facilities or other locations, when so authorized, including during an emergency situation.”⁸ SRT officers work full-time as corrections officers (of various degrees of rank), but undertake additional responsibilities in the event of emergency or security situations. SRT is supposed to have a commander, but that position has been vacant for nearly three years. SRT has instead been led by the Assistant Commander.

SRT is organized into two “squads” totaling approximately twenty-two corrections officers, each with assigned team leaders and assistant team leaders. According to the relevant BCSO policy, SRT officers are required to follow the “Chain of Command” and are subject to disciplinary action for disobeying the command

Chapter 61 of the Acts of 2009, An Act Transferring County Sheriffs to the Commonwealth, enacted August 6, 2009 (except where specified, transferring all functions, duties, and responsibilities of certain sheriffs’ offices, including the BCSO, to the Commonwealth).

⁷ The BHOC is an eleven hundred-bed facility that houses post-conviction inmates and certain pre-trial detainees, and the Women’s Center houses up to 106 women serving sentences. See BCSO, “Facilities,” <https://www.bcsoma.us/facilities.htm> (last visited December 3, 2020). In addition to the North Dartmouth detention complex, the BCSO also operates the Ash Street Jail and Regional Lockup, which houses up to 200 pre-trial detainees.

⁸ Bristol County Sheriff’s Office, Policy No. 09.24.00, Sheriff’s Response Team (“SRT Policy”), at 09.24.02(A) (general operational procedures).

structure.⁹ The SRT commander (in this instance, the Assistant Commander) reports to Superintendent Souza.

SRT officers are selected through a competitive application and screening process.¹⁰ To be selected, SRT officers must satisfy certain physical fitness standards and complete various in-service training and weapons requirements. Once selected, SRT officers are issued equipment for use in emergency situations (e.g., gas masks, riot helmets with face shields, 24-inch collapsible batons),¹¹ and must complete annual training developed by the SRT commander.¹² These trainings must include use of force and restraint related topics; these trainings may include additional topics related to de-escalation and conflict avoidance, though such topics are not independently mandated by the relevant BCSO policy.¹³ SRT officers also reported receiving some training on the ICE National Detention Standards as part of the annual in-service training for all BCSO officers, but only recalled isolated portions of those standards, such as the ban on the use of mace against ICE detainees.

The K9 Division

The BCSO's K9 Division is used "for correctional, law enforcement, and crime prevention functions."¹⁴ At BCSO facilities, the K9 Division is primarily responsible for patrolling and securing facility perimeters and conducting contraband searches. The K9 Division also supports local law enforcement activities and participates in a regional drug enforcement task force.¹⁵ The K9 Division Captain is responsible for the day-to-day

⁹ *Id.* at 9.24.02(D) ("SRT members shall face disciplinary action for deliberately disobeying the chain of command."); *see also id.* at 09.24.06(C)(1) (noting that SRT members can also be removed for having "an uncooperative attitude" or for "irresponsibility" and "unprofessionalism," among other reasons). Notwithstanding this policy, the SRT Acting Commander told us that officers have the right to refuse orders.

¹⁰ *Id.* at 09.24.04 (application and screening procedures), 09.24.05 (conditions for membership).

¹¹ *Id.* at 09.24.08 (uniform and equipment).

¹² *Id.* at 09.24.07(C) (noting that SRT members must complete 40 hours of entry level training within the first year of membership, followed by 16 hours of annual in-service SRT training in subsequent years).

¹³ *Id.* at 09.24.07 (Sheriff's Response Team training procedures).

¹⁴ Bristol County Sheriff's Office, Policy No. 09.07.00, Canine Division Operations ("K9 Policy"), at 09.07.02(A) (general policy).

¹⁵ Many sheriffs' offices in Massachusetts maintain canine units to assist in patrol and/or contraband or explosive detection within county houses of correction and jails. Although

operation of the K9 Division. K9 officers are assigned full-time to the K9 Division. At the time of the May 1 Incident, the BCSO's K9 Division was comprised of seven active duty dogs (Rony,¹⁶ Eros, Will, Sharpy, Jerry, Kofy, and Xiro) and their handlers.¹⁷ These dogs are all large breed dogs, including German Shepherds, Dutch Shepherds, and Belgian Malinois, and may weigh up to 80 pounds.

Each member of the K9 Division is required to attend a sixteen-week training academy, where the "canine team" (meaning the dog and handler pair) learns "tracking, criminal apprehension, building searches, crowd control, felony car stops, jail cell extractions,¹⁸ article searching, legal issues and K-9 first aid." Each K9 team must also complete 16 hours of monthly in-service training.

the BCSO K9 Division's other "law enforcement" and "crime prevention" activities are beyond the scope of this report, we note that the primary purpose of any sheriff's office in Massachusetts is the care and custody of inmates and detainees and the effectuation of service of process, not community policing. *Compare* Mass. Gen. Laws ch. 41, § 98 (authorizing the appointment of police officers for cities and towns) and *Commonwealth v. Gernrich*, 476 Mass. 249, 253-55 (2017) (describing the differences between the powers of deputy sheriffs and police) *with* Mass. Gen. Laws ch. 37, § 13 (describing peace officer powers of sheriffs) and Lyle Moran, "Mass. Sheriffs Draw Criticism as They Broaden their Activities, Lowell Sun (December 5, 2010), <https://www.lowellsun.com/2010/12/05/mass-sheriffs-draw-criticism-as-they-broaden-their-activities/> ("[Sheriff] Hodgson said sheriffs have every right and responsibility to step in when they feel local law-enforcement officers are not fulfilling their duties. He cited a time when he sent some of his men into New Bedford to halt drug-dealing activity because local police did not have a plan to stem the drug flow in certain neighborhoods.").

¹⁶ K9 Rony has since retired.

¹⁷ BCSO K9 Program, <https://www.bcsoma.us/k9.htm>. An eighth canine, Robika, was in training at the time of the May 1 Incident.

¹⁸ Canines are prohibited from participating in cell extractions in Massachusetts, 103 CMR 924.10(6), which is also true in most of the rest of the country and world. *See generally* Human Rights Watch, *The Use of Dogs in Cell Extractions for U.S. Prisons* (October 9, 2006), <https://www.hrw.org/report/2006/10/09/cruel-and-degrading/use-dogs-cell-extractions-us-prisons>. The ban on the use of canines for cell extractions is accurately reflected in the BCSO's K9 Policy. *See* K9 Policy at 09.07.12(B) ("No Canine Officer shall use their dog to extract inmates from their cells. This is prohibited."). Nevertheless, the events of May 1—which began with the detainees' refusal to leave the unit for testing and isolation and ended with the forceful removal of the detainees from their housing unit—culminated in a cell extraction and forced move within the meaning of the BCSO's cell extractions and forced movements policy. *See, e.g.*, Bristol County Sheriff's Office, Policy No. 09.18.00, Cell Extractions and Forced Inmate Movements ("Cell Extractions Policy"), at 09.18.01(A) (defining a cell extraction as the "forcible

The Health Services Unit

Inmates within the BCSO are entitled to “unimpeded access to a continuum of health care services so that their needs . . . are met in a timely and efficient manner.”¹⁹ The BCSO contracts with a private for-profit company, Correctional Psychiatric Services, P.C. (“CPS”),²⁰ to provide health care services to inmates, including ICE detainees. Such contracts have been criticized by some for the ways in which contracted medical care may limit access to adequate medical care and/or disincentivize the use of hospitals and other external providers.²¹

CPS has appointed a licensed physician to serve as the Medical Director²² for BCSO facilities. The Medical Director is responsible for clinical decision-making at BCSO facilities, including the type of medical treatment to be provided to an inmate, whether on or off-site.²³ The Medical Director is also responsible for medical treatment

removal of an inmate from their cell or other living quarters”). Therefore, canines should not have been utilized. Some BCSO officers and Superintendent Souza told us that the BCSO’s forcible removal of the detainees on May 1 was not a cell extraction because of the scale of the extraction and the number of detainees involved. But this distinction is neither reflected in the text of the BCSO’s cell extractions policy, which does not differentiate between an extraction and forced move in a single bed cell, a multi-bed cell, or a bunkroom and which expressly applies to the Detention Center (*see* Cell Extractions Policy at 09.18.15), nor is it consistent with the spirit of the policy, which is intended to govern the forcible removal of inmates from their living quarters by a tactical response team—in other words, precisely what happened on May 1. And in any event, the use of canines on May 1 equally violated the ICE National Detention Standards which prohibit the use of canines for “force, control or intimidation” of immigration detainees. *See infra* pp. 20-21.

¹⁹ Bristol County Sheriff’s Office, Policy No. 12.01.00, Health Care Management and Organization (“HSU Policy”), at 12.01.03 (treatment philosophy/access to care).

²⁰ Dun & Bradstreet reports that CPS has received approximately \$12.6 million in revenue in 2020. Dun & Bradstreet, Correctional Psychiatric Services, P.C., https://www.dnb.com/business-directory/company-profiles/correctional-psychiatric-services_pc.1d6692d4db058c5355cbfc89e1198e28.htm 1 (last visited December 3, 2020).

²¹ *See, e.g.*, Beth Healy and Christine Willmsen, “Pain and Profits: Sheriffs Hand Off Inmate Care to Private Health Companies,” WBUR (March 24, 2020), <https://www.wbur.org/investigations/2020/03/24/jail-health-companies-profit-sheriffs-watch>.

²² HSU Policy at 12.01.01 (definitions) and 12.010.02 (general operational procedures).

²³ *Id.* at 12.01.02(J) (definition of “Medical Director”).

decisions for ICE detainees. In medical emergencies, the Medical Director is exclusively responsible for making such decisions for ICE detainees.²⁴

The Medical Director is on-site at the beginning of each week. CPS also provides other clinical staff, including nurses of varying degrees of professional licensure, advance practice clinicians, and mental health workers. These clinicians are responsible for much of the day-to-day medical and mental health care at the Dartmouth Complex.²⁵ CPS physicians are also “on-call” outside of normal hours.

The BCSO also employs a “Director of Medical Services” who is responsible for, among other things, liaising between the BCSO and CPS, ensuring compliance with all policies, procedures, and standards relating to the provision of health care services to inmate and detainees, advising the Sheriff and other BCSO staff on the specific health care needs of the inmate population,²⁶ consulting on lawsuits and inmate grievances that relate to health care, and ensuring that inmates or detainees with special needs have access to whatever assistive devices or medication are necessary.

The current Director of Medical Services is a licensed attorney, and holds no medical or clinical licenses.

Sheriff Thomas M. Hodgson

Sheriff Thomas M. Hodgson has served as the Bristol County Sheriff since 1997 and was last elected in 2016. During Sheriff Hodgson’s lengthy tenure, the BCSO has garnered criticism for its treatment of inmates and detainees,²⁷ including taking such steps as instituting chain gangs,²⁸ attempting to charge inmates for room and board,

²⁴ *Id.* at 12.01.04(F) (responsibilities of the contracted medical provider – ICE detainees).

²⁵ See Office of the State Auditor, Other Matters in the Audit of the Bristol County Sheriff’s Office (February 13, 2019), <https://www.mass.gov/info-details/other-matters-in-the-audit-of-the-bristol-county-sheriffs-office> (reviewing staffing levels in the health services unit).

²⁶ HSU Policy at 12.01.05 (responsibilities of the Director of Medical Services).

²⁷ For example, in response to a troubling increase in the rate of inmate suicides at BCSO facilities, just two years ago, the AGO asked the Massachusetts Executive Office of Public Safety and Security to investigate the conditions at BCSO facilities.

²⁸ “County Sheriff Brings Back Chain Gangs,” *Chicago Tribune* (June 17, 1999), available at <https://www.chicagotribune.com/news/ct-xpm-1999-06-17-9906170166-story.html>.

medical services, and haircuts,²⁹ and offering to send detainees to work in chain gangs to build President Donald J. Trump’s border wall.³⁰

b. The BCSO’s Participation in Federal Immigration Enforcement

The BCSO has opted to participate in federal immigration enforcement. The BCSO does so primarily in two ways: (1) through an Intergovernmental Services Agreement (“IGSA”) between the BCSO and ICE, which governs the BCSO’s immigration detention program; and (2) through the 287(g) program.

ICE enters into IGSA’s (which are contractual agreements between government entities) with state or local jails or prisons to provide detention beds for people in ICE custody. The BCSO first entered into an IGSA with ICE in 2000, and has continually renewed its contract with ICE since that time. The BCSO’s IGSA includes standard provisions that address covered services (*e.g.*, bed space and basic needs), medical care, facility inspections, transportation, and the fixed per-detainee reimbursement rate paid to the facility by ICE. The IGSA also requires that the BCSO comply with the “most current edition of ICE National Detention Standards.”³¹

The BCSO also participates in the federal government’s 287(g) program. The 287(g) program authorizes state and local law enforcement officers to collaborate with the federal government in the enforcement of federal immigration laws. In specific, Section 287(g) of the Immigration and Nationality Act (“INA”) allows the Department of Homeland Security (“DHS”) to enter into formal written agreements with state or local police departments and deputize selected law enforcement officers to perform the functions of federal immigration agents.

Massachusetts is the only New England state with local agencies that participate in the 287(g) program,³² and it is an open question whether or not the BCSO has the authority to enter into a 287(g) agreement or an IGSA for immigration detention. *See*

²⁹ *Souza v. Sheriff of Bristol County*, 455 Mass. 573 (2010) (Sheriff acted in excess of statutory authority by charging higher fees for haircuts than authorized and by imposing fees for cost-of-care, medical visits, and GED testing).

³⁰ Shannon Dooling, “Bristol County Sheriff Offers Up Inmates to Build the Border Wall Trump Promises,” *WBUR* (January 5, 2017), <https://www.wbur.org/morningedition/2017/01/05/sheriff-hodgson-inmates-border-wall>.

³¹ Inter-Governmental Service Agreement between the DHS ICE Office of Detention and Removal and the Bristol County Sheriff’s Office, September 27, 2007.

³² *See* U.S. Immigration and Customs Enforcement, Delegation of Immigration Authority Section 287(g) Immigration and Nationality Act, <https://www.ice.gov/287g> (last updated August 8, 2020).

Souza, 455 Mass. at 583-85 (“A government agency or officer does not have authority to issue regulations, promulgate rules, or . . . create programs that conflict with or exceed the authority of the enabling statutes.”); *Lunn v. Commonwealth*, 477 Mass. 517, 531-36 (2017) (state law enforcement officers cannot arrest and hold an individual solely on the basis of an immigration detainer); *see also* 8 U.S.C. § 1357(g) (authorizing state and local governments to enter into 287(g) agreements “to the extent consistent with State and local law.”). The BCSO has participated in the 287(g) program since 2017. The BCSO’s Memorandum of Agreement with ICE outlines the process for appointing and training officer-participants in the 287(g) program, ICE’s supervision of designated officers, and the scope of authorized 287(g) activities, which is limited to the following activities: (1) interrogating persons in custody at BCSO facilities regarding their right to be or remain in the United States and processing for immigration violations any removable person who has been arrested for any violation of state or federal law; (2) serving warrants of arrest for immigration violations; (3) administering oaths, taking and considering evidence, and completing required processing in connection with immigration violations; (4) preparing charging documents; (5) issuing immigration detainers (among other documents); and (6) detaining and transporting arrested people subject to removal to ICE-approved detention facilities.³³

c. *The BCSO’s Response to the COVID-19 Pandemic*

Before the COVID-19 pandemic took hold in Massachusetts, the BCSO housed a daily average of 943 detainees and convicted prisoners,³⁴ of whom 148 were immigration detainees as of March 27, 2020.³⁵ ICE Unit B is a large communal bunkroom with shared bathrooms, laundry facilities, and an enclosed recreation pen.

Once the COVID-19 pandemic took hold in Massachusetts, the immigration detainees at the Dartmouth Complex began to advocate for access to COVID-19 testing, improved sanitation measures, and institutional depopulation to safeguard against the spread of COVID-19. In part, this advocacy was driven by the fact that the communal nature of the bunkrooms, which each housed at that time up to 66 detainees at once, made it impossible to practice social distancing. In part, it was driven by detainees who reported medical conditions or histories that left them particularly vulnerable to COVID-

³³ Memorandum of Agreement between U.S. Immigration & Customs Enforcement and the Bristol County Sheriff’s Office (January 18, 2017), *available at* https://www.ice.gov/doclib/287gMOA/Bristol_MOA_01182017.pdf.

³⁴ Massachusetts Sheriffs’ Association, County Populations – Average Daily Population Report – March 2020, <https://www.mass.gov/lists/county-population-reports#fy2020-county-population-reports-> (last visited December 5, 2020).

³⁵ *Savino v. Souza*, 459 F. Supp. 3d 317, 321 (D. Mass. May 12, 2020).

19, including, for example, chronic medical conditions such as asthma, diabetes, COPD, and emphysema.³⁶

In February 2020, the BCSO put in place some measures designed to curtail the spread of COVID-19, including restricting outside visitors, conducting temperature screenings, and splitting up detainees during meal and recreation times.³⁷ The BCSO insisted that they did not have any COVID-19 cases in any BCSO facility as late as May 2, 2020.³⁸

On March 27, 2020, federal immigration detainees held at the Detention Center filed a class action lawsuit, *Savino v. Souza*,³⁹ in federal district court seeking emergency release due to COVID-19. The district court expeditiously began to consider each immigration detainee individually for bail. However, ICE and the BCSO consistently objected, throughout the *Savino* suit, to the release of the detainees on bail.

On April 23, 2020, the federal district court ordered the BCSO to submit a report on the results of COVID-19 testing of the detainees on or before May 7, the date of the hearing on the detainees' motion for a preliminary injunction.⁴⁰ By May 1, however, no detainee had been tested for COVID-19.

³⁶ Letter from ICE Unit B Detainees to ICE, *et al.*, March 23, 2020, at p. 3.

³⁷ *Savino v. Souza*, 453 F. Supp. 3d 441, 441-42 (D. Mass. April 8, 2020).

³⁸ See Sheriff Hodgson Press Conference, May 2, 2020, https://www.facebook.com/watch/live/?v=662822427595859&ref=watch_permalink. Sheriff Hodgson emphasized during this press conference that the BCSO had no COVID-19 cases at the facility at the time of May 1 Incident. We do not know how Sheriff Hodgson could have credibly made this claim since none of the detainees had been tested for COVID-19 by this time, except for one detainee who had tested positive on May 1 at the hospital following the May 1 Incident.

³⁹ *Savino v. Souza*, No. 1:20-cv-10617, ECF No. 1.

⁴⁰ *Savino v. Souza*, No. 1:20-cv-10617, ECF No. 132 (April 23, 2020). On May 12th, the federal district court found that the BCSO likely acted with “deliberate indifference” to the substantial risk of serious harm faced by the immigration detainee class members because of “three cavernous holes in [the BCSO’s] mitigation strategy . . . [that] it has obstinately refused to plug throughout this litigation”: (1) the rigid and blanket objection to the release of any ICE detainee, (2) lack of testing, and (3) lack of contact tracing. The federal district court again ordered that all individuals in immigration detention at the BCSO, as well as all staff who come into contact with them, be tested for COVID-19 as soon as reasonably possible; that no new individuals be admitted to immigration detention at the BCSO; and that no transfers be made from the BCSO to another facility until the required testing has taken place and come back negative. *Savino*, 459 F. Supp. 3d at 328-31.

d. The ICE B Detainees

By the time of the May 1 Incident, twenty-five⁴¹ immigration detainees were housed in ICE Unit B, most of whom were subject to detention under 8 U.S.C. §1226(a), which governs the detention of noncitizens who do not have a serious criminal history,⁴² or under 8 U.S.C. § 1231, which governs the detention of noncitizens who are subject to a final order of removal. Some of the detainees have lived and worked in the United States for decades. Many have spouses, children, and other family members and friends in or around New England and have worked and gone to school in these communities. Some may have viable defenses to removal that would permit them to remain in the United States. Others are recent arrivals who have no or limited English language proficiency and instead speak a range of different languages and dialects including Spanish, Portuguese, Kichwa, and Jamaican Patois.

IV. LEGAL FRAMEWORK

The Massachusetts Attorney General is the chief lawyer and law enforcement officer in Massachusetts. Mass. Gen. Laws ch. 12, §§ 3, 10. The Attorney General is authorized by statute to take cognizance of, investigate, and institute civil or criminal proceedings to protect the general welfare of the people. Mass. Gen. Laws ch. 12, § 10; *see also Attorney General v. Sheriff of Worcester Cty.*, 382 Mass. 57, 58-60 (1980). And the Attorney General is specifically authorized by statute to investigate and bring civil actions “[w]henver any person or persons, whether or not acting under color of law, interfere by threats, intimidation or coercion, or attempt to interfere by threats, intimidation or coercion, with the exercise or enjoyment by any other person or persons

⁴¹ Twenty-six detainees resided in ICE Unit B as of May 1, but one of those detainees had been transferred to the HSU by the time of the May 1 Incident.

⁴² Sheriff Hodgson emphasized the criminal histories of the detainees during his press conference about the May 1 Incident—at one point calling them “bad people” and “bad apples” and at another point referring to select portions of specific criminal histories. However, this is *civil* and not *criminal* detention, and these detainees are held because of alleged civil immigration violations, and not because they have been convicted of or accused of any crimes. And whether or not these detainees had convictions or arrests before their civil detention is irrelevant to the BCSO’s use of force and related treatment of the detainees on May 1. Indeed, aside from Sheriff Hodgson’s public statements after the May 1 Incident, no BCSO security staff member that we interviewed cited any detainee’s criminal history as a factor in determining their response on May 1. And although we have reviewed the detainees’ criminal histories in view of Sheriff Hodgson’s public statements after the May 1 Incident, we have considered those histories only to the extent that they involved convictions that would bear on a witness’s credibility or veracity.

of rights secured by the constitution or laws of the United States, or of rights secured by the constitution or laws of the commonwealth.” Mass. Gen. Laws ch. 12, § 11H.

The INA permits the federal government to detain noncitizens during the pendency of their removal proceedings and noncitizens who are subject to a final order of removal. *See* 8 U.S.C. §§ 1226, 1231. Immigration detainees are protected by the Due Process Clause of both the Fourteenth Amendment of the United States Constitution, which extends to “all ‘persons’ within the United States, including [noncitizens], whether their presence here is lawful, unlawful, temporary, or permanent,” *Zadvydas v. Davis*, 533 U.S. 678, 693 (2001), and article 12 of the Massachusetts Declaration of Rights. And these protections apply equally in civil detention (including immigration detention), as well as in criminal detention. *Id.* at 690.⁴³

The Due Process Clause prohibits “the use of excessive force that amounts to punishment” against immigration detainees and pretrial detainees. *Graham v. Connor*, 490 U.S. 386, 395 n.10 (1989). The use of force against a detainee is constitutionally excessive if “the force purposely or knowingly used against him was objectively unreasonable.” *Kingsley v. Hendrickson*, 576 U.S. 389, 396-97 (2015).⁴⁴ This turns on the “facts and circumstances of each particular case,” looking at the situation “from the perspective of a reasonable officer on the scene, including what the officer knew at the time, not with the 20/20 vision of hindsight.” *Id.* at 397 (quoting *Graham*, 490 U.S. at 396). The inquiry takes into account “the ‘legitimate interests that stem from [the government’s] need to manage the facility in which the individual is detained,’ appropriately deferring to ‘policies and practices that in th[e] judgment’ of jail officials ‘are needed to preserve internal order and discipline and to maintain institutional security.’” *Id.* (quoting *Bell v. Wolfish*, 441 U.S. 520, 540, 547 (1979)). The following nonexclusive list of factors may “bear on the reasonableness or unreasonableness of the

⁴³ Federal courts of appeals across the country have held that immigration detainees are entitled to the same constitutional protections as criminal pretrial detainees. *See, e.g., Velasco Lopez v. Decker*, 978 F.3d 842, 850 (2020); *E. D. v. Sharkey*, 928 F.3d 299, 306–07 (3d Cir. 2019); *Chavero-Linares v. Smith*, 782 F.3d 1038, 1041 (8th Cir. 2015); *Belbachir v. County of McHenry*, 726 F.3d 975, 979 (7th Cir. 2013); *Porro v. Barnes*, 624 F.3d 1322, 1326 (10th Cir. 2010); *Edwards v. Johnson*, 209 F.3d 772, 778 (5th Cir. 2000); *see also Hernandez v. Sessions*, 872 F.3d 976, 993 (9th Cir. 2017) (“[T]he Supreme Court has recognized that criminal detention cases provide useful guidance in determining what process is due non-citizens in immigration detention.”).

⁴⁴ The standard under the Massachusetts Declaration of Rights is likely the same as under federal law. *See, e.g., Commonwealth v. Adams*, 416 Mass. 558, 571, n. 1 (1993) (Lynch, J., concurring) (arguing that the objective reasonableness standard is the appropriate standard to test excessive force claims under the Fourth Amendment); *Foster v. Comm’r of Corr.*, 484 Mass. 698, 719 n. 17 (2020) (rejecting the application of the *Kingsley* standard to a conditions-related lawsuit on the grounds that the “objective reasonableness” standard applies to excessive force claims).

force used: the relationship between the need for the use of force and the amount of force used; the extent of the [detainee's] injury; any effort made by the officer to temper or to limit the amount of force; the severity of the security problem at issue; the threat reasonably perceived by the officer; and whether the detainee was actively resisting." *Id.* (citing *Graham*, 490 U.S. at 369).

The government also violates the Due Process Clause when it "so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs—e.g., food, clothing, shelter, medical care, and reasonable safety." *DeShaney v. Winnebago Cty. Dep't of Soc. Servs.*, 489 U.S. 189, 200 (1989).⁴⁵ In specific, the Due Process Clause obliges the government "to refrain at least from treating a pretrial detainee with deliberate indifference to a substantial risk of serious harm to health." *Coscia v. Town of Pembroke*, 659 F.3d 37, 39 (1st Cir. 2011). "Proof of deliberate indifference requires a showing of greater culpability than negligence but less than a purpose to do harm," *id.* (citing *Farmer v. Brennan*, 511 U.S. 825, 835 (1994)), "and it may consist of showing a conscious failure to provide medical services where they would be reasonably appropriate," *id.* (citing *Estelle v. Gamble*, 429 U.S. 97, 104 (1976)).

The BCSO's Policies and Procedures

In addition to and informing the bounds of constitutionally permissible (*i.e.*, objectively reasonable) use of force in the specific context of the BCSO, various policies and procedures place limits on the conduct of officers and other staff in their interactions with ICE detainees. The BCSO has adopted policies that govern many of the issues within the scope of this investigation, including in relevant part, Use of Force (09.06.00), Use of Canines (09.07.00), Use of Restraint Equipment (09.09.00), Emergency Management System (09.15.00), Cell Extraction and Forced Inmate Movements (09.18.00), Special Management Units (10.03.00), and Special Needs Inmates (12.03.00).

The BCSO's Use of Force Policy prohibits the use of "excessive force," which is defined as "[a]n application of force that exceeds the use of reasonable force or a use of force that was reasonable at the start but continued beyond the need of its necessary, reasonable, and suitable application."⁴⁶ The Use of Force Policy contains a Use of Force continuum⁴⁷ and defines "[r]easonable force" as "the legal, reasonable, and suitable

⁴⁵ This standard is essentially the same under article 26 of the Massachusetts Declaration of Rights. *See, e.g., Foster*, 484 Mass. at 716.

⁴⁶ Bristol County Sheriff's Office, Policy No. 09.06.11, Use of Force (the "Use of Force Policy"), at 09.06.01(K) (definitions).

⁴⁷ *Id.* at 09.06.05 (use of force continuum). The use of force continuum makes clear that "compliance techniques" (such as pepper spray) is only appropriate in the case of "active resistance" (meaning "us[ing] strength or muscle to resist control") and not "passive resistance" (which does not involve muscle or strength), and that "defensive tactics"

amount of force necessarily applied during a given situation, based on the totality of the circumstances, the amount/type of resistance presented, and the degree of danger displayed. Reasonable force shall only be justified and lawfully applied when some form of resistance is present.”⁴⁸

“Calculated” uses of force can be used against an inmate in the following circumstances: (1) when an inmate refuses an order to be placed into restraints and exit a cell; (2) when an inmate exhibits threatening behavior; (3) when an inmate possesses a weapon; and/or (4) when an inmate creates property damage.⁴⁹ The Use of Force Policy is clear that “de-escalation/non-confrontation techniques” must be used before a calculated use of force,⁵⁰ and that less-lethal force can only be applied after verbal warnings have not resulted in compliance.⁵¹ And the BCSO’s Emergency Management policy (which applies to inmate disturbances, including riots) requires the BCSO to make “translation services available for involved inmates during a hostage crisis or other emergency management situation, if necessary and when time permits.”⁵²

Prior to a calculated use of force, a “qualified health care practitioner” must “conduct a review of the inmate’s health record for medical contraindications” in order to assess whether the calculated use of less lethal force should be deployed based on the inmate’s medical history.⁵³ The notification to medical providers, the provider’s review

(such as “empty hand or baton striking techniques”) are only appropriate in the case of assaultive conduct (meaning “attempting to harm the employee or another”). *See also id.* at 09.06.04(C), 09.06.06 (less-lethal force).

⁴⁸ *Id.* at 09.06.02(E) (expected practices); *see also* Bristol County Sheriff’s Office, Policy No. 09.09.00, Use of Restraint Equipment (“Restraints Policy”), at 09.09.02(B) (noting that the application of restraint equipment is considered a use of force, subject to certain limited exceptions).

⁴⁹ Use of Force Policy at 09.06.01(C)(definitions), 09.06.04(B) (reasonable force).

⁵⁰ *See, e.g., id.* at 09.06.01(C), 09.06.06(B); *see also* Restraints Policy at 09.09.09(A)(1), 09.09.06(B)(1)(a) (“Restraint equipment can be applied once all other reasonable, non-confrontational control methods (such as verbal persuasion) have been tried and deemed inappropriate or impractical to address a situation.”); Cell Extractions Policy at 09.18.04, 09.18.06(B) (outlining de-escalation and conflict avoidance steps required to be taken prior to a cell extraction).

⁵¹ Use of Force Policy at 09.06.06.

⁵² Bristol County Sheriff’s Office, Policy No. 09.15.00, Emergency Management Systems (“Emergency Management Policy”), at 09.15.04(I).

⁵³ Use of Force Policy at 09.06.12(A)(1) (medical notification procedures). A separate portion of the policy that deals with special needs inmates (which includes those with

of the records, the recommendations made, and the high ranking officer's decision to proceed with the calculated force all must be documented by the medical provider and the officer.⁵⁴

When chemical agents or less-lethal aerosols (such as oleoresin capsicum spray, commonly referred to as "O.C. spray" or "pepper spray," or pepper-ball, which is essentially powdered oleoresin capsicum delivered in pellet projectiles) are used, the Use of Force Policy outlines the decontamination procedures that must be followed, including that: (1) fresh air, clean water, and clean, dry clothes be provided as soon as possible; (2) inmates be "monitored constantly for possible medical concerns" and any inmate experiencing difficulty breathing, gagging, profuse sweating, loss of consciousness, or other related symptoms receive medical attention; and (3) EMTs be notified and made available on scene.⁵⁵ The Use of Force Policy also limits the use of distraction devices, such as extended range batons and flash bang grenades, to situations where there is a "reasonable belief that conditions are not safe to approach an individual within contact distance and the threat encountered may cause bodily injury" or "when an inmate or another person is displaying pre-attack indicators or when they are assaulting another person."⁵⁶

Both the Emergency Management Policy and the Cell Extraction Policy make clear that the Use of Force Policy must be followed in responding to inmate disturbances and in conducting cell extractions.⁵⁷ The Cell Extraction Policy also makes clear that, prior to a cell extraction and in addition to employing de-escalation and conflict avoidance techniques, inmates must be "warned that the failure to modify their behavior and/or follow staff orders/rules will be a sufficient reason for the Sheriff's Office to conduct a cell extraction and move the inmate by force to a pre-determined housing location, such as a segregation unit."⁵⁸ If the inmate refuses to comply, the Cell Extraction Policy requires that a supervisor then repeat the warning "and also notify the

medical conditions, such as asthma or COPD) reiterates that a medical review must be conducted before a calculated use of force. *Id.* at 09.06.12(C)(1); *see also* Restraints Policy at 09.09.01(C); 09.09.09(A)(1); Bristol County Sheriff's Office, Policy No. 12.03.00, Special Needs Inmates ("Special Needs Policy"), at 12.03.05 (governing use of force against special needs inmates).

⁵⁴ Use of Force Policy at 09.06.12(A)(1)(a).

⁵⁵ *Id.* at 09.06.13 (decontamination procedures).

⁵⁶ *Id.* at 09.06.14(A).

⁵⁷ Cell Extraction Policy at 09.18.03(A) (cell extraction); Emergency Management Policy at 09.15.10 (inmate disturbances).

⁵⁸ Cell Extraction Policy at 09.18.04(A).

inmate that the use of chemical agents, OC, special impact munitions, and/or a restraint chair may also be authorized.”⁵⁹ A cell extraction may proceed only if these warnings have failed to result in compliance.⁶⁰ And like the Use of Force Policy, a qualified medical professional must review the inmate’s or detainee’s medical history to determine if there are any contraindications or other concerns which may factor into the operation, particularly with respect to the use of chemical agents and O.C. spray, and the cell extraction team must wait for the results of that evaluation before the team is “put into action.”⁶¹ Where there is a legitimate health concern, O.C. spray or other aerosols may be withheld.⁶²

As to the application of restraint equipment (such as flex cuffs), the BCSO’s policies make clear that such equipment should only be applied “for the least amount of time necessary to achieve desired behavioral objectives,” that restraints may need to be “adjusted or modified, as needed, depending on the totality of the circumstances,” and that they should be applied in such a way to avoid causing “excessive physical pain” or “imped[ing] circulation.”⁶³ The BCSO’s policies also make clear that no “person shall be moved face down on their stomachs,” no employee or other person is permitted to “sit down or place their weight on a person’s back or chest area during or after the application of restraints, even if the restrained person continues to struggle,” and that O.C. spray, pepper-ball, or other chemical agents are not to be used against a person who is already restrained.⁶⁴

As to documentation, the Use of Force Policy requires the Watch Commander to prepare a “Use of Force Packet” that includes the following documents: (a) a description of the events leading up to the use of force; (b) a precise description of the incident and the reasons for employing force; (c) a description of the severity of the security problem/crime at issue and perceived threats; (d) a description of the type of force used; (e) a description of whether the subject was actively resisting; (f) a description of observed injuries, extent of injuries and medical treatment given; (g) a list of known participants and witnesses; (h) related photos and/or audio/visual tapes collected; (i) related incident reports and disciplinary reports; (j) a use of force report, and (k) a

⁵⁹ *Id.* at 09.18.04(B).

⁶⁰ *Id.*; *see also id.* at 09.18.06(B).

⁶¹ *Id.* at 09.18.10(2).

⁶² *Id.*

⁶³ Restraints Policy at 09.09.06(A), (B).

⁶⁴ *Id.* at 09.09.11(5), 09.09.13.

summary report.⁶⁵ The Use of Force Policy also requires the use of audio/visual cameras whenever a calculated use of force has been authorized to record, among other things, the name, title, and faces of all involved personnel, the de-escalation techniques and issuance of the use of force order, and the medical examinations of inmates following the calculated use of force, focusing on the presence or absence of any injury.⁶⁶ The Use of Force Policy requires an administrative review to be conducted by the Facility Major after each use of force to determine, among other things, whether any policies were violated and whether the use of force was reasonable.⁶⁷ After the completion of this administrative review, the entire use of force packet is required to be sent to the Superintendent's Office for final review.⁶⁸

The K9 Policy makes clear that canines can never be used in cell extractions,⁶⁹ and integrates the Use of Force Policy with one noteworthy exception. The Use of Force Policy is clear that canines can never be used “for the force, control, or intimidation of ICE detainees.”⁷⁰ But the K9 Policy contains an exception to this prohibition that permits ICE detainees to come into “contact” with canines during an “emergency situation when the use of a Canine Unit (dog and handler) has been considered to be the most effective method to curtail a disturbance/riot and/or to save a life.”⁷¹

⁶⁵ Use of Force Policy at 09.06.17(B). The only documentation requirement on the employees themselves is that they submit “truthful, legible and appropriate documentation to the incident” before the end of their shift, whenever possible. *Id.* at 09.09.17(A). This appears to be inconsistent with 103 CMR 924.09(4)(b), which requires that each sheriff's policy require each employee to submit documentation before the end of their shifts “unless prevented by extraordinary circumstances such as injury” that includes (1) an accounting of events leading up to the use of force; (2) a precise description of the incident and the reason for employing force; (3) a description of type of the force used; (4) a description of observed injuries and treatment given; and (5) a list of participants and witnesses. We found, during our investigation, that the incident reports prepared by the responding officers varied widely in terms of the level of details provided, ranging from a report that consisted of a single handwritten paragraph to comprehensive, multi-page reports.

⁶⁶ Use of Force Policy at 09.06.17(B)(7).

⁶⁷ *Id.* at 09.06.17(B)(3).

⁶⁸ *Id.* at 09.06.17(B)(3)-(4).

⁶⁹ K9 Policy at 09.07.12(B).

⁷⁰ Use of Force Policy at 09.06.02(L).

⁷¹ K9 Policy at 09.07.10(C) (search of ICE detainee housing units).

And finally, the BCSO has a policy that governs special management inmates—that is, inmates who are placed in the Restrictive Housing Unit (“RHU”) for administrative, disciplinary, or protective reasons. The Special Management Inmates Policy sets forth the procedural requirements for transferring an inmate to the RHU, as well as the rights and privileges of the detainees after placement in the RHU. Among other requirements, this policy requires that detainees be provided with essential items (e.g., clothing) and that the BCSO adequately document when such items are denied for mental health or medical reasons.⁷²

ICE Detention Standards

As noted above, the BCSO’s IGSA with ICE requires that the BCSO comply with the “most current edition of ICE National Detention Standards.”⁷³ Some of the particularly relevant the ICE National Detention Standards (the “Detention Standards”)⁷⁴ are as follows:

- Canines “will not be used for force, control or intimidation of detainees.”⁷⁵ “Canine units (in facilities that have them) may be used for contraband detection

⁷² Bristol County Sheriff’s Office, Policy No. 10.03.00, Special Management Inmates (“Segregation Policy”), at 10.01.03 (H), (J)-(L).

⁷³ Inter-Governmental Service Agreement between the DHS ICE Office of Detention and Removal and the Bristol County Sheriff’s Office, September 27, 2007.

⁷⁴ See 2008 ICE Performance-Based National Detention Standards, <https://www.ice.gov/detention-standards/2008>. The most current edition of the ICE Detention Standards are the 2011 Performance-Based National Detention Standards as amended in 2016. However, because DHS has conducted recent compliance inspections of the BCSO pursuant to the 2008 Performance-Based National Detention Standards, see Office of Detention Oversight, Compliance Inspection, Enforcement and Removal Operations, Boston Field Office, Bristol County Detention Center, North Dartmouth, Massachusetts (July 20-23, 2020), https://www.ice.gov/doclib/foia/odo-compliance-inspections/bristolCoDetCntrNorthDartmouthMA_Jul20-23_2020.pdf, we focus the foregoing analysis on those standards. And, in any event, which set of ICE Detention Standards applies to the BCSO is of no consequence for the purposes of this report because there are virtually no meaningful differences between the relevant portions of the 2008 and amended 2011 standards.

⁷⁵ ICE/DRO Detention Standard, Use of Force and Restraints (December 2, 2008), Section II(12), available at https://www.ice.gov/doclib/dro/detention-standards/pdf/use_of_force_and_restraints.pdf (“Use of Force Detention Standard”); ICE/DRO Detention Standard, Emergency Plans (December 2, 2008), Section V(D)(6), available at https://www.ice.gov/doclib/dro/detention-standards/pdf/emergency_plans.pdf (“Emergency Plans Detention Standard”) (noting that

when detainees are not present, but canine use for force, intimidation, control, or searches of detainees is prohibited.”⁷⁶

- “Facilities will endorse the concept that confrontation avoidance is the recommended method for resolving situations and should always be attempted prior to any calculated use of force,” including during emergency situations.⁷⁷
- “Staff may not use restraint equipment or devices (for example, handcuffs) . . . [t]o cause physical pain or extreme discomfort. While some discomfort may be unavoidable even when restraints are applied properly, examples of prohibited applications include: improperly applied restraints [and] unnecessarily tight restraints.”⁷⁸
- “The following acts and techniques are specifically prohibited . . . (4) striking a detainee for failing to obey an order . . . (6) using force against a detainee offering no resistance.”⁷⁹
- Less-lethal weapons may be used in situations where a detainee is armed and/or barricaded, where a detainee cannot be approached without danger to self or others, or where a delay in controlling the situation would seriously endanger the

any force used to control an emergency situation must comply with the Use of Force Detention Standard).

⁷⁶ ICE/DRO Detention Standard, Searches of Detainees (December 2, 2008), Section II(10), available at https://www.ice.gov/doclib/dro/detention-standards/pdf/searches_of_detainees.pdf (“Detainee Searches Detention Standard”); see also ICE/DRO Detention Standard Facility Security and Control (December 2, 2008), Section V(F)(3), available at https://www.ice.gov/doclib/dro/detention-standards/pdf/facility_security_and_control.pdf. Superintendent Souza explained that ICE may grant the BCSO waivers from compliance with specific Detention Standards that conflict with existing BCSO policies, but that the BCSO had not received a waiver from the use of force detention standard that bars the use of canines with immigration detainees. And in any event, ICE’s annual compliance inspections have focused on the BCSO’s Use of Force Policy (which accurately states that canines can never be used for the “force, control or intimidation” of the detainees), and not the BCSO’s K9 policy, which contains an exception to this prohibition.

⁷⁷ Use of Force Detention Standard at Section II(2); Emergency Plans Detention Standard at Section V(D)(6).

⁷⁸ Use of Force Detention Standard at Section V(B)10).

⁷⁹ *Id.* at Section V(E).

detainee or others or would result in a major disturbance or serious property damage.⁸⁰

- Only certain less-lethal weapons can be used against detainees—namely, O.C. spray, collapsible steel batons, and riot batons. However, “[s]taff shall consult medical staff before using pepper spray or other [less lethal] weapons unless escalating tension makes such action unavoidable. When possible, medical staff shall review the detainee’s medical file for a disease or condition that [a less lethal] weapon could seriously exacerbate, including, but not limited to, asthma, emphysema, bronchitis, tuberculosis, obstructive pulmonary disease, angina pectoris, cardiac myopathy, or congestive heart failure.”⁸¹
- In a calculated use of force, “the ranking detention official, a designated health professional, and others as appropriate shall assess the situation. Taking into account the detainee’s history and the circumstances of the immediate situation, they shall determine the appropriateness of using force.”⁸² Qualified health professionals are required to determine, after gaining control of the situation, whether the detainee or detainees require continuing care and to treat any injuries and document the medical services provided.⁸³
- The detention facility is also required to conduct an “After-Action Review” to “assess the reasonableness of the actions taken and determine whether the force used was proportional to the detainee’s actions.” This review is required to assess, among other steps, “[w]hether team members applied only as much force as necessary to subdue the detainee, including whether team members responded appropriately to a subdued or cooperative detainee or a detainee who discontinued his/her violent behavior;” “[w]hether the detainee received and rejected the opportunity to submit to restraints voluntarily before the team entered the cell/area. If he or she submitted, team action should not have been necessary;” “[t]he amount of time needed to restrain the detainee. Any non-resisting detainee restrained for longer than necessary could indicate training problems/inadequacies;” “[w]hether a medical professional promptly examined the detainee, with the findings reported on the audiovisual record;” and “[w]hether use of

⁸⁰ *Id.* at Section V(G)(3).

⁸¹ *Id.*

⁸² *Id.* at Section V(I)(1); *see also* Section (V)(I)(3)(d) (requiring the shift supervisor in a calculated use of force to “seek the advance guidance of qualified health personnel (based on a review of the detainee’s medical record) to identify physical or mental problems and, whenever feasible, arrange for a health services professional to be present to observe and immediately treat any injuries.”).

⁸³ Use of Force Detention Standard at Section V(H).

chemical agents, pepper spray, etc., was appropriate and in accordance with written procedures.”⁸⁴

- “Searches of detainees, housing, and work areas will be conducted without unnecessary force and in ways that preserve the dignity of detainees . . . A strip search will be conducted only when there is reasonable suspicion that contraband may be concealed on the person, or when there is a reasonable suspicion that a good opportunity for concealment has occurred, and when properly authorized by a supervisor.”⁸⁵
- Information must be provided to detainees in a language or manner that the detainees can understand throughout the detention process, including with respect to the provision of medical care and in connection with obtaining informed consent for treatment.⁸⁶
- Detainees in special management units “may be denied such items as clothing, mattress, bedding, linens, or pillow for medical or mental health reasons if his or her possession of such items raises concerns for detainee safety and/or facility security. All denials of such items shall be documented.”⁸⁷
- Detainees may only be subject to disciplinary segregation for no more than 60 days subject to certain procedural requirements, and detainees may be placed in administrative segregation for longer periods of time, but there are a number of procedural requirements that must be fulfilled, including periodic review at the 72-hour and 7-day benchmarks and on a weekly basis thereafter with increasing procedural requirements after 30 days.⁸⁸

⁸⁴ *Id.* at Section V(P).

⁸⁵ Detainee Searches Detention Standard at Section II(3), (6).

⁸⁶ ICE/DRO Detention Standard, Medical Care (December, 2, 2008), at Section (V)(I), (T), available at https://www.ice.gov/doclib/dro/detention-standards/pdf/medical_care.pdf (“Medical Care Detention Standard”). See also ICE Language Access Plan (June 14, 2015), 10, available at <https://www.ice.gov/sites/default/files/documents/Document/2015/LanguageAccessPlan.pdf> (noting that the 2008 and 2011 PBNDS requires that information be provided to the detainee in a language or manner that they can understand and that ICE frequently notifies detention facilities when a detainee with Limited English Proficiency is transferred into a detention facility).

⁸⁷ ICE/DRO Detention Standard, Special Management Units (December 2, 2008), at Section (V)(B)(11), available at https://www.ice.gov/doclib/dro/detention-standards/pdf/special_management_units.pdf (“Segregation Detention Standard”).

⁸⁸ *Id.* at Section V(C), (D).

V. FINDINGS AND CONCLUSIONS

The AGO's findings support a conclusion that the BCSO violated the civil rights of the detainees on May 1 by using excessive force against the ICE B detainees and by acting with deliberate indifference to a substantial risk of serious injury or harm to the detainees and their health. To understand why and how the AGO has reached these conclusions, however, it is important to first understand what happened on May 1. So we begin with the facts.

a. Factual Findings

The Detainees' Non-Violent Refusal of COVID-19 Screening

We start our discussion with an undisputed fact: the May 1 Incident started with COVID-19. Around 2 pm on May 1, a BCSO nurse entered ICE Unit B to screen the detainees for COVID-19 by asking them a series of questions about their symptoms. The screening was verbally conducted in English and no formal translation or interpretation services were provided.⁸⁹ English-speaking detainees attempted to translate for limited-English Proficient ("LEP") detainees, but those detainees were confused by the screening and did not understand the process or the purpose of the screening. Nevertheless, the detainees complied with the screening assessment.

Several of the detainees who understood English reported that the nurse who conducted the screening assessment did not adequately explain the purpose of the screening assessment, the process they were engaging in, or the risks and benefits of undergoing a COVID-19 diagnostic test in the event that symptoms were identified.

The screening assessment ultimately resulted in the identification of ten detainees who reported two or more symptoms consistent with COVID-19. Shortly thereafter, a BCSO staff member entered Unit B, along with a nurse, to transport these ten detainees to the HSU, where they would be tested for COVID-19 and then quarantined in isolation until they received a negative test result. The detainees expressed concern, anxiety, and fear related to the BCSO's plan to test and quarantine them. In particular, the detainees

⁸⁹ Several BCSO security staff members suggested that translation and interpretation services were unnecessary because other detainees were available to translate and/or because the detainees seemed able to understand enough English to follow the conversation. We reject this explanation. There is ample evidence that some of the detainees did not understand English at all and/or were Limited English Proficient, including evidence provided by the BCSO itself showing that BCSO officers had to translate some of the medical and mental health evaluations in order to place the detainees in the RHU. In addition, it is inappropriate to rely on other detainees to accurately and reliably translate or interpret medical information necessary to obtain informed consent and/or to explain medical care or treatment.

explained to BCSO staff that they were afraid that they would be exposed to COVID-19 in the HSU because that unit serves the entire jail population, including individuals who had recently arrived at the jail from the community, and that they were concerned about the conditions that they would face in isolation. The detainees ultimately refused to leave Unit B.

Because the BCSO had not yet undertaken efforts to conduct widespread testing of the detained population, the BCSO had no protocol or contingency plan in place to address refusals to comply with testing and isolation orders. Without direction or guidance on how to respond to the detainees' refusal, the BCSO security staff member notified the Watch Commander. The Watch Commander, in turn, emailed the chain of command, including Superintendent Souza, to notify them that the detainees were "peacefully" refusing to go to the HSU and to ask: "What should be the next course of action? I don't want to handle this wrong."⁹⁰ The Watch Commander did not receive any instructions or guidance from his superiors in response to this email.

At the same time that the Watch Commander was notified of the situation, the nurse notified the Director of Medical Services (not to be confused with the Medical Director, who is a licensed physician). The Director of Medical Services, in turn, notified the Sheriff of the emerging situation in ICE Unit B. Sheriff Hodgson then decided—in a departure from customary practice⁹¹— to speak directly and in-person with the detainees about their refusal to submit to testing and isolation.

Sheriff Hodgson Arrives at the Unit and the Situation Rapidly Escalates

Shortly before 5:30 pm, Sheriff Hodgson, along with Special Sheriff Bruce Assad, the Director of Medical Services, the Watch Commander, the nursing supervisor for the ICE units, and several corrections officers entered Unit B to speak with the detainees about their refusal to leave the unit for testing and isolation. All detainees were ordered to gather together near the control desk, and the detainees complied. Sheriff Hodgson spoke in English and did not provide translation or interpretation services for those who did not speak English. And, once again, some of the detainees reported that they were not able to understand what was happening or what was being said. Several detainees reported that Sheriff Hodgson appeared to become increasingly agitated and told the detainees that

⁹⁰ Email to Superintendent Souza (May 1, 2020, 5:17 pm).

⁹¹ We did find one other example where Sheriff Hodgson addressed the detainees directly. This event also involved the ICE B detainees and occurred approximately 4-6 weeks before the May 1 Incident. Like the May 1 Incident, this event involved the detainees' concerns related to the BCSO's response to the COVID-19 pandemic and an associated work stoppage, but unlike the May 1 Incident, this situation resolved through communication and conflict avoidance techniques without a need for any force.

they would be transported by force, if necessary.⁹² When Sheriff Hodgson finished speaking, he instructed a corrections officer to read aloud the names of the ten detainees slated to be transported and tested, and reiterated the directive to comply with this order.

The first detainee whose name was called refused to go and attempted to explain why he had identified certain symptoms in response to the COVID-19 screening assessment.⁹³

The next detainee (“M.B.”⁹⁴) whose name was called had, by this point, left the area to call his attorney at the telephone kiosk in the far corner of the bunkroom. Sheriff Hodgson and a corrections officer (“A.S.”) approached the phone kiosk and told M.B. to hang up the phone. What happened next is unclear.

M.B. alleges that Sheriff Hodgson grabbed the phone out of his hand, shoved him against the phone kiosk, and then pulled him into close proximity in a threatening manner. M.B.’s attorney, who was on the phone at the time, reported that he overheard M.B. “crying out as if in pain” and “scuffling sounds” before the phone call was terminated.

Sheriff Hodgson denies M.B.’s account of this incident. While Sheriff Hodgson acknowledged in his incident report that he approached the phone kiosk to address M.B. and that he “reached to take hold of the receiver to terminate the telephone call,” Sheriff Hodgson maintains that M.B. “pulled the receiver over to his left shoulder,” “put the mouthpiece of the telephone close to his own mouth, and began shouting ‘don’t you touch me don’t you put your hands on me’.” Sheriff Hodgson claims that M.B. “was attempting to falsely portray that he was being assaulted and that he was in a physical struggle with [me].”

⁹² Several BCSO security staff reported that Sheriff Hodgson appeared relatively calm when he arrived on the unit, but acknowledged that the situation became more “argumentative” as it went on and that Sheriff Hodgson told the detainees that they would be “escorted out” if necessary.

⁹³ In response to the screening assessment, this detainee, who is Muslim, told us that he reported a persistent cough, which he attributed to his medical history (which included tuberculosis), and diarrhea, which manifested acutely when this detainee began fasting for Ramadan and consumed large quantities of milk to compensate for the BCSO’s refusal to provide his meals after sunset. According to this detainee, BCSO medical staff never discussed with him his symptoms or explained to him why, in view of his medical history, he should be tested for COVID-19 and subjected to a period of isolation. Absent that information, this detainee refused to be tested for COVID-19 on May 1.

⁹⁴ Where necessary in this report to identify specific detainees or BCSO staff members, we refer to them by initials to protect their privacy and confidentiality.

Officer A.S., who was present with Sheriff Hodgson for some or all of this incident, offered a third version of this event. Officer A.S. claims that he approached the phone kiosk by himself and ordered M.B. to terminate the phone call. According to this officer, Sheriff Hodgson then approached the telephone kiosk while M.B. was continuing to refuse direct orders. When Sheriff Hodgson arrived, M.B. supposedly raised into the air his left hand while holding the phone receiver in an “attempt to assault Sheriff Hodgson” and got into a “fighting stance” in relation to the Sheriff. Officer A.S. claims that he then grabbed M.B.’s hand and shirt collar, and pinned M.B. against the wall.

Several detainees claim that they witnessed Sheriff Hodgson “grab,” “drag,” and/or “assault” M.B. at the phone kiosk. Several BCSO security staff members initially claimed in their incident reports that Sheriff Hodgson did not physically touch or assault M.B. However, many of these officers explained in interviews that they did not actually witness this incident and, instead, based their written statements on what they overheard—that is, a struggle involving a detainee and Sheriff Hodgson—or what they had been later told.

Beyond these conflicting witness statements, there is no other evidence that sheds light on what happened at the phone kiosk. There was surveillance footage from Unit B at the time, but the view is obstructed by another phone kiosk. But regardless of what happened at the phone kiosk, the struggle resulted in a dramatic escalation of the situation—an escalation that detainees and BCSO security staff alike uniformly described as “scary” (albeit for very different reasons).

At approximately 5:47 pm, several other BCSO security staff members and many of the detainees rushed toward the phone kiosk area. The evidence shows that, at that point, there was a struggle involving many of the BCSO staff members and some of the detainees who sought to aid M.B. The evidence also shows that other detainees rushed to the area to observe the situation, but did not engage with or struggle against the BCSO staff.

During the ensuing struggle, one of the corrections officers (“G.C.”) deployed several bursts of O.C. spray in the direction of “multiple detainees.”⁹⁵ We do not know precisely how many detainees were exposed to O.C. spray, but Officer G.C. described spraying the O.C. in essentially a sprinkler head pattern with the goal of exposing as many detainees as possible. In disbursing the O.C. spray, Officer G.C. did not differentiate between those detainees who were involved in the melee and those who were bystanders. Officer G.C. told us that he gave verbal warnings in English before

⁹⁵ Officer G.C. could not recall precisely how many bursts of O.C. spray he ultimately deployed, but estimated it to be around 10 bursts. At least one other corrections officer noted in his incident report that he had “retrieved” his O.C. spray canister, but determined that it was ultimately unnecessary to use it “to create a safe distance” for the BCSO personnel to exit the unit.

disbursing O.C. spray, but we note that he did not reference verbal warnings in his incident report.

Officer G.C. succeeded in exposing multiple detainees to O.C. spray. Many detainees reported that they were O.C. sprayed in the face, including in their mouths and eyes. This O.C. spray exposure caused detainees to experience burning sensations on their skin and in their eyes; in some instances, detainees experienced difficulty breathing. Several minutes later, some of these detainees can be heard coughing, wheezing, and/or struggling to breathe in recorded phone calls with their family and friends. Indeed, so much O.C. spray was used in the unit that many of the detainees became convinced that noxious gas was being pumped into the unit through the ventilation system,⁹⁶ and at least one other corrections officer was inadvertently O.C. sprayed in the face.

As the BCSO personnel exited the bunkroom, two or three unidentified detainees threw plastic chairs over the bunks in the direction of the corrections officers. These plastic chairs struck, but did not injure, three corrections officers. Sheriff Hodgson also reported being struck by a fourth chair and suffering a bruise as a result. Unlike the other instances of chair-throwing, however, this is not captured on the surveillance video. We have no reason to disbelieve Sheriff Hodgson's account, which was corroborated by one other corrections officer (although not Officer A.S. who was standing next to him), but, in the absence of independent corroborating evidence, we cannot conclude with any degree of reasonable certainty that a chair struck Sheriff Hodgson.

All of the BCSO personnel, including Sheriff Hodgson, were able to safely exit Unit B. The entire struggle between the detainees and the BCSO staff was over within seconds.

Some Detainees Erupt in Destructive Conduct, Which Stops After SRT and K9 Arrive

At approximately 5:50 pm, some of the detainees began engaging in destructive and disruptive conduct on the unit that included damaging property, such as breaking appliances, smashing through walls, breaking mirrors, sinks, and tiles in the bathroom, filling a trash can with hot water, dumping soap or shampoo on the floor, throwing liquid at the surveillance camera, and attempting to barricade the doors with tables, appliances, trash bins, mattresses, and other furniture.⁹⁷

⁹⁶ The ventilation system to the unit was shut off prior to SRT's later entry trapping on the unit whatever O.C. spray remained at that time and all of the subsequently deployed O.C. spray and pepper-ball. The BCSO also eventually shut down the water system in the unit.

⁹⁷ The video evidence from the May 1 Incident makes clear that only a handful of the detainees engaged in this conduct. Many detainees did not engage. Instead, they were on the phone or were walking around, sitting down, or simply watching the situation unfold.

This conduct continued in earnest for approximately five minutes. Then, most of the destructive conduct slowed and then largely stopped. By 6:10 pm, the vast majority of detainees are visible on the surveillance and other video footage walking around the unit, sitting in chairs, laying in bunk beds, and using the phone.

This calmer state in the bunkroom largely continued for the next hour, while SRT and the K9 Division arrived on scene and formulated a plan for a calculated use of force. During this time, two corrections officers in the ICE B control room bubble kept a contemporaneous log of destructive conduct on the part of the detainees, which identified those detainees who were observed damaging property or brandishing weapons. Between 6:10 pm and 7:15 pm, the only such conduct documented on the log involved a detainee who was observed throwing an object against the wall at 6:23 pm (which is visible on the video footage), detainees observed purportedly holding an item that might have been a pipe at 6:33 pm, 6:42 pm, 6:46 pm, and 6:54 pm (which is not clearly visible on the footage and, in any event, the last entry on the log at 7:04 pm states that the detainee no longer had whatever item this was), and a detainee who flashed a flashlight in the direction of the officers (which is visible on the footage).⁹⁸

The log also notes that some detainees were wearing masks or towels on their heads “to conceal their identities.” The detainees have explained that they placed wet t-shirts and towels on their faces to alleviate the symptoms of O.C. spray exposure. We found some evidence to support the detainees’ explanation in the recorded phone calls. In particular, when a detainee reported to a family member the symptoms of O.C. exposure, that person encouraged the detainee to put a wet towel or t-shirt on his face to

⁹⁸ The log starts with a series of entries without documenting the time. These entries are consistent with the initial barricading and destructive conduct immediately following the BCSO personnel’s exit from the unit. The log also documents some of the movements or other activities of some of the detainees during this intervening hour, but none of those entries involve conduct related to brandishing or possessing a weapon or actively destroying property.

alleviate those symptoms.⁹⁹ And because several detainees believed that noxious gas was being pumped into the unit through the ventilation system, they thought that face coverings might protect them against further exposure. Indeed, the video evidence shows detainees at various times pointing to the HVAC system in the ceiling while holding towels to their faces.

As noted above, during this hour while SRT and K9 continued to form outside the unit and plan their calculated use of force, several detainees contacted their family members, friends, lawyers, and advocates to ask for help. The recorded phone calls largely corroborate the statements of the detainees, and include near-contemporaneous explanations of their concerns related to COVID-19 testing, Sheriff Hodgson's altercation with M.B. at the phone kiosk, their exposure to large quantities of O.C. spray, and the ensuing period of property damage. Some of the detainees expressed concern about how Sheriff Hodgson would respond to the situation as they observed SRT and K9 forming outside the unit, including a detainee who told his wife that "I'm really afraid for my life right now;" a detainee with COPD and other serious medical conditions who told an advocate that he could not breathe and needed medical help; a detainee who told a friend that he could see the "SWAT team" outside the unit and was feeling "pretty scared;" and a detainee who told his wife that the Sheriff was acting "crazy," that he was scared, that she would need to take care of their kids if something happened to him, and asked to tell his son how much he loved him. Many of these detainees can be heard coughing, wheezing, and struggling to breathe throughout these phone calls. And detainees eventually wrote on a window facing out to the recreation pen where Sheriff Hodgson, SRT, and the K9 Division were located: "We need help" and "Help us!!"

⁹⁹ BCSO security staff repeatedly emphasized that, based on their training and experience, the use of face coverings by inmates during a large-scale disturbance indicated both that the detainees were attempting to conceal their identities and that they were taking steps to protect themselves from an anticipated use of O.C. spray so that they could "fight" through it. We have no reason to doubt that BCSO staff drew these assumptions based on their training and experience (although we do point out that none of the BCSO security staff with whom we spoke had ever responded to a disturbance of this magnitude before), and we understand why the use of face coverings by inmates in a disturbance may pose a security concern. But the problem is that the BCSO acted upon those assumptions without gathering additional information about why these detainees were wearing face coverings, and/or ordering the detainees to remove their face coverings prior to SRT's entry and giving them an opportunity to remove the coverings, or warning the detainees about the steps that would be taken if the coverings were not removed, and/or otherwise alerting the detainees of the significance of the face coverings to BCSO staff and how that would impact what happened next.

The BCSO Fails to Take Any Steps to De-Escalate the Situation, Avoid Conflict, and to Appropriately Prepare for a Calculated Use of Force

During this same approximately one-hour time period, SRT, the K9 Division, and several other corrections officers, as well as BCSO leadership (including Sheriff Hodgson, Special Sheriff Assad, and Superintendent Souza) gathered outside of Unit B to plan a calculated use of force. Yet, in planning the calculated use of force, the BCSO failed to take critically important steps that may have tempered or altogether eliminated the need for additional force and that would have better protected the detainees and BCSO staff.

First, at no point between the time when BCSO staff initially exited the unit around 6 pm and when SRT re-entered the unit around 7:15 pm did BCSO personnel take any steps to de-escalate the situation, to order or instruct the detainees on how they could avoid further conflict with BCSO staff, or to warn the detainees about what would happen if they continued to refuse to comply with orders. As the Watch Commander put it, it would have been practically impossible at that point for any or all of the detainees to remove themselves from the situation and avoid further conflict, even if some or all of the detainees wanted to comply.

Importantly, the detainees could see SRT (and their weapons systems and riot gear), as well as the K9 Division (and their unmuzzled and muzzled dogs) from the windows in the unit. As the BCSO staff explained, a simple “show of force” like this will often scare or intimidate detainees into compliance, obviating the need for further force.¹⁰⁰ And in this instance, the show of force outside of Unit B had the desired effect—the detainees were intimidated and scared by the mere presence of SRT and K9 outside of the unit, as reflected in their recorded phone calls prior to SRT’s entry. Yet there was no attempt by the BCSO to engage with the detainees to determine if they were ready to peacefully comply with BCSO orders.

Second, there is no evidence that the BCSO supervisors or other commanding officers on scene attempted to gather or rely on real-time information about what was happening inside the unit as they planned their calculated use of force. The two officers in the ICE control room bubble were monitoring the unit in real-time, but generally did not convey their observations to SRT or K9. When those officers did communicate information to SRT and K9, they relayed only specific instances of perceived misconduct and not information that would have been relevant to assessing the overall threat-level on the unit, such as the fact that most detainees were not engaging in disruptive or destructive conduct. Rather than relying on real-time information about the unit, SRT and K9 were told by Superintendent Souza (who had since appeared on-scene) that the detainees had make-shift weapons, including shivs, shanks, pieces of glass, pipe, and pieces of broken toilets, that they had donned multiple layers of clothing to prepare for a

¹⁰⁰ At one point, a BCSO staff member can be overheard on the video footage saying, “When [the detainees] see K9 coming in, they’re going to love that.”

physical altercation, that they were actively rioting and engaging in property damage, that they were wearing face coverings to avoid the effects of O.C. spray, and that all twenty-five detainees were participating in the misconduct. Much of this information was demonstrably false or otherwise misleading, according to the evidence available to the AGO.¹⁰¹ And there is no reason why the BCSO supervisors or commanding officers could not have gathered and provided accurate information about the detainees' conduct and changing threat-level as all of this information was readily available and accessible to those involved in planning the calculated use of force.

Finally, the BCSO took no steps whatsoever to evaluate the detainees' medical history or records for any potential contraindications to O.C. spray or to otherwise assess how the calculated use of force might have medically impacted the detainees. Some of these detainees suffered from respiratory or pulmonary illnesses, such as asthma or COPD, that put them at heightened risk of an adverse reaction to O.C. spray or pepper-ball. This omission is particularly troubling given that large quantities of O.C. spray had already been dispersed against multiple detainees, including those with pre-existing respiratory or pulmonary illnesses and including the ten detainees who had been identified as exhibiting symptoms of COVID-19—an infection that can cause severe respiratory illness.¹⁰²

While the HSU and the CPS Health Services Administrator were notified of the calculated use of force consistent with the BCSO's policies,¹⁰³ no one notified the Medical Director (who is solely responsible for making treatment decisions for ICE detainees in emergency situations) or other on-call physicians, nor did they make EMTs available on-scene prior to, during, or immediately following the calculated use of force. While some BCSO nurses responded to the scene prior to SRT's entry to assist in treating any staff or detainees with injuries, these nurses can be heard on the video footage

¹⁰¹ In particular, prior to SRT's entry, the BCSO's staff documented only one possible weapon—an object that appeared to be a pipe that was alternately held by a few detainees. But even that object had not been observed in the hands of any detainee in the time leading up to SRT's entry. There is no evidence that any BCSO staff observed, in the time leading up to SRT's entry, any detainee holding or wielding a shiv or a shank or any piece of broken glass or toilet in a manner consistent with a weapon. Similarly, there is no evidence of active property destruction after 6:23 pm—more than 45 minutes before SRT's entrance.

¹⁰² Superintendent Souza told us that any contraindications to O.C. spray or other less-lethal aerosols were not relevant to the calculated use of force because the BCSO was going to use O.C. spray and pepper-ball, regardless of any potential health risk to the detainees.

¹⁰³ The Health Services Administrator is the on-site administrator responsible for the daily operation of the inmate medical system and the contracted medical staff that facilitate this system. *See* HSU Policy at 12.01.01(H).

anxiously calling for emergency response equipment, like oxygen tanks, that would have been essential in the event of an adverse reaction to O.C. spray and should have been more readily available.

The BCSO's Calculated Use of Force

Sixteen SRT officers, led by the Assistant Commander, ultimately responded on May 1. The SRT Bravo Squad Leader (“D.M.”) was armed with a flash bang grenade. In addition to O.C. spray canisters and 24-inch collapsible batons, SRT officers were also armed with other less-lethal weapons, including two polycaptor anti-riot shields, two shotguns with beanbag rounds, two pepper-ball launchers, and two battering rams.¹⁰⁴ SRT’s mission was to enter and “gain compliance” of the unit.

In addition to SRT, the entire K9 Division responded with all active duty dogs, three of which were muzzled and the rest of which were not. The K9 Division’s mission in responding to the May 1 Incident was twofold. First, the muzzled dogs would enter the unit with SRT to serve as a “compliance tool”—meaning, according to the Captain of the K9 Division, that the canines would scare and intimidate the detainees into compliance. In the event that the detainees were non-compliant or combative, the muzzled dogs would deliver “muzzle hits” or “muzzle strikes”—which, according to the K9 Division Captain, are akin to baton strikes. Second, the unmuzzled dogs would be staged around the perimeter of the recreation pen to apprehend any detainees who managed to escape. These dogs were unmuzzled for two reasons—to scare and intimidate the detainees and to engage in “bite work” should a detainee escape and require apprehension.

Another approximately twelve corrections officers were assigned to the restraint team. The restraint team’s mission was to enter the unit after the SRT and K9 teams “gained compliance” of the unit to restrain and remove the detainees from the unit.

¹⁰⁴ For a discussion of some of these less-lethal weapons, see Kelsey D. Atherton, “What ‘Less Lethal’ Weapons Actually Do,” *Scientific American* (June 23, 2020), <https://www.scientificamerican.com/article/what-less-lethal-weapons-actually-do/>; see also Larry Neumeister, *Injuries at Protests Draw Scrutiny to Use of Police Weaponry*, *J. of Emergency Med. Servs.* (June 22, 2020), <https://www.jems.com/2020/06/22/injuries-at-protests-draw-scrutiny-to-use-of-police-weaponry/> (last visited Oct. 1, 2020) (noting that one study concluded that projectiles fired from non-lethal weapons had resulted in 53 deaths, 300 permanent disabilities, and 1,984 serious injuries in over a dozen countries from 1990 to 2015); David A. Koplow, *Tangled up in Khaki and Blue: Lethal and Non-Lethal Weapons in Recent Confrontations*, 36 *Geo. J. Int’l L.* 703, 709-11 (2005) (explaining that the use of so-called non-lethal or less-lethal weapons carries an “inherent, irreducible danger of fatalities” and that “projectile, chemical, or other mechanism that would merely disable or temporarily incapacitate one person . . . might well inflict mortal injury on another.”).

Shortly before 7:15 pm, SRT marched in “stack formation” to the exterior entrance of Unit B, flanked by three canine officers with muzzled dogs. Sheriff Hodgson stood approximately 75 feet from the entrance to the door, outside the recreation pen. Four canine officers with unmuzzled dogs surrounded the recreation pen.

The entry into the unit was captured on video from multiple angles and documented in incident reports by participating officers. The evidence shows that Squad Leader D.M. opened the door to Unit B and threw in the flash bang grenade, which detonated with a bang and flash of light approximately 15-16 feet away from the detainees. Smoke immediately filled the bunkroom. Squad Leader D.M. yelled, “Get on the ground!” contemporaneously with throwing in the flash bang. At the same time, one other SRT officer motioned toward the ground with his finger, apparently to suggest to the detainees that they should get on the ground. However, because these warnings were essentially contemporaneous with the flash bag, the detainees had no meaningful opportunity to comply before the flash bang was used and/or to take steps to avoid injury.

After the flash bang grenade detonated, the detainees ran further inside the unit and away from the site of explosion. Because the door to the unit opened into the recreation pen, and opposite to the barricade, SRT officers were able to gain entrance to the unit almost immediately upon entry.¹⁰⁵ SRT officers repeatedly yelled at the detainees to get down on the ground, but all commands were given in English and no translation or interpretation services were provided. Pepper-ball launchers rapidly discharged from the moment of entry, even before the detainees could have reasonably been expected to comply with orders to get on the ground.

The video footage of the entry itself is relatively unclear due to rapid camera panning, but it does show that the majority of the detainees were compliant with verbal directives and/or were acting in a non-threatening manner. This is consistent with our interviews of SRT and K9 officers, who reported that most detainees were compliant with verbal commands and that many of those who were non-compliant were simply non-responsive to verbal commands, rather than combatting, assaulting, or actively resisting staff.

Despite the fact that detainees were largely compliant and not actively resisting or combative, the evidence shows that:

- At least thirty rounds of pepper-ball were fired at several detainees. In one instance, an SRT Team Leader (“C.G.”) (who was using the pepper-ball launcher

¹⁰⁵ BCSO personnel suggested that the flash bang was necessary both because of the threat posed by the detainees and because they needed to distract the detainees while they removed the barricade of the door. We reject this explanation because the detainees no longer posed a serious threat to officer safety based on their conduct in the unit at the time of SRT’s entry and because the door opened into the recreation pen, and opposite to the barricade, and so the barricade was ineffectual.

for the first time outside of training) described inadvertently hitting one or two detainees with pepper-balls when he was attempting to fire at the floor to saturate the area with O.C. In another instance, Team Leader C.G. fired a volley of 4-6 pepper-balls at a detainee who stepped out from a corner in the TV room and moved toward where Team Leader C.G. was standing. Team Leader C.G. said that he fired these rounds because he was “scared” by the unexpected presence of a detainee in the corner and not because the detainee had assaulted or attempted to assault him.

- K9 officers deployed “muzzle hits” on detainees who were already on the ground and not combatting or assaulting staff.
- O.C. spray was used against multiple detainees, including in one incident where an unidentified SRT officer is visible on the camera aiming an O.C. canister at detainees in the bathroom who were already on the ground, and another incident where a single detainee was exposed to both O.C. spray and 4-6 pepper-balls, which had been fired at his extremities.
- SRT members applied “hands-on” force against several detainees.¹⁰⁶
- Polycaptor shields were used to force detainees to the ground when they did not comply with verbal commands.
- Restrained detainees were forcefully pushed to the ground.

Notably, the vast majority of the forty-three incident reports by BCSO staff contain no indication that the detainees were non-compliant with verbal commands at the time of SRT’s entry or that the detainees were actively resisting, threatening, or fighting BCSO personnel. Six incident reports of BCSO officers who entered Unit B with SRT or as part of the restraint team indicate that some detainees were non-compliant with (English-language) verbal commands to get on the ground or to submit to flex cuffs, but those reports do not state that any of these detainees were acting in an assaultive or combative manner toward staff. These incident reports note that, where detainees did not respond to verbal commands, officers used a range of less-lethal weapons, including O.C. spray, pepper-ball, a polycaptor anti-riot shield, and canine muzzle hits, to “gain compliance” of these detainees, even though these detainees were not combatting, assaulting, or actively resisting staff. This is consistent with the account of several detainees who claimed that SRT officers O.C. sprayed or otherwise struck them, even though they were not resisting or fighting, but simply did not understand what was happening because they did not speak or understand English.

Seven incident reports by BCSO officers who entered the unit with SRT (including three from the K9 Division) or the restraint team state that less-lethal weapons,

¹⁰⁶ We note that not all instances of hands-on force were noted in the incident reports.

including O.C. spray, pepper-ball, a closed fist punch, and canine muzzle hits were used against assaultive or combative detainees. However, we were unable to identify any of these incidents on the video footage. And we note in particular that the video actually appears to contradict one report issued by a K9 officer, who stated that, “I immediately proceeded to my left and saw multiple detainees running towards me. I gave several orders to get on the ground. Several of the detainees did not comply and I utilized [my] K9 to deliver muzzle hits in order to gain compliance.” The video shows a K9 officer who entered the unit and immediately went to the left was met with a single detainee who immediately got on the ground with his hands raised. And with respect to other incident reports, the officers we interviewed explained that they did not personally observe detainees engaging in assaultive or combative conduct, but rather either saw an officer go “hands-on” with a detainee, which led them to assume that the detainee was being combative or assaultive, or saw that the detainee was not presenting his hands for cuffing, despite orders to do so.

In addition to these specific instances of force, the detainees have alleged, among other things, that:

- SRT officers O.C. sprayed and/or fired pepper-balls at detainees *before* ordering them to get on the ground, even though the detainees were not resisting or acting in an assaultive or combative manner;
- SRT officers O.C. sprayed and/or fired pepper-balls at detainees who were already on the ground and/or restrained; and
- SRT officers and restraint team officers pressed their knees on the backs and/or necks of at least four detainees¹⁰⁷ who were already on the ground and/or restrained, causing them to struggle to breathe and/or forcing their heads into glass on the floor causing lacerations or abrasions to their faces.

After a few minutes, the restraint team entered the unit, most of whom were wearing gas masks, to restrain and remove any detainee who had not yet been restrained or removed. Superintendent Souza also entered Unit B to personally assist in restraining and removing the detainees.

The Recreation Pen and the Provision of Emergency Medical Care

After the detainees had been restrained, SRT and the restraint team took them outside one-by-one and placed them, with varying degrees of force, on their knees facing the wall in the recreation pen. At the same time, certain SRT officers searched the bunk

¹⁰⁷ One of these detainees alleges that he informed a corrections officer, in response to a directive to submit to flex cuffs, that he had been recently diagnosed with a broken hand. Nevertheless, according to this detainee, he was flex cuffed in a painful position and forced to the ground, where the corrections officer stepped or kneeled on his neck.

area, which included flipping mattresses and rummaging through the detainees' personal effects. After all of the detainees were placed on their knees in the recreation pen, SRT officers conducted a thorough pat search for weapons, and none were found.

While the detainees were on their knees against the wall, three muzzled dogs were positioned a few feet behind them. The unmuzzled dogs were staged at spaced intervals on the other side of the recreation pen fence. The purpose of the continued presence of these dogs was to continue to ensure the detainees' compliance through intimidation, fear, and control. And even though all of the detainees were restrained in hand (and in some cases leg) restraints in a gated area surrounded by thirty or more officers, including Sheriff Hodgson himself, the unmuzzled dogs remained on-scene to apprehend and bite any detainee who managed to escape.

Shortly after the detainees were taken outside, one detainee ("G.L.") fell onto his back and appeared to be unconscious. It took nearly two minutes for a corrections officer to notice that G.L. was laying on his back, even though an officer walked by G.L. to address a different detainee. Several corrections officers ultimately responded to G.L., including an officer ("J.A."), who noted in his report that he "could hear a gurgling noise coming from his mouth along with small gasps" and "rendered medical aid with the assistance of" a different corrections officer ("M.A.").¹⁰⁸ Officer M.A. ultimately administered three chest compressions to revive G.L. Once G.L. had been revived, he was escorted outside the recreation pen, where he was briefly evaluated by a nurse in the parking lot before being transported to dispatch and ultimately the RHU.

At no point was G.L. taken to a hospital or evaluated by a medical doctor, notwithstanding his apparent cardiac arrest. There is no evidence that G.L. was monitored or evaluated for cardiac or pulmonary issues following this incident, nor that he was ever evaluated for potential injuries resulting from the administration of chest compressions, including potential injuries to his ribs, chest, or sternum. The Director of Medical Services told us that the administration of chest compressions should, of course, be documented and result in further medical evaluation or treatment. But, based on the information provided to the AGO, none of this happened. Instead, G.L. was placed in a solitary cell without any additional medical evaluation or care related to his apparent cardiac arrest or the administration of chest compressions.

Officer M.A. told us that he believed that G.L. was "faking it" and noted that he has administered chest compressions in other situations to detainees or inmates whom he believed to be "faking" their symptoms. We found no justification in the BCSO's policies

¹⁰⁸ Officer M.A.'s report was just seven handwritten sentences that referred to the wrong ICE unit and said simply that "all detainees complied with all orders without further incident nor injury." Officer J.A.'s report, however, notes that M.A. "administered three chest compressions. On the third chest compressions [*sic*] [the] Detainee made a substantial gasp for air and began to have what appeared to be normal respirations. He was then assisted off the ground by two officers who then escorted him out of the recreation yard where they were met by medical staff."

or elsewhere—for the administration of chest compressions to a person whom the responding officer does not reasonably believe to be exhibiting symptoms of cardiac arrest.

After G.L. was removed from the recreation pen, another detainee (“F.P.”) began to exhibit symptoms of serious respiratory distress. F.P. had been positioned on his knees, in arm and leg restraints, close to the exterior door to Unit B. F.P. was struggling to breathe and to stay in an upright position on his knees for several minutes. Two corrections officers eventually tried to forcibly position F.P. upright on his knees, and when F.P. could not stay in that position, those officers dragged F.P. by his shoulders across the recreation pen, where they again attempted to force him into an upright position on his knees. In doing so, one of the officers appeared to forcefully push F.P.’s head into the wall. At this same time, an unmuzzled dog positioned on the other side of the fence, approximately two feet away from this detainee, intermittently barked in or near F.P.’s face while he gasped for air.

Eventually, F.P. fell over onto the ground. At this point, BCSO nursing staff entered the recreation pen and called for an ambulance after determining that his oxygen saturation was critically low. F.P. continued to violently gasp for air, and drifted in and out of consciousness, while BCSO nurses continually attempted to revive him with smelling salts. Eventually, F.P. was provided with oxygen and his arm and leg restraints were removed. But nearly half an hour had elapsed between the time when F.P. first began to exhibit respiratory symptoms and when he was finally transported to the hospital.

While F.P. struggled to breathe, other corrections officers began to load the detainees one-by-one into transport vans. Some of the detainees were put on their knees at the entrance to the recreation pen again to wait to be placed in a transport van. One detainee (“L.W.”), in particular, was forcibly brought to his knees at the entrance to the recreation pen in front of Sheriff Hodgson where leg restraints were applied. L.W. screamed out to the ICE nursing supervisor that he had “bad knees” and begged her to tell the corrections officers about his bad knees so that he would not have to kneel again. Corrections officers continued to force L.W. to his knees while he screamed in pain. At least one corrections officer had his arm near L.W.’s upper torso as they forced him to the ground and pressed his face into the fence.¹⁰⁹ Sheriff Hodgson personally observed this

¹⁰⁹ A single incident report by Officer J.A. indicated that he overheard a struggle between corrections officers and L.W. at the recreation pen gate and that L.W. was attempting to “strike officers with his feet.” When we interviewed Officer J.A., however, he stated that he did not personally witness the initial interaction between SRT officers and L.W. By the time Officer J.A. became aware of the struggle, he saw L.W. “flailing his legs” in an attempt to resist the officers and Officer J.A. attempted to assist SRT officers by “grabbing hold of his knees” and “pushing him to the ground.” Officer J.A.’s clarified statement is important because there is a difference between a detainee who is actively trying to kick and assault staff, and a detainee who is requesting medical attention and attempting to avoid being needlessly placed in a painful position.

incident from where he was standing, just a few inches away. When asked about this incident, several corrections officers told us that they simply assumed that L.W. was lying about his knee pain because he had been kneeling without issue for several minutes just prior. We reject this explanation, however, as there are an array of knee problems that could cause a person to experience acute pain in connection with prolonged kneeling, and we note that a nurse could have evaluated L.W.'s knees at that time, but did not. We also note that the incident report from L.W.'s medical evaluation after the incident and before his placement in the RHU documented his report of bilateral knee pain and an injury to L.W.'s right knee.

At the same time, a K9 officer ("R.I.") brought an unmuzzled dog over to L.W. and positioned his dog's muzzle within just a few inches of L.W.'s face on the other side of the fence. A muzzled dog was also brought up behind L.W. from inside the recreation pen and brought into extremely close physical proximity to L.W. The unmuzzled dog aggressively barked in L.W.'s face, while the muzzled dog also barked within inches of L.W.'s feet and legs.¹¹⁰ When asked why K9 Officer R.I. took these steps, he explained that he intended to scare and intimidate L.W. into compliance, and that he wanted to be nearby in the event that L.W. produced a weapon or escaped. We reject this explanation because L.W. had already been pat searched for weapons and none were found, and because L.W. was in hand restraints and surrounded by multiple SRT officers who were "hands-on" with him, which made the prospect of an escape impossible. The only plausible explanation, therefore, is that K9 Officer R.I. took these steps for the purpose of scaring and intimidating L.W. into compliance.

Eventually, SRT officers placed L.W. in leg restraints (in addition to the flex cuffs on his hands), and carried him to the transport van by his arms and feet in a prone position.

Shortly after this incident, yet another detainee ("D.M."), who had a known medical history that included COPD and other respiratory/pulmonary issues, began to exhibit serious symptoms of respiratory distress as a result of exposure to O.C. spray. Like the other detainees, D.M. had been placed on his knees against the wall in restraints, where he remained for approximately thirty minutes without medical attention. D.M. told the corrections officer positioned directly behind him that he was having trouble breathing and asked for assistance in retrieving his on-person inhaler. The officer refused

¹¹⁰ The video evidence is not clear whether or not this canine delivered a "muzzle strike" to L.W., and none of the K9 officers documented their involvement in this incident in their reports.

and instead summoned a nearby nurse to evaluate D.M.¹¹¹ By the time that D.M. was evaluated, however, his oxygen levels were concerningly low. The nurse then permitted D.M. to use his on-person inhaler, but it was no longer effective given his dangerously low oxygen level. The nurse administered oxygen and summoned a second ambulance to the scene.

The video footage of the recreation pen also shows several other noteworthy incidents, including the following:

- Officers were continually warned that the dogs on the exterior perimeter of the recreation pen were unmuzzled and that, for this reason, the officers needed to “be careful” when escorting detainees to the recreation pen.
- Muzzled dogs (who were inside the recreation pen) and unmuzzled dogs (who were outside the recreation pen) were repeatedly brought into close proximity to detainees as they were being escorted out of the recreation pen and in situations where detainees appeared to be non-compliant (for example, when F.P. was struggling to remain upright on his knees).
- Sheriff Hodgson was present outside the recreation pen and, at times, filmed the activity in the recreation pen on his cell phone. We noted two incidents in particular where officers brought detainees to their knees directly in front of Sheriff Hodgson before loading them in the transport van. Sheriff Hodgson did not intervene in any of the incidents described above.

¹¹¹ This officer’s incident report notes that this detainee was “breathing erratically” and that the officer instructed him to “keep calm and breathe in through his nose out through his mouth to attempt to steady his breathing.” The report notes that this detainee requested assistance in accessing his on-person inhaler, but rather than assisting with such access, the officer summoned a nearby nurse. When we interviewed this officer, the officer explained that the nurse was able to respond within seconds and so this officer did not think it was necessary to give him permission to use or to help him access his on-person inhaler before he was evaluated. However, while summoning a nurse was certainly appropriate given D.M.’s symptoms, denying him access to an on-person inhaler—even if only briefly—defeats the purpose of having an on-person inhaler and undermines the clinical judgment that a detainee requires unfettered access to a rescue inhaler. This is particularly troubling given that the BCSO took no steps to evaluate detainees’ medical histories and prepare for the likelihood that detainees, like D.M., would experience serious medical contraindications to exposure to large quantities of O.C. spray.

- An unidentified corrections officer in a position of authority admonished other officers for being “pussies” in struggling to get a detainee (“A.F.”), who had become resistant, into the transport van.¹¹²
- Several detainees had circular residue on their clothing that appeared to be consistent with the use of less-lethal projectiles, like pepper-ball.
- SRT officers removed the detainees’ masks, latex gloves, and shoes before the pat search, putting the detainees and BCSO personnel at increased risk of COVID-19 exposure. This is particularly troubling because ten detainees had been identified as exhibiting COVID-19 symptoms and several BCSO staff members were in close proximity to those detainees without facemasks or other personal protective equipment (“PPE”).

Medical and Mental Health Evaluations After the May 1 Incident

Each of the detainees (except for the two transported to the hospital from the recreation pen) were transported to the HSU for a medical evaluation related to their placement in the RHU and then to decontaminate from O.C. exposure. Some of these evaluations were filmed, and show a relatively cursory evaluation. Of those evaluations that were filmed, most of them were conducted in English. In some instances, however, corrections officers translated for LEP detainees. We note that the BCSO had access to a language line to provide interpretation services, but there is no evidence that it was used at any time.

During one medical evaluation, a detainee (“D.G.”) reported serious shoulder pain resulting from the incident. D.G. had circular powder residue on his clothing consistent with the use of pepper-ball. The nurse who conducted this evaluation concluded that D.G. had a “very limited range of motion,” and needed to be taken to the hospital. This nurse also noted that D.G. had “an open area on the top of his left ear.” D.G. was transported to the hospital, where he tested positive for COVID-19.

The BCSO nursing staff also prepared medical incident reports that were supposed to document the results of the medical and mental health evaluations conducted on each detainee. While these reports should have documented each symptom or injury reported by the detainees, they generally did not. Instead, each of these reports consists of one paragraph of about 3-4 sentences, many of which are very similar to one another. Few of the incident reports actually document any injuries or symptoms at all. Those incident reports that consistently documented injuries or symptoms were generally prepared by the same nurse, who noted that seven (out of eight) detainees that she evaluated after completion of the decontamination process had bilateral redness in both

¹¹² A.F. repeatedly yelled out “Allahu Akbar,” which is part of a Muslim affirmation of faith. Multiple officers noted this statement in their incident reports or during their interviews as apparent evidence of an imminent threat, and the commanding officer of SRT described this statement as “terrorist words.”

eyes due to the use of O.C. spray and redness and irritation around the wrists. Among the remaining reports,¹¹³ knee injuries were noted for three detainees, including L.W., abdominal pain was noted for two detainees, and a minor abrasion on a wrist was noted for one detainee. And of the three nursing staff reports for G.L., one notes that he was on the ground in the recreation pen because of his asthma,¹¹⁴ another notes that he had no symptoms of respiratory distress, and a third notes that he had no symptoms or injuries whatsoever. None mention the administration of chest compressions.

Several detainees claim that they reported injuries to nursing staff, including lacerations caused by broken glass, welts and bruising due to the use of pepper-ball and/or hands-on force, respiratory symptoms and difficulty breathing, significant wrist pain due to the prolonged period of restraint in overly tight flex cuffs, and burning skin and eyes from the O.C. spray. Lawyers who interviewed the detainees in the aftermath of the May 1 Incident made personal observations of some of these injuries, including welts and bruises, lacerations, indentations on wrists consistent with overly tight flex cuffs, and persistent coughing/wheezing due to the lingering effects of O.C. spray.

With the exception of the incident reports described above, none of these symptoms or complaints appear in any of the medical reports associated with the May 1 Incident. Indeed, M.B. was filmed complaining to BCSO nursing staff about his wrists and the tightness of his flex cuffs, during which time indentations on his wrists from the flex cuffs were clearly visible, but none of these complaints appear in his medical incident reports. And, when M.B.'s flex cuffs were finally removed hours later, the video footage appears to show that M.B.'s hands were uncontrollably shaking.

The BCSO Assigns All Detainees to Solitary Cells in the RHU

After the HSU evaluations, the detainees were taken one-by-one to the RHU, where they were assigned to solitary cells. The detainees were strip-searched and finally, many hours later, permitted to decontaminate from O.C. exposure by taking brief cold-water showers to wash out the O.C. spray from their eyes and skin. Some detainees reported that they were not allowed an opportunity to adequately decontaminate from the O.C. spray exposure and that the O.C. spray continued to irritate their skin and eyes for several days. Three detainees were placed on mental health “eyeball” watches in the RHU, where they were denied access to clothing and provided with only a Ferguson blanket. With respect to one of these detainees, however, the medical incident reports

¹¹³ The medical reports for the three detainees taken to the hospital document the symptoms that necessitated emergency medical care.

¹¹⁴ This medical report notes that the nurse was summoned to the scene to respond to a “Code 99” (the code used to indicate a possible cardiac arrest), and brought a defibrillator with her to the scene. But, as noted, this report makes no mention of any treatment or aid rendered to G.L. for his apparent cardiac arrest, nor does it indicate that this nurse took any steps at any point to evaluate or assess G.L.’s cardiac functioning or symptoms.

provided to the AGO state that he was medically “cleared” by the BCSO for the RHU and do not document any reason why he would have been placed on a mental health watch and denied access to clothing.¹¹⁵

The BCSO placed all twenty-five detainees in administrative segregation in either Unit EE (the segregation unit) or Unit EC (the special offenders unit), regardless of the degree or extent of the detainees’ participation in the disturbance.¹¹⁶ The detainees were formally placed on administrative segregation (“ASO”) status on May 7 and were provided with paper and hygiene kits, underwear, and clean uniforms on that day.¹¹⁷ We also found it noteworthy that none of the detainees had facemasks or PPE to mitigate the risk of COVID-19 exposure when they were placed in the RHU on May 1, and that masks were not requested for the detainees until May 4.¹¹⁸ While in the RHU, the detainees were denied phone privileges (except for attorney calls, which had to first be approved by Superintendent Souza)¹¹⁹ and visitation privileges, and were subject to a mail monitor.¹²⁰

¹¹⁵ The BCSO’s failure to adequately document this denial of clothing and other essential health items in connection with the placement of this detainee into the RHU violates the Segregation Policy and the Segregation Detention Standard.

¹¹⁶ Some of the detainees reported unsanitary conditions and other mistreatment in segregation, including repeated denial of access to medical treatment (including one detainee who required emergency medical treatment immediately upon arrival at a different ICE detention facility) and the inappropriate use of restraint equipment and O.C. spray. While these allegations were beyond the scope of our investigation, we note that, to the extent these allegations are true, they would provide a reasonable basis to conclude that the civil rights violations against the ICE B detainees were systemic and persisted beyond the May 1 Incident.

¹¹⁷ Emails to and from Superintendent Souza (May 7, 2020, 9:04 am, 10:56 am, 11:54 am, 4:15 pm). *See also* Executed Notices of Placement into Awaiting Action or Administrative Segregation Order Status for the detainees (all dated May 7, 2020). Each of the Executed Restrictive Housing Transfer Orders for all of the detainees, dated May 1, 2020, makes clear that the RHU transfer was “due to Unit disturbance in ICE B” (as opposed to a medical need for isolation related to COVID-19) and so the failure to place the detainees on ASO status in a more expeditious manner delayed triggering certain time-based procedural protections for the detainees.

¹¹⁸ Email to Steven Souza (May 4, 2020, 2:22 pm) (“25 masks needed.”).

¹¹⁹ Email from BCSO Director of Immigration Services (May 5, 2020, 1:16 pm) (“Per the Superintendent, all phone call request[s] [from] attorney[s] for the detainees involved in the ICE B incident have to go to him for his approval.”).

¹²⁰ Email to Superintendent Souza (May 4, 2020, 11:37 pm); email from Superintendent Souza (May 4, 2020, 12:43 pm).

The BCSO's Investigation of the May 1 Incident

After the May 1 Incident, the Special Investigations Unit (“SIU”) opened an investigation into the incident. The SIU investigation focused on identifying those detainees who participated in the destructive and disruptive conduct and/or those detainees who threw chairs at BCSO staff and Sheriff Hodgson.¹²¹

While the sufficiency of the BCSO’s internal investigation was beyond the scope of our investigation, we nevertheless identified some concerns about the integrity and independence of that investigation. First, while almost all BCSO security staff properly completed their incident reports before their shifts were over, we identified an email between the lead investigator and Superintendent Souza, in which the investigator indicated that he was going to review the incident reports and surveillance tape with certain BCSO staff members who were “in the building at the time with Sheriff Hodgson during the ICE B Disturbance” to see if “there is anything else they might remember.”¹²² One of those meetings caused a commanding officer to issue an addendum to his report identifying a detainee whom he now believed to have thrown a chair that struck another officer. Another officer (who did not issue an addendum to his report) told us that he did not have to “change much” in the report, but when asked to clarify, this officer said that, in fact, “no changes” were made to his report. We do not know with any degree of certainty what happened with respect to this officer’s report, but we are nevertheless concerned about the impact that these meetings may have had on the incident reports and in shaping or influencing the recollections of the officers who responded to the May 1 Incident.

Second, we are concerned that the BCSO made little or no attempt to determine whether or not the BCSO’s use of force was appropriate. Indeed, we received no evidence suggesting that the BCSO undertook an After-Action Review as required by its policies¹²³ to ensure that the various uses of force against the detainees on May 1 were reasonable and proportional to the circumstances. Not only does this omission indicate (at best) a lack of interest on the part of BCSO leadership in ensuring that the force was used reasonably and proportionally to the circumstances and in a way that is consistent with BCSO policies, but it also indirectly communicates to officers that there will be no investigation into and no consequences for uses of force that may have crossed a line.

¹²¹ One of the SIU investigators who participated in the investigation reported that he had received largely “on the job” training in conducting internal investigations.

¹²² Email to Superintendent Souza (May 7, 2020, 1:52 pm).

¹²³ Use of Force Policy at 09.06.17(B); *see also* Use of Force Detention Standard at Section V(P).

Finally, we note that some of the detainees reported that they were interrogated by BCSO staff as part of the BCSO internal investigation and denied access to counsel and/or interrogated after invoking their right not to answer questions. To the extent that these allegations are true, we emphasize that it is unconstitutional to deny access to counsel and/or coerce participation in a custodial interrogation in connection with a criminal investigation.

b. Legal Conclusions

We conclude that the evidence made available to us sufficiently supports the conclusion that the BCSO violated the civil rights of the ICE B detainees, as well as several applicable policies, procedures, and standards.

i. Violations of the Detainees' Due Process Rights to Be Free from Excessive Force

Based on our review of the available evidence, we conclude that the BCSO violated the civil rights of the ICE B detainees in two distinct ways: by applying constitutionally excessive force to the ICE B detainees and by acting with deliberate indifference to a substantial risk of serious harm to the detainees' health and safety.

The evidence made available to us—in particular, the video footage, recorded telephone calls, and BCSO witness interviews—supports the conclusion that the May 1 Incident involved disproportionate and excessive force that violated at least some of the detainees' rights under the Fourteenth Amendment and the Massachusetts Declaration of Rights. We start our discussion by acknowledging that protecting the health and safety of the people who live and work in correctional facilities is not easy. Effective communication by security staff and fostering trust by inmates in the operation of a jail are critical tools in maintaining institutional order. It requires leadership that is invested in the health, safety, and well-being of every person who walks through its doors—whether in chains or in uniform. And it is certainly true that, in prisons and jails, officers are frequently called upon to make snap judgments in responding to inmate disturbances without the benefit of time to consider alternatives to force or to safely attempt de-escalation and conflict avoidance techniques. But we confront here an entirely different situation: a *calculated* use of force—that is, a deliberate and intentional use of force—that was carefully planned by BCSO leadership over the course of an hour, during which time the BCSO could and should have taken steps to de-escalate the situation as required by its own policies and the Detention Standards and to ensure that the calculated use of force plan was proportionate to the threat and properly accounted for the health and safety of all involved.

Our conclusion that the BCSO violated the detainees' civil rights during the calculated use of force is based on several facts, including that the BCSO applied objectively unreasonable force—such as a flash bang grenade, pepper-ball launchers, and canines—against detainees who were not assaulting, combatting, or actively resisting staff and that the BCSO disregarded several provisions of its own policies and procedures

that were intended to protect the detainees and the BCSO officers during emergency situations.

In particular, the evidence shows that the calculated use of force plan bore little relationship to the threat demonstrated by the detainees in the hour before its execution. During that hour, the detainees appeared generally calm and nonviolent. Yet the BCSO carefully planned for the use of—and then indiscriminately deployed—multiple powerful less-lethal weapons immediately upon entry into the unit. *See, e.g., Kingsley*, 576 U.S. at 397. (the severity of the security problem at issue and the relationship between the need for the use of force and the amount of force used are factors that bear on the objective reasonableness or unreasonableness of the force used). Indeed, the BCSO detonated the flash bang grenade and launched multiple rounds of pepper-ball before detainees had any chance to comply with the entering team’s orders.

The BCSO staff that we interviewed cited the detainees’ initial disruptive and destructive conduct as a factor that influenced this plan. While there is no question that the disruptive and destructive conduct by the detainees, including throwing plastic chairs at security staff, posed a serious security threat at the time that it happened, the BCSO did not take any steps to determine during the intervening hour whether the need for force or the amount of force necessary had changed. Had the BCSO leadership taken those steps, they would have learned that the situation had substantially de-escalated on its own.¹²⁴ Instead, Superintendent Souza and others conveyed inaccurate and misleading information about the threat-level on the unit to the SRT and K9 officers in preparation for the calculated use of force. This included information that was demonstrably false (for example, that many or all of the detainees had make-shift weapons, such as shivs or shanks, and that all twenty-five detainees participated in the initial destructive conduct, when only a subset of detainees participated), or stale (for example, that the detainees were continuing to actively destroy property). No information was provided to these officers that reflected the reduced security risk evident from the evidence. If accurately conveyed, this information could have been factored into the calculated use of force plan and communicated to the SRT and K9 officers before they made entry, which likely would have reduced, or altogether eliminated, the force needed to gain compliance of the unit.

Moreover, the BCSO officers applied force against detainees who were not combative, assaultive, or actively resisting staff at the time of SRT’s entry. *See id.* at 397 (whether detainee was “actively resisting” is a factor that bears on the objective reasonableness or unreasonableness of the force used). Rather than engaging in

¹²⁴ This information was readily available to the BCSO. Indeed, two officers were in the ICE control room bubble monitoring the situation in real-time and recording a log of supposedly relevant detainee conduct. This log—which is corroborated by the video evidence—shows almost no destructive or dangerous conduct on the part of the detainees between 6:10 pm and 7:15 pm—certainly not the type of conduct that would justify the extent of force ultimately applied.

combative or assaultive conduct or actively resisting the BCSO staff, the evidence shows that a handful of detainees did not immediately respond to verbal directives that were not necessarily given in a language or manner that they could understand—for example, detainees who failed to get on the ground but raised their hands in the air, or detainees who were already on the ground, but failed to present their hands for flex cuffing when and in the manner ordered to do so. The evidence shows that the BCSO used unreasonable force against some of these detainees, including pepper-ball, O.C. spray, muzzle hits, and hands-on force, despite the fact that these detainees offered no active resistance and were no longer a threat to officer safety.

In addition to this evidence, we also found evidence that, in some instances, the use of flex cuffs was objectively unreasonable insofar as they were applied in such a manner that caused some detainees to experience excessive physical pain and remained on those detainees beyond the amount of time reasonably necessary. Many detainees were left in flex cuffs for as long as two hours and, in at least one instance, a detainee complained repeatedly within that time period about the tightness of his flex cuffs. However, this detainee's flex cuffs were not adjusted or loosened until they were removed at around 9 pm. And when they were finally removed, the flex cuffs left visible and deep indentations on this detainee's wrists.

Our conclusion that the BCSO's use of force on May 1 was objectively unreasonable is also based on the BCSO's numerous violations of its own policies and procedures.¹²⁵ While violations of internal policies do not alone give rise to a constitutional violation, they are nevertheless "germane" to the reasonableness inquiry in an excessive force claim. *Scott v. Henrich*, 39 F.3d 912, 915-16 (9th Cir. 1994); *see also Tennessee v. Garner*, 471 U.S. 1, 18-19 (1985) (reviewing trends in police department policies as part of the reasonableness inquiry in a deadly force case); *Adams*, 416 Mass. at 562-63 (citing the "disregard" of Boston Police Rules as evidence of a constitutional violation in an excessive force case). And here, the myriad violations of BCSO policies in planning and executing the calculated use of force, coupled with the BCSO's failure to adequately train and supervise its officers to ensure compliance with those policies, supports the conclusion that the BCSO's use of force on May 1 was objectively unreasonable.

We are particularly troubled by the BCSO's violation of the total ban on the use of canines in cell extractions and the total ban on the use of canines for the force, control, or intimidation of immigration detainees.¹²⁶ Notwithstanding the ban on the use of

¹²⁵ The use of force against detainees who were not actively resisting, assaulting, or attempting to assault staff and the application of restraint equipment for prolonged periods of time that resulted in extreme physical pain are also violations of the BCSO's Use of Force and Restraint Equipment Policies, as well as the Use of Force Detention Standard.

¹²⁶ As discussed *supra* at pp. 7-8, 19, this ban is not only found in the BCSO's Use of Force and Cell Extraction policies, but is also mandated by 103 CMR 924.10 (which

canines in both of these contexts, the commanding officer of the K9 Division, who is responsible for the training and day-to-day supervision of the BCSO's K9 officers, told us that the BCSO may use canines for the force, intimidation, or control of ICE detainees and in cell extractions as a tool of "last resort." But this is not consistent with the law, and the BCSO should never have deployed its K9 Division on May 1.

As one illustration of this unlawful use of canines, we highlight K9 Officer R.I.'s placement of his unmuzzled canine's face within inches of L.W.'s face, who was restrained and surrounded by multiple officers at the time. From that position, the unmuzzled canine proceeded to intermittently bark aggressively in L.W.'s face. And while muzzled canines (one of which was positioned directly behind L.W. during this particular incident) present less risk of serious injury to the detainees than the unmuzzled canines, the muzzled canines nevertheless delivered "muzzle hits" or "muzzle strikes" to multiple detainees inside Unit B—which one K9 officer described as akin to being struck

applies to cell extractions) and the Use of Force Detention Standard. The ban on the use of canines in both of these contexts is based on the near universal recognition that even the most highly trained and effective canines are inherently less controllable and, therefore more dangerous to inmates, than other types or methods of force. Indeed, ICE banned the use of canines for the "force, control, or intimidation" of immigration detainees after several high profile incidents in which canines were used to intimidate and terrorize detainees in immigration detention facilities and following widely disseminated images of leashed unmuzzled canines terrorizing restrained detainees at the Abu Ghraib prison in Iraq. *See, e.g.*, Nina Bernstein, "9/11 Detainees in New Jersey Say They Were Abused with Dogs," *New York Times* (April 3, 2006), <https://www.nytimes.com/2006/04/03/nyregion/911-detainees-in-new-jersey-say-they-were-abused-with-dogs.html>; *see also* Daniel Zwerdling, "Immigrant Detainees Tell of Attack Dogs and Abuse," *National Public Radio* (November 17, 2004), <https://www.npr.org/2004/11/17/4170152/immigrant-detainees-tell-of-attack-dogs-and-abuse>. Massachusetts banned the use of canines in cell extractions in recognition of the serious risks of injury to inmates associated with using large breed dogs in this context and because even the most highly trained and effective canines are simply not as controllable or predictable as other methods of force. Human Rights Watch, *Cruel and Degrading: the Use of Dogs for Cell Extractions in U.S. Prisons* (October 9, 2006) (<https://www.hrw.org/report/2006/10/09/cruel-and-degrading/use-dogs-cell-extractions-us-prisons>); *see also* Jonathan K. Dorriety, *Police Service Dogs in the Use-of-Force Continuum*, 16 *Crim. Just. Pol'y Rev.* 88, 94-95 (2005) (detailing the two primary apprehension techniques taught to police dogs, "bite and hold" and "circle and bark," and noting that even dogs trained to "circle and bark" will bite if it perceives the suspect as attempting to flee); Mark Weintraub, *A Pack of Wild Dogs: Chew v. Gates and Police Canine Excessive Force*, 34 *Loy. L.A. L. Rev.* 937, 974 (2001) (noting that even "find and bark" dogs, which are not trained to bite suspects unless threatened or attacked, still pose a risk of inflicting serious harm because such dogs are often trained to bite at movement).

with a “furry baton”¹²⁷—who were already on the ground, not actively resisting, and no longer posed a threat to officer safety. Even in those very limited circumstances in which canines may be lawfully used to control criminal detainees or inmates (none of which are present here), canines certainly can never be used against individuals who are not actively resisting or assaulting officers. *See Kingsley*, 576 U.S. at 397 (whether detainee was “actively resisting” is a factor that bears on the reasonableness or unreasonableness of the force used); *see also Parker v. Gerrish*, 547 F.3d 1, 10 (1st Cir. 2008) (increasing the force applied after a person stops resisting and becomes largely compliant is unreasonable, even if the individual was harassing and/or actively resisting earlier in the encounter).

The BCSO also failed to comply with its de-escalation policy, which required the BCSO to take steps to de-escalate the situation and avoid further conflict before a calculated use of force.¹²⁸ The BCSO’s de-escalation policy is an important part of its Use of Force and Cell Extraction Policies because a successful de-escalation may temper, limit, or altogether eliminate the need for further force. *See, e.g., Kingsley*, 576 U.S. at 397 (efforts made by officers to “temper or limit the amount of force” is a factor that bears on the reasonableness or unreasonableness of the force used). But even though the BCSO had over an hour to attempt different conflict avoidance techniques or otherwise try to de-escalate the situation, they made no effort to do so.

And there is ample evidence that those efforts might have been successful. As discussed above, multiple SRT and K9 officers told us that, in past experiences, their mere presence on-scene—without taking any further action—provided such a strong deterrent and was so intimidating to prisoners that the situation resolved itself without the use of any force. So too here, the evidence shows that the arrival of the SRT and K9 teams had precisely that desired effect. Yet the BCSO took no steps to determine whether the arrival of SRT and K9 on scene had changed the dynamic in Unit B.

Instead of taking steps to de-escalate the situation and avoid further conflict as required by BCSO’s policies, several BCSO staff members told us that it was incumbent on the detainees to de-escalate the situation if they wanted to do so, and the fact that they did not suggested to those BCSO staff members that the detainees wanted a fight. However, when we asked those BCSO staff members how the detainees could have de-escalated the situation, we received a range of responses. For example, one officer suggested that the detainees could have “asked to speak to the Sheriff or the higher-ups.”

¹²⁷ This K9 officer and the commanding officer of the K9 division said that “muzzle hits” or “muzzle strikes” are the equivalent to baton strikes on the Use of Force Continuum. We note that baton strikes are a level four on the Use of Force Continuum, which is just one level below deadly force and is only supposed to be used when an inmate or detainee is actively trying to harm an employee. Use of Force Policy at 09.06.05.

¹²⁸ In addition to de-escalation requirements contained in the BCSO’s Use of Force Policy, ICE’s Use of Force Detention Standard also required the BCSO to attempt to avoid conflict prior to the calculated use of force.

But the detainees had no means of reaching Sheriff Hodgson or Superintendent Souza. Other officers suggested that the detainees should have approached the door with their hands in the air, or laid on the ground in front of the windows, or returned to their bunks. But no one told them to do this. And, in any event, the evidence shows that at least some detainees did take steps to avoid further conflict, as detainee wrote “We need help” and “Help us!!” on the exterior window facing the BCSO staff, and other detainees returned to their bunks. Despite these actions, however, the BCSO did not make any effort to communicate with the detainees or take any steps to de-escalate the situation as required by their policies.

The BCSO also did not provide verbal warnings before using force against the detainees, even though it was feasible to do so and was required by its policies. *See also Conlogue v. Hamilton*, 906 F.3d 150, 155-56 (1st Cir. 2018) (noting that warnings should be given, when feasible, if the force used may result in serious injury or death and that the warning must be adequate under the circumstances); *see also Young v. City of Providence ex rel. Napolitano*, 404 F.3d 4, 23 (1st Cir. 2005) (same). We found the use of a flash bang grenade without advance warning to be particularly troublesome. The evidence shows that Squad Leader D.M. threw in the flash bang while yelling “Get on the ground!” However, the detainees had no practical opportunity to comply with the order to get on the ground before the flash bang grenade detonated, nor did they have any opportunity to take steps to protect themselves from the explosion. The flash bang grenade detonated just 15-16 feet away from the detainees—some of whom had no involvement in any of the conduct that gave rise the incident. Flash bang grenades pose a serious risk of injury—particularly when used in an interior space—and should only be used (if at all) when absolutely necessary because of a serious and active threat to officer safety, which was simply not the case here.¹²⁹ *See, e.g., Boyd v. Benton County*, 374 F.3d 773, 777-79 (9th Cir. 2004) (use of flash bang device constituted unconstitutional use of excessive force where police deployed it without either looking or sounding a warning when there were both suspects and innocents in the room); *Milan v. City of Evansville*, No. 3:13-cv-1-WTL-WGH, 2015 WL 71036, at *5-*6 (S.D. Ind. January 6, 2015) (canvassing case law on the reasonableness of the use of flash bangs); *see also United States v. Boulanger*, 444 F.3d 76, 85 (1st Cir. 2006) (recognizing the dangers associated with the use of flash-bang grenades and noting that such devices should not be used as a routine matter)

During the calculated use of force itself, some officers told us that they gave verbal warnings prior to using force against individual detainees, as required by the BCSO’s policies, and that those warnings often resulted in compliance without the need for any force. But others told us that they did not provide any verbal warnings before using force, such as pepper-ball or canines, nor did they provide an opportunity for compliance. And one officer told us that he exposed a detainee to O.C. spray after the

¹²⁹ As discussed at p. 34, the flash bang was also not necessary to distract the detainees while officers removed the barricade because the barricade was totally ineffectual and the SRT officers were able gain entrance to the unit immediately upon entry.

detainee did not respond to an English-language warning or verbal commands. The officer thought that this detainee's non-responsiveness may have been attributable to a language barrier. Had the BCSO provided interpretation services as required by its policies and the Detention Standards, and had this warning been provided in a language that this detainee understood, it may not have been necessary to expose this detainee to O.C. spray at all.

In the end, the use of force against those detainees who were not actively resisting, combatting, or assaulting staff, and the BCSO's complete disregard of its policies and procedures provides compelling evidence that the BCSO's calculated use of force was objectively unreasonable.

ii. **The BCSO's Deliberate Indifference to a Substantial Risk of Serious Harm to the Detainees**

The evidence made available to us also supports the conclusion that the BCSO was deliberately indifferent to a substantial risk of serious harm to the health of the detainees. In particular, the evidence shows that the BCSO unreasonably exposed some detainees with serious respiratory and pulmonary conditions to large quantities of O.C. spray and pepper-ball without taking any advance precautions and then denied those detainees access to adequate medical care after the fact and the ability and opportunity to adequately decontaminate.¹³⁰ And not only was the extensive use of O.C. spray constitutionally excessive, but it was also extremely dangerous under the circumstances. Several detainees had documented medical conditions that put them at serious risk of complications resulting from exposure to O.C., including "special needs inmates" as defined by the BCSO's policies, and some of those detainees had also been identified as possibly having COVID-19. By failing to take any precautions—such as, for example, notifying the on-call physician or EMS and ensuring that they were on-scene before SRT's entry—the BCSO seriously endangered the lives of several detainees. And in the end, so much O.C. spray was used that two of these detainees had to be taken to the hospital, one had to be revived with chest compressions, and the BCSO was advised to throw away library books, magazines, and many of the detainees' personal cosmetics and other personnel effects due to the degree of O.C. contamination.¹³¹

We specifically conclude that the BCSO was deliberately indifferent to the substantial risk of serious harm to G.L.'s health. G.L. (an asthmatic) required emergency medical aid in the form of three emergency chest compressions in the recreation pen. Yet the BCSO failed to transport this detainee to a hospital for further evaluation, or provide

¹³⁰ Even though the BCSO took no steps to determine whether or not any of the detainees were at risk of adverse health consequences from exposure to O.C. spray or pepper-ball, Superintendent Souza told us that this step in this case was unnecessary because the BCSO would have used O.C. spray against the detainees, regardless of any of their medical histories or any risks to their health and safety.

¹³¹ Email to Superintendent Souza (May 4, 2020, 3:38 pm).

him with any medical attention to assess either his cardiac functioning or any injuries to his ribs, chest, or sternum from the chest compressions. Instead, G.L. was briefly assessed in a parking lot by a nurse and then ultimately transported to the RHU with the other detainees. To compound this already inexcusable indifference to G.L.'s health and safety, the BCSO did not document in the medical incident reports any of G.L.'s symptoms of cardiac arrest or the emergency treatment provided to him so that other BCSO clinical staff knew what had occurred in the event that he later developed symptoms or exhibited signs of injury. We also note that, even if we were to accept that the responding officer who applied the chest compressions believed this detainee to be "faking it" (which we do not), this explanation would not obviate the need for further medical evaluation given that this officer's belief is not based on clinical knowledge, that another responding officer documented symptoms of cardiac arrest, and that there are serious risks of injury associated with the act of applying chest compressions, even apart from any underlying cardiac arrest. And, in any event, the application of chest compressions to a person who is not exhibiting symptoms of cardiac arrest as a means of stopping a person from "faking" such symptoms would be, itself, an unreasonable use of force.

In addition to G.L., detainees D.M. and F.P.—both with pre-existing conditions—were transported to the emergency room with symptoms of respiratory distress. But in both of their cases, there was a substantial delay between the onset of symptoms and their transport to the hospital. In F.P.'s case, there was also a delay between when he first started audibly gasping for air and when his leg and arm restraints were ultimately removed and medical aid rendered by BCSO nursing staff. And in D.M.'s case—a detainee with COPD, basilar airspace disease, and bilateral carotid dissection resulting from a recent stroke—he was denied immediate access to an on-person inhaler and was not evaluated by a nurse until he began exhibiting symptoms of serious distress, when his oxygen level was already dangerously low. Fortunately, neither of these individuals required serious medical intervention at the hospital. But the failure to account and plan for the likelihood that some detainees with known medical histories would require emergency medical care put them at an unreasonable risk of serious illness or death.

We also conclude that the BCSO's provision of medical care to those detainees who were not taken to the hospital after the May 1 Incident was inadequate. In particular, the BCSO nursing staff on-site conducted only cursory evaluations of each detainee that consisted of a brief discussion, vitals, and a visual examination. When we compared the medical reports with the video footage of some of these evaluations, we noted instances where the detainees reported symptoms or injuries to nursing staff that were not captured in the medical reporting and were apparently not treated. This includes reported injuries resulting from overly tight flex cuffs and/or other injuries resulting from SRT's entry to the unit, and breathing difficulties associated with O.C. exposure, some of which were still visible or apparent to visiting attorneys days later.

Finally, our conclusion that the BCSO acted with deliberate indifference to a substantial risk of serious harm to the health of the detainees is informed, again, by several violations of the BCSO's own policies and procedures and the Detention

Standards. In particular, the BCSO did not ensure that a “qualified health care practitioner” conducted a review of the detainee’s health record for “medical contraindications” in connection with assessing whether the calculated use of force should be deployed based on the inmate’s medical history (in violation of the BCSO’s Use of Force Policy and the Use of Force Detention Standard); the BCSO did not notify the Medical Director of the situation, and the Medical Director was not consulted or otherwise involved in the emergency medical treatment decisions for G.L., F.P., D.M., and D.G. (in violation of the HSU Policy); and the BCSO failed to adequately document the injuries to the detainees and the treatments provided to them (in violation of the BCSO’s Use of Force Policy).

VI. RECOMMENDATIONS

In determining what actions to take based on the findings of this investigation, the AGO determined that the interests of the detainees, the BCSO, and the public would be best served by providing the BCSO with an opportunity to implement necessary reforms and providing regulators, legislators, and other stakeholders with an opportunity to consider these findings without delay as they fulfill their respective roles. To that end, we issue the following recommendations that, taken together, lay out both short- and long-term remedies to the issues that we identified in our investigation. In particular, we issue recommendations to DHS and the Massachusetts General Court related to the limited issue of the BCSO’s involvement in federal immigration enforcement. We also issue equally important recommendations to the BCSO, the Massachusetts Department of Public Health (“DPH”), and the Massachusetts Executive Office of Public Safety and Security (“EOPSS”) that are intended to address the systemic issues across the BCSO that we identified in our investigation.

Of course, another avenue for seeking reform is litigation alleging violations of the detainees’ civil rights and requesting injunctive relief.¹³² But we believe that the systemic changes that are necessary may best be achieved outside of litigation, and so we offer the following recommendations with that goal in mind and in the spirit of collaboration.

a. Recommendations Related to the BCSO’s Participation in Federal Immigration Enforcement

The myriad violations of law and policy described in this report pose a serious and ongoing risk of harm to the immigration detainees in custody at the BCSO. And while we seriously question whether the BCSO actually has the authority to enter into IGSA’s and 287(g) agreements in the first instance, we nevertheless recommend that

¹³² While we certainly believe that these recommendations adequately and meaningfully address the issues that surfaced during our investigation, we reserve our right to pursue litigation on some or all of these issues in the event that these recommendations are not satisfactorily implemented or addressed.

formal action be taken to terminate the BCSO's participation in federal immigration enforcement. In particular, we recommend:

Recommendation Number 1: As expeditiously as possible, DHS should terminate its IGSA and 287(g) agreement with the BCSO. In view of the clear evidence that the BCSO violated the Detention Standards, we urge DHS to terminate its partnership with the BCSO and immediately transfer all federal immigration detainees held at the BCSO to other detention facilities.

Recommendation Number 2: As expeditiously as possible, the Massachusetts General Court should enact legislation that: (1) rescinds and/or terminates the authority of the Bristol County Sheriff to enter into IGSA's for the purposes of immigration detention and to enter into 287(g) agreements with DHS; (2) terminates, effective immediately, the IGSA's and 287(g) agreements that are currently in effect; and (3) prohibits the Bristol County Sheriff from participating in federal immigration enforcement in any respect.

b. Recommendations to the BCSO

Whether or not the BCSO continues to be permitted to participate in federal immigration enforcement, our findings suggest that changes are needed across the institution to address systemic problems identified by our investigation, particularly with respect to policies and procedures, as well as training and supervision.

For these reasons, we recommend as follows to the BCSO:

Recommendation Number 3: The BCSO should review and revise its policies and procedures to ensure that they are in compliance with all applicable laws (including the relevant Detention Standards if the BCSO continues to house federal immigration detainees notwithstanding Recommendation Numbers 1 and 2). We found a number of examples of policies—for instance, the canine policy—that facially violate the Detention Standards.

Recommendation Number 4: The BCSO should adopt enhanced language access policies, procedures, and protocols to ensure that information is conveyed to LEP individuals in a manner and language that they can understand. These policies must specifically address how translation and interpretation services will be provided in the context of a large-scale disturbance, the provision of medical care (including in emergency situations), and in providing verbal directives or commands that could result in force in the event of non-compliance. As part of these enhanced policies and procedures, the BCSO should make clear that the language line should be utilized to the maximum extent possible.

Recommendation Number 5: The BCSO should adopt enhanced policies and procedures for progressive de-escalation and conflict avoidance within the context of a calculated use of force. These enhanced policies and procedures must include progressive warnings that specifically identify the means of less-lethal force that will be applied to gain compliance, and provide meaningful and multiple opportunities for detainees to come into compliance

prior to a calculated use of force. These enhanced policies and procedures must provide a mechanism to communicate with inmates (*e.g.*, phones, intercom speakers, etc.) in a manner and language that they can understand during an emergency situation or large-scale disturbance. These enhanced policies and procedures must make clear that the burden of de-escalation and conflict avoidance is always on the BCSO staff members (and, in the context of a calculated use of force, the commanding officer on-scene), and not on the inmates or detainees. These enhanced policies and procedures also must require that each attempt at conflict avoidance and de-escalation be adequately documented, including when and how those attempts were made, by whom, in what language(s), and any response.

Recommendation Number 6: The BCSO should adopt enhanced policies and procedures for medical consultation and review before, during, and after a calculated use of force. The BCSO clearly violated its existing policy that requires a medical consultation and review before a calculated use of force, and that requires notification and presence and/or involvement of EMTs and the Medical Director. The BCSO should adopt more fulsome policies and procedures that address how this review will happen in the context of a large scale disturbance, who will conduct those reviews and what information they will consider, what medical staff will be available on-scene, and what steps they will take to immediately evaluate inmates or detainees, including special needs inmates and others with relevant medical conditions, following a chemical agent exposure. The BCSO should include within this enhanced policy a mechanism to review or audit compliance after any calculated use of force.

Recommendation Number 7: The BCSO should adopt enhanced use of force reporting requirements. We observed a wide degree of variability among the incident reports prepared by responding officers. Some reports failed to document when an officer applied hands-on force and what, if any, warnings were given before the application of that force. Others mischaracterized detainee conduct (for example, stating that a detainee was being assaultive and combative when, in fact, they were simply not complying with verbal directives). And others failed to document injuries to detainees and/or the provision of emergency medical treatment. The enhanced use of force reporting requirements must address and remedy all of these deficiencies, and provide a mechanism to audit compliance and to address and/or discipline officers who fail to submit accurate and timely reports. The enhanced use of reporting should make clear that an after-action review must be conducted by a committee comprised of senior facility staff who did not participate in the use of force. The BCSO is also strongly encouraged to utilize a checklist in connection with any calculated use of force that documents all steps that must be taken prior to a calculated use of force and that is included as part of the Use of Force packet.

Recommendation Number 8: The BCSO should adopt enhanced reporting requirements for health care staff following a calculated use of force. The medical incident reports following the May 1 Incident were grossly deficient. These enhanced requirements must make clear that *all* reported injuries and symptoms are to be documented, as well as what medical treatment was provided, the reason for the denial of any medical treatment, *any*

apparent contraindications to O.C. spray, pepper-ball, or any chemical agents, any necessary or clinically indicated follow-up, and whether translation or interpretation services were provided. These enhanced requirements must also clearly document any medical or mental health reason for denying an inmate or detainee access to any essential items, such as clothing.

Recommendation Number 9: The BCSO should adopt a robust training program that is focused on the implementation of these enhanced policies and procedures. The BCSO is strongly encouraged to distribute all revised and/or enhanced policies and procedures at roll call and require all security staff to execute a written acknowledgement that they reviewed and understood those policies and procedures. The BCSO should specifically require that SRT members undergo additional conflict avoidance and de-escalation trainings focused on large-scale disturbances and on addressing LEP individuals as part of the SRT annual in-service training.

Recommendation Number 10: The BCSO should include a training module for all staff and CPS contractors who work on-site on diversity, inclusion, and cultural humility. The purpose of this training is to ensure that BCSO staff approach their duties and responsibilities with cultural competence. This training should specifically address interacting with LEP individuals.

Recommendation Number 11: To the extent that the BCSO continues to house federal immigration detainees notwithstanding Recommendation Numbers 1 and 2, the BCSO should adopt a training module as part of its annual in-service training on federal immigration detainees. This module must emphasize that federal immigration detainees are civil detainees and are to be treated accordingly, and include, at a minimum, topics relating to LEP detainees and the relevant ICE Detention Standards.

Recommendation Number 12: To the extent that the BCSO continues to house federal immigration detainees notwithstanding Recommendation Numbers 1 and 2, the BCSO should immediately remedy all deficiencies identified in the recent DHS ERO inspection report¹³³ and, in particular, those that relate to special management inmates, use of force, and medical care.

Recommendation Number 13: The BCSO should retain an external auditor or consultant to assess its compliance across the institution with all relevant laws, policies, and procedures, including those that relate to the use of force, special needs inmates, cell extractions and forced moves, canines, special management units, emergency situations, and the provision health care. In the interests of promoting transparency and accountability, the BCSO should provide the results of this audit or compliance review to the public.

¹³³ Office of Detention Oversight, Compliance Inspection, Enforcement and Removal Operations, Boston Field Office, Bristol County Detention Center, North Dartmouth, Massachusetts (July 20-23, 2020), https://www.ice.gov/doclib/foia/odo-compliance-inspections/bristolCoDetCntrNorthDartmouthMA_Jul20-23_2020.pdf.

Recommendation Number 14: The BCSO should ensure that all members of the SIU receive adequate training in proper interviewing and investigative techniques in order to conduct meaningful internal investigations, and that all policies, procedures, and protocols associated with conducting internal investigations are in keeping with best practices.

Recommendation Number 15: The BCSO should revise and update its policies related to the chain of command, including the SRT chain of command, to make clear that officers will not be disciplined for disobeying actual or perceived unlawful orders. The BCSO should also adopt a bystander intervention policy that obligates officers to intervene in instances of unlawful or excessive force. This policy should be clear that bystanders will not be disciplined for intervening or attempting to intervene in situations involving actual or perceived excessive force, but will be disciplined for failing to do so.

c. Recommendations to Other State Agencies

We also acknowledge that DPH and EOPSS have regulatory oversight over the BCSO. Therefore, in light of the seriousness of our findings, we also recommend as follows:

Recommendation Number 16: DPH should conduct a robust and thorough review of the BCSO's compliance with 105 CMR 205.000 (minimum standards for medical records and the conduct of physical examinations in correctional settings), and take any necessary corrective action. We acknowledge that DPH inspected the facility in June 2020 to assess the BCSO's compliance with 105 CMR 451.00 (minimum health and sanitation standards) and identified some health and safety violations. Through our investigation, however, it became clear that inmate medical records may not be accurate or complete, and may not document all reported injuries and symptoms, all medical treatments or emergency aid rendered, and all clinical decision-making. We also found a wide variability among BCSO staff in understanding which inmates and detainees qualify as "special needs inmates" under BCSO's policies, and how those types of special needs are to be documented. For example, the Director of Medical Services defined "special needs inmates" as essentially confined to those individuals who need ambulatory or sensory assistance, which is inconsistent with the BCSO's policies and procedures. This poses a risk to those detainees with chronic medical conditions or "invisible illnesses" that their needs will not be recognized or addressed in emergency situations. As part of this review, DPH should specifically audit detainee and inmate medical records to ensure that all special needs detainees and inmates have been properly identified.

Recommendation Number 17: EOPSS should conduct a robust and thorough review of BCSO's policies and procedures to ensure that they meet the minimum regulatory requirements, including specifically those policies that address use of force, emergency management situations, cell extractions and forced moves, the provision of medical care, and special needs inmates. We found evidence indicating that some of the BCSO's policies and procedures may not sufficiently address and/or are inconsistent with 103

CMR 900.00 through 979.00. EOPSS should take all necessary steps to ensure that the BCSO's policies and procedures meet these minimum regulatory requirements. EOPSS should also audit the BCSO's compliance with these standards, and take any necessary corrective action. In particular, we recommend that EOPSS audit the BCSO's use of force reporting and evaluate the efficacy and sufficiency of the BCSO's training materials related to the use of force. For example, we found several examples of use of force reporting that fell below minimum regulatory requirements and where no corrective action had been taken by the BCSO with respect to those officers relative to those reports. And as to training, for example, while the BCSO's canine policy appears to comply with minimum regulatory requirements for the use of canines in county correctional facilities, canines were deployed in a cell extraction in violation of 103 CMR 924.10 and we found evidence that some BCSO canine officers believed that canines could be used in cell extractions in certain situations. Finally, we recommend that, as part of this review, EOPSS assess whether the appropriate BCSO personnel have been adequately informed of, and trained in, the institutional response plan for large-scale disturbances.