July 25, 2014

Jonathan M. Smith, Chief  
U.S. Department of Justice  
Civil Rights Division  
Special Litigation Section, PHB  
950 Pennsylvania Avenue, NW  
Washington, D.C. 20530

Re: Complaint Against the County of San Diego Department of Probation  
Regarding the Excessive Use of Pepper Spray and Other Civil Rights Violations in San Diego Juvenile Detention Facilities

Dear Chief Smith:

The Youth Law Center, California Rural Legal Assistance, Inc., and San Diego-based community organizations, El Grupo, the National Association for the Advancement of Colored People (NAACP) - San Diego Branch, Border Angels, Latinos Organizing for Action, Alliance San Diego, CSA San Diego County, American Friends Service Committee - San Diego, San Diego La Raza Lawyers Association and Kali Konnect, write to file this formal complaint and to request the Department of Justice’s Special Litigation Section (DOL) to investigate the use of Oleoresin Capsicum spray (“OC spray” or “pepper spray”) and other behavior management practices used in San Diego County juvenile detention facilities. OC spray is routinely used in these facilities in violation of youths’ constitutional rights to be free from excessive force and not to be incarcerated in conditions that pose a substantial risk of serious harm. This harmful practice not only violates youths’ rights, but also fosters a punitive, dehumanizing atmosphere that runs directly counter to the rehabilitative goals of the juvenile justice system.

Further, a review of incident reports and other documents from San Diego County juvenile facilities has raised serious concerns about other policies and practices at these facilities that violate youths’ civil and constitutional rights. Juvenile detention staff routinely impose solitary confinement as a disciplinary measure, even for mentally ill and suicidal youth. The County’s treatment of young people who are at risk of self-harm is especially troubling. Youth who express an intent to self-harm are often isolated and restrained, and incidents of self-harming behavior are sometimes treated as disciplinary matters. Certain practices at San Diego County juvenile facilities also violate the Prison Rape Elimination Act, 42 U.S.C. § 15601 et seq. (PREA). For example, the staffing ratios at San Diego County juvenile detention facilities fall below the minimum requirements of PREA, and youth who are placed on suicide watch have been asked to disrobe by staff of the opposite gender.
All young people detained in San Diego County juvenile facilities deserve protection from the harms caused by the routine and indiscriminate use of OC spray and other behavior management practices that violate their rights. In addition, as legal, civil rights and community-based advocacy organizations, we are particularly concerned that the youth subjected to what we consider inhumane and abusive practices are disproportionately youth of color, in particular, Latino and African American youth. While Latino and African American youth make up 53% of San Diego County’s total high school enrollment, they comprise 81% of all youth detained in the county’s juvenile detention facilities.1 The San Diego County Probation Department (SDPD) has not assessed the language status of detained youth,2 but juvenile court school data confirms that a significant number of detained youth are likely to be limited English proficient (LEP) or come from homes where English is not the primary language.3 Many Latino, African American and LEP youth come from communities of poverty and have already experienced significant trauma in their lives. They should not be subjected to further trauma or dehumanizing practices while under the care and supervision of the SDPD.

The complainants request that DOJ investigate the treatment of young people in San Diego County juvenile detention facilities under the authority granted by the Civil Rights of Institutionalized Persons Act, 42 U.S.C. § 1997 et seq. (CRIPA). We ask DOJ to investigate, and to order SDPD to eliminate the use of pepper spray and other behavior management practices that violate youth’s civil and constitutional rights.

I. Introduction

Concerns over the use of OC spray in San Diego County juvenile detention facilities have been repeatedly brought to the attention of SDPD over a period of many years. In 2006, an advocacy group investigated the excessive use of pepper spray in San Diego facilities and exacted promises of reform. However, any changes that may have occurred did not result in long term improvement.4 In May 2012, San Diego City Beat initiated a series of media reports


2 It is sobering, given its obligations under Title VI of the Civil Rights Act of 1964, that the SDPD has not done an assessment of the LEP status of youth under its care and supervision. SDPD also confirmed that no documents existed that included provisions for LEP youth with respect to use of force and pepper spray, including any analyses of how many LEP youth are detained and in what living units, how many staff who speak the language of LEP youth were assigned to living units where they were housed, and how use of force incidents involving LEP youth were handled.

3 Approximately 35% of all youth enrolled in San Diego County juvenile court schools are identified as LEP or English Learner students, 54% come from homes where English is not the primary language, and Spanish is the primary language of 98% of the LEP groups. CDE DataQuest Report, Selected School Level Data- San Diego County—San Diego Court-(3710371-0128538 (2013-14); CDE DataQuest Report, English Learner Students by Language by Grade—San Diego County Court (3710371-0128538 (2013-14), http://data1.cde.ca.gov/dataquest/.

4 David Hasemyer, Reform at juvenile halls, San Diego Union Tribune (Nov. 12, 2006), http://legacy.utsandiego.com/uniontrib/20061112/news_1m12juvie.html.
detailing the results of its investigation into the rampant use of OC spray at these facilities. The investigation revealed that in 2011, the SDPD recorded 461 incidents involving OC spray – an average of 1.26 uses of OC spray per day.\(^5\) At one facility, the East Mesa Juvenile Detention Facility, OC spray was used, on average, more than five times a week.\(^6\) Of the 461 incidents recorded in 2011, 67 – about 15% – did not involve fights.\(^7\)

Spurred by these reports of excessive OC spray use, Victor Torres and a coalition of community organizations, along with the Youth Law Center, approached the SDPD administration in October 2012 to begin a dialogue on the use of OC and the improvement of behavior management practices in juvenile detention. SDPD expressed its commitment to facility safety and interventions that focused on building rapport and addressing the needs and delinquency factors of detained youth, but remained steadfast in its belief that using OC is an effective and necessary tool to reduce violence and improve safety in San Diego’s juvenile detention facilities. Throughout the course of the dialogue SDPD took the position that OC was not used as a behavior management tool, and claimed to have made efforts to reduce OC use. This dialogue culminated in a meeting in April of 2013 where SDPD explained a series of changes in training and practices designed to reduce violence in its facilities that it believed would in turn continue to reduce the use of OC. However, SDPD remained and remains steadfast in its position that its existing policies and practices related to the use of OC spray are valid and necessary.

After meeting with SDPD in April 2013, Youth Law Center filed a formal request for public records to obtain incident reports of OC spray use and other documents relating to its use. After nearly a year of extensive discussions and negotiations with County Counsel, the Center obtained data, redacted incident reports, grievances, policies and other documents related to OC spray use and behavior management practices. Youth Law Center analyzed the incident reports for all San Diego juvenile facilities for 2012 and 2013.\(^8\) The analysis revealed a use of OC spray that is shocking both in the incidence of use, and the circumstances under which it is employed. Although the reported incidents of OC spray have declined over the last three years,\(^9\) SDPD used OC in 320 incidents in 2013 alone. The incident reports confirmed that it is utilized in a manner

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\(^6\) *Id.*

\(^7\) *Id.*

\(^8\) San Diego has five secure juvenile facilities. Two of those facilities – Kearny Mesa Juvenile Detention Facility and East Mesa Juvenile Detention Facility – are juvenile halls. Both Kearny Mesa and East Mesa house youth of both genders. Three of San Diego’s facilities – Girls Rehabilitation Facility, Juvenile Ranch Facility, and Camp Barrett – are secure juvenile rehabilitation facilities. The investigation focused on OC spray use at Kearny Mesa and East Mesa facilities. However, the incident reports obtained through the Public Records Act request reveal that OC spray is used in all of San Diego’s juvenile facilities.

\(^9\) Annual incidents of OC use in all facilities declined from 461 in 2011 to 394 in 2012 and 320 in 2013. The average daily population has declined as well from 764 in 2011 to 750 in 2012 and 678 in 2013. *California Board of State and Community Corrections, Juvenile Detention Profile, 2\(^{nd}\) Quarter Survey Results.* http://www.bscn.ca.gov/s_fsojuvenile detentionprofile.php.
and with a frequency that results in injury and substantially departs from accepted juvenile detention practice and standards. In short, the documents uncovered a pattern and practice of OC use that is totally incompatible with SDPD’s expressed commitment to facility safety and interventions that focus on building rapport and addressing the needs and delinquency factors of detained youth.

As disturbing as the sheer number of OC incidents is, the numbers do not tell the whole story. In San Diego’s juvenile halls, staff use OC spray as an all-purpose behavioral management tool. The result is that juvenile hall staff deploy OC spray in manifestly improper and dangerous situations. Pepper spray has been used not only to stop fights and assaults, but also in situations where a detainee has failed to follow instructions, in room extractions, and in several instances, when a suicidal or self-harming detainee has refused to kneel, change into a safety gown, or submit to a strip search. In many instances, and in virtually every instance involving a fight or an assault, staff resort to OC spray with no attempt or with only minimal attempts to de-escalate the situation. Usually, the only de-escalation of a fight or assault that is attempted is to give the “cover” command.10 It is not uncommon for youth not involved in the incident to be “oversprayed,” especially when the incident occurs in a quad or during recreation. Often, OC spray alone is insufficient to resolve an incident. In sixty-seven cases at Kearny Mesa in 2012, hands-on intervention was used after OC spray was deployed. The incident reports reveal situations in which youth with medical contraindications, such as asthma, have been sprayed and where youth as young as twelve were sprayed.

SDPD’s use of OC spray as a first resort and its routine deployment of OC spray in juvenile facilities represent a radical departure from widely-accepted professional standards. OC spray is rarely used in juvenile detention facilities around the country. A 2011 national survey of correctional administrative staff by the Council of Juvenile Correctional Administrators (CJCA) revealed that only 12% of agencies surveyed authorized staff to carry pepper spray in secure facilities and only 29% of agencies authorize the use of chemical restraints at all.11 A number of practice standards call either for the outright prohibition of OC use in juvenile facilities or for its use to be restricted to extreme situations to prevent serious injury.12

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10 The orientation manual provided to young people in San Diego facilities describes the cover command this way: “Whenever there is a problem or an emergency, such as a fight, staff may command the group or individual to ‘COVER.’ When you hear the ‘COVER’ command, you must immediately come to a kneeling position with your hands clasped behind your head so that the arms cover the side of your head and face area. Your head is pushed down towards your knees as far as possible and your feet are crossed. This ‘COVER’ position is held without talking or movement until the officer gives further direction. You basically ‘cover’ yourself up so that if unit officers need to use OC spray on someone for fighting, you will be protected.” (Exhibit 1.)


12 See infra Section IV.C.
The increasing public scrutiny of the use of OC spray appears to have resulted in some reduction in the number of OC spray incidents in 2013.\(^\text{13}\) Even so, the number of OC spray incidents in 2013 is extremely high, especially considering the relatively low number of juvenile detention facilities nationwide employing OC spray. Moreover, SDPD has made no changes to its written policies regarding OC spray use and use of force that would limit the frequency or manner of OC use in the future. SDPD’s lack of recognition that its OC policies contradict its expressed commitment to facility safety and youth-centered behavioral interventions strongly suggests that the frequency of OC use will remain high and is likely to increase when the spotlight dims. There is little reason to believe that San Diego has effected any substantive change in its “spray first, write a report later” culture and every reason to believe that young people detained in San Diego juvenile facilities are at continued risk of being exposed to inappropriate and dangerous levels of OC spray use.

Furthermore, although the review of incident reports focused on the use of OC spray, in the course of this review other policies and practices were discovered that raise serious concerns. These issues include solitary confinement, the treatment of youth with mental health issues, non-compliance with PREA, staffing ratios and cross-gender supervision. These issues are discussed below.

II. **Examples of Inappropriate Use of Pepper Spray**

A. **Use of OC Spray on Youth at Risk of Suicide or Self-Harm**

Perhaps the most disturbing incidents involve the use of pepper spray by San Diego detention staff on youth in response to threats or acts of self-harm.\(^\text{14}\) It is clear from the documented incident reports that staff have *carte blanche* to use OC spray on young people who are either threatening suicide or who are attempting to harm themselves. The following are summaries of several self-harm related instances documented by staff involving the actual use of pepper spray.\(^\text{15}\)

- A minor stated that she felt suicidal to her attorney, who then informed detention staff. Staff explained to the minor the suicide watch procedure, which, regardless of the circumstances, involves removing a minor’s clothing, a strip search, and donning a suicide smock. Four staff were present at the time, one of whom was male. The girl, who was in her cell and seated on her bunk, twice refused to take off her clothes. Based on this refusal alone, staff determined that the use of OC spray was warranted.

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\(^{14}\) Staff also use the threat of OC spray to manage the behavior of youth at risk of self-harm. See infra Section IV.D.
\(^{15}\) SDPD’s decontamination process following the use of OC spray is not discussed in this complaint. However, the incident reports and policies for the Kearny Mesa and East Mesa facilities reveal inconsistencies regarding the options offered to youth when sprayed. At Kearny Mesa youth are offered the option of being sprayed in the face with a water bottle and being placed in front of a fan. At East Mesa youth are also offered the option of showering. This inconsistency raises concern about the decontamination process in general.
calling out “cover, cover OC,” staff sprayed a burst of OC toward the minor’s face and closed the door to the minor’s cell. After two minutes, staff asked the minor if she would cooperate. When the minor refused, staff sprayed her in the face again and closed the door. As the minor remained seated on her bunk, her face covered by her sweatshirt, staff again asked her to cooperate. When she refused, staff opened the door again, sprayed the minor’s face with OC spray, and closed the door. The girl then vomited. Nevertheless, “cover, cover OC” was called again, and staff sprayed the girl for a fourth time. After she had been sprayed four times, the girl assumed the cover position. Staff opened the door and instructed her to crawl out of her room and lie on her stomach and she complied. According to the incident report, throughout the entire process “the minor remained seated on her bunk in a non-threatening manner,” and “did not display any physically aggressive behaviors nor did she use any aggressive verbiage [sic] other than stating that she was not going to remove her cloth[e]s.” The minor was cuffed. Staff removed her clothes, her bra and shirt were cut off, she was strip-searched, and she was dressed in a suicide prevention gown. As a result of refusing to voluntarily remove her clothes, the minor was also given forty-eight hours of room confinement. (Exhibit 2.)

- A minor placed rubber bands in her mouth, stated that she wanted to kill herself, and refused to speak to staff. Staff called the doctor, who was not available as she was speaking with the minor’s mother. While apparently waiting for the doctor to arrive, staff watched as the girl put rubber bands around her neck, cut her wrists with her fingernail, wrote “I want to die, I’m tired of life, FU” on the wall with her blood, banged her head against the wall, threw and broke her sandals, and cut the inside of her forearms. Staff asked the girl, who was in her cell, to remove her clothes and informed her that if she would not remove her clothes, staff would cut them off. The girl refused to remove her clothes and stated that she would not allow them to be taken off. At least one staff member present was male. Approximately forty minutes after the incident began, staff called “cover,” and sprayed the minor. Staff then entered the cell and assisted the minor to the ground. When staff handcuffed the girl and chained her legs together, two staff members held her as two other staff members cut her clothing off and placed her in a suicide watch gown. The minor was later given her medication and was placed in an isolation room for approximately five hours. (Exhibit 3.)

- A minor who was on suicide watch was observed with a long piece of string. When asked by staff to turn over contraband, she stated that she had none. She was taken to the restroom and when she saw staff begin to search her cell, she rushed back to her cell and attempted to enter while it was being searched. Staff intercepted her and told her she could not go in. Staff found cardboard, several brown paper towels and a couple of pieces of string. She had also written on the wall with her own blood. The minor entered

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16 One staff member’s account of the incident states that the girl was sprayed five times, not four.
her room with paper towels in hand. Staff asked for the paper towels from her and she refused, became verbally aggressive, and began to rub the paper towels on her arms to try to open up previous cuts. She became increasingly agitated as staff continued to speak to her, and eventually, she ran up to the door and said “Ok you want to do this” with her fist clenched. Staff then gave the “cover, cover OC” command, sprayed the minor in the face, and closed the door to the cell. The minor remained standing and began to pull string from her blanket. After the girl refused to relinquish her blanket, staff again gave the command to cover. The girl covered her face with her hands as staff sprayed her again and closed the door. When the girl continued to refuse to cover or relinquish her blanket, four staff members entered the room to cuff her. The girl resisted, attempting to hit her head on the concrete bunk. She was handcuffed and taken to the dayroom. The minor was later given her medication and forty-eight hours of room confinement as a result of the incident. (Exhibit 4.)

- A minor who was on suicide watch refused to take off her socks, as was required by the protocol, and stated “I will fight you all.” The girl faced the wall, and staff called “cover.” The minor responded that she would not cover. Staff called “cover OC” and sprayed her face with OC. The minor turned to staff with her hands in front of her, and staff grabbed her, took her to the floor, and handcuffed her. She eventually stopped screaming. She was taken to her room, strip searched, and was later given her medication. (Exhibit 5.)

- A minor who was on suicide watch refused to put on his suicide gown after taking a shower. After being told that he could not be taken off of suicide watch status, he began to argue. Staff told the minor to go to his room and when he refused, gave the cover command. When the minor did not comply with the cover command, staff sprayed him in the neck, grabbed the towel the minor had wrapped around his head, and sprayed him in the face. The minor went to the cover position and staff handcuffed him. Staff recommended that he be given forty-eight hours of room confinement for the incident. (Exhibit 6.)

- A minor was placed on suicide watch after indicating that she wanted to hurt herself. She was strip-searched, dressed in a suicide gown, and placed in a different room. The minor began ripping the Velcro off of the suicide gown and wrapping it around her neck. At that point, five staff members entered the room, handcuffed the minor, took the gown, and left the girl with a suicide prevention blanket. When the girl began to rip up the blanket, staff entered the room and took it, leaving her naked and without any form of covering. The girl then began peeling paint from the wall and using it to cover the window and scratch her arms. Staff decided to move her to a different room and ordered her to cover. When she did not comply, they sprayed her in the face and closed the door. The door was opened when the minor agreed to cover; she was handcuffed. After being handcuffed, she began to resist, yelling and spitting. She was taken to an isolation room, where she was allowed to hit herself for about fifteen minutes. The minor was given forty-eight hours of room confinement as discipline for this incident. (Exhibit 7.)
• A minor became agitated in the evening and began to jump on the sink in her room and cover the window with paper. The minor was instructed to go into the cover position and complied. She attempted to hide some paper under her legs, and staff handcuffed her and moved her out of her room. When she was placed in a different room and staff removed her handcuffs, the minor disrobed, began crying, and threatened to kill herself. Staff told the minor to go into the cover position and stated that if she was not in the cover position when the door was opened, staff would spray her. When staff opened the door, the minor popped up from the cover position and grabbed a sweatshirt to protect her face from the OC spray. Staff sprayed her twice in the back of the neck. The minor went to the cover position and staff closed the door to the room for about five minutes. The minor was given forty-eight hours of room confinement for this incident. (Exhibit 8.)

• A minor was upset because she received markdowns. A staff member talked to her, and the minor responded belligerently toward the staff member. The girl stated that she would hurt or kill herself and began to scratch her arm and pre-existing cuts. Five additional staff members responded, including one male staff member. The staff member continued to speak with her, but the minor continued to verbally threaten the staff member and refused to comply with the suicide watch procedure. The minor stated that she would stay seated in the hallway. A staff member called “cover” twice. When the minor raised her arms, another staff member sprayed her in the face with OC, apparently without warning. Staff directed the minor to lie down and, when the minor did not comply, staff “placed” her in the prone position, holding down her arms and legs and handcuffing her. When the minor began spitting, staff held down her head and placed a “spit sock” on her head. The incident report notes that the minor had a history of cutting herself and had been placed on suicide watch in the past. The incident report also notes that “[a]lthough the minor did not comply with the cover command as directed, she did not pose an immediate threat.” (Exhibit 9.)

• A minor who was on suicide watch got into a fight with another detainee. Staff ordered both minors to go to cover, and sprayed them both in the face when they continued to fight. (Exhibit 10.)

• A minor was placed on suicide watch after yelling that he wanted to kill himself. A female staff member asked the minor to comply with a strip search. The minor repeatedly refused to comply with a strip search and refused to cover when ordered to. Staff gave the “cover, cover, OC” command twice. When the minor refused to comply, staff sprayed his face with OC. The minor continued to refuse to cover, and staff physically intervened to get him on the ground and handcuffed. The minor resisted, biting and kicking. Eventually, the minor began to spit blood on the floor and staff applied a spit sock. The minor was sent to a suicide prevention room, and when he calmed down, staff cut off his clothes and dressed him in a suicide prevention gown. The minor received two days of room confinement for “health and safety violations and for not following instructions.” (Exhibit 11.)
These examples illustrate the fact that SDPD uses OC to manage the behavior of youth at risk of self-harm. San Diego Probation staff have used OC spray on youth who were self-injuring, on suicide watch and refusing to disrobe at the request of opposite gender staff members, or at risk of self-harm and vomiting from repeated application of OC spray. In three instances, staff not only sprayed a young person in the confined space of her room, but also shut the door to exacerbate the effects of the OC spray. In one incident, a staff reviewer discussed efforts to avoid exposing fellow staff members to OC spray, while demonstrating little concern about spraying a suicidal girl with OC – not once, but at least four times.

DOJ has criticized the use of OC spray in juvenile detention facilities in similar situations. In a 2003 findings letter resulting from an investigation of Los Angeles County juvenile halls, DOJ expressed particular concern as to the use of pepper spray on self-injuring youth, and stated that lower levels of force combined with counseling would have been appropriate.\(^1^8\) DOJ expressed similar concerns in its findings letter detailing a 2003 investigation of Mississippi’s Oakley and Columbia training schools, objecting to the use of pepper spray on youth who were making suicidal gestures and recounting one incident in which a female detainee was sprayed for refusing to take off her clothes.\(^1^9\) Similarly, here, the San Diego incident reports confirm that SDPD has deployed pepper spray on youth engaging in self-harm and on young people who were refusing to take off their clothing.

DOJ’s concern about such pepper spray use are consistent with accepted professional practice. OC spray should never be used in response to a detainee’s threats of self-harm or self-harming behavior. Statements about suicide and self-harming behavior should be taken seriously by staff and should trigger consultation with medical professionals and counseling. They should not be a trigger for punishment or for the use of force. Experiencing suicidal thoughts or engaging in self-harm is inherently traumatic. The use of pepper spray on such youth only worsens the trauma that they are experiencing and risks further alienating young people – making it far less likely that they will inform staff the next time they are thinking about hurting themselves. San Diego’s regular use of OC spray in such manifestly improper situations is deeply troubling.

B. Use of OC Spray on Youth for Failing to Follow Instructions or for Verbal Defiance

San Diego County also deploys OC spray against young people simply for failing to follow instructions or for being verbally defiant. In some instances, the young people involved have not physically harmed, or even threatened to physically harm, anyone. The review of 2012 and 2013 incident reports from Kearny Mesa and East Mesa juvenile detention facilities, reveals many instances in which staff justified their use of OC spray by stating that the detainee had


\(^{19}\) Findings Letter from Ralph F. Boyd, Jr., Assistant Attorney General, to Ronnie Musgrove, Governor of Miss. (June 19, 2003) at 11.
failed to follow instructions or had been verbally defiant in some way. This practice appears to be a particularly significant problem at Kearny Mesa.

The review of these incidents demonstrates that in many cases, OC spray was used in the absence of any threat to staff or detainee safety. For example, in one case, a detainee refused to return to her room and used profanities towards staff. After giving the “cover OC” command, staff sprayed the minor in the face. A supervisor’s review of the incident found this use of OC justified because the minor had failed to comply with the “cover OC” command and because the minor’s profanity and verbal defiance allegedly presented a threat to officer safety. (Exhibit 12.) In another incident, staff sprayed a twelve-year-old in the face after he refused to take a seat during recreation, and instead remained standing against a wall and swearing. The minor also received forty-eight hours of room confinement. (Exhibit 13.)

The incident reports include dozens of similar incidents. Described below are several incidents that occurred at Kearny Mesa in 2012 and 2013:

- Staff sprayed a minor because she refused to cover, walked towards a hallway “in a defiant motion,” used profanity, and turned toward staff “in a threatening manner.” The minor received forty-eight hours of room confinement as punishment. (Exhibit 14.)

- Staff decided to remove a minor from his room. Staff informed the minor that he would be sprayed with OC spray if he was not in the cover position when the door to his room was opened. When staff opened the door, staff observed that the minor “was responding to the directive very slowly,” so staff sprayed the minor in the face and closed the door. A staff review found the use of OC inappropriate because the minor was sprayed even after he was fully in the cover position. (Exhibit 15.)

- Staff sprayed a minor because the minor “hesitated going to the cover position.” A staff review found the use of OC appropriate because the minor had a history of violence and, according to the reviewer, staff reasonably believed that the minor was not going to cover. The minor received forty-eight hours of room confinement. (Exhibit 16.)

- Staff sprayed a minor who sat up from the cover position and swung his arms. Staff did not give a “cover OC” warning prior to spraying. The minor received seventy-two hours of room confinement. Two youth who were not involved were oversprayed. (Exhibit 17.)

- Three staff members simultaneously sprayed a minor in the face. The minor stood up after being in the cover position for two minutes with her fists clenched by her shoulders and refused to return to cover. The minor was later placed on suicide watch and given medication and seventy-two hours of room confinement. (Exhibit 18.)
• A minor flipped over a table and yelled at staff to spray her. When staff ordered her to cover, the minor covered her face with her shirt. Staff sprayed her in the face twice. The minor received forty-eight hours of room confinement. (Exhibit 19.)

• Two minors were staring at each other. Staff instructed all minors to their seats, and all minors, including the two who were staring at each other, complied. When staff gave the command to cover, they continued to stare at each other. Staff sprayed both in the face. Both minors received forty-eight hours of room confinement. (Exhibit 20.)

• A minor performed calisthenics “in an inappropriate manner by swaying her hips sexually.” The minor was instructed to stop, and eventually, to sit down. The minor refused requests to sit down where she was asked to, instead sitting in a different area of the quad. When staff ordered her to cover, she lay on her side with her hands on her face and then went into a push-up position. Staff sprayed her using a large MK-9 canister. A staff review found that the spraying staff member should have handled the situation better by calling for backup earlier and using a smaller can of OC. The review stated that the minor was not a threat when she lay down on the ground, especially as the minor was small in stature and young, and the staff member was six feet away. (Exhibit 21.)

• Staff sprayed a minor who refused to return to his room and began to use profanity toward staff. The minor was apparently seated when staff sprayed him. The minor received 48 hours of room confinement. A staff review of video stated that the minor did not appear to be attempting to stand up; the review stated that the incident would be investigated and that that there appeared “to be some issues.” (Exhibit 22.)

• A minor took more grievance forms than was permitted. She went to cover outside her door without being instructed to, then stood up and began running down the hall. Staff sprayed her without warning as she ran by.20 The minor was given forty-eight hours of room confinement. A staff review found the use of spray appropriate because the minor was “unpredictable” and her intentions were “unknown.” (Exhibit 23.)

• A minor was upset after a difficult visit with her mother. She began throwing soap bottles and shower mats at staff, but did not actually hit staff. The minor was sprayed in the face and received seventy-two hours of room confinement. (Exhibit 24.)

• A minor went to the bathroom and refused to leave. Eventually, the minor stood up and started down the hallway. Staff called the minor to cover, but he did not respond. Staff sprayed the minor in the face. The minor turned down a different hallway, where staff grabbed him by his shoulders and “spun” him to the ground. The minor received forty-eight hours of room confinement. One staff reviewer stated that the minor did not pose a threat while on the toilet and that the use of OC spray could have been avoided; another

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20 The incident report includes conflicting descriptions by staff present as to whether any warning was given.
stated that the minor did pose a threat. The incident was sent to the use of force committee. (Exhibit 25.)

- A minor refused a request to go to his room and instead began walking to a different hallway, towards a staff member. When the minor did not go to cover, staff sprayed him in the face. In the incident report, staff stated that he felt threatened because of prior statements the minor had made to him. The minor received forty-eight hours of room confinement. (Exhibit 26.)

- A minor became upset, mistakenly believing that he was going to be penalized for sitting out recreation. The minor began to stand up and did not follow a command to assume the cover position. Staff sprayed him in the face. The minor received seventy-two hours of room confinement. (Exhibit 27.)

- A minor walked to the water cooler without permission. When staff threatened to spray the minor if he did not sit down, the minor sat down. After sitting for a while, the minor stood up and began walking toward a group playing handball. Staff gave the command to cover. When the minor did not go to the cover position, staff sprayed him. As the minor stood and rubbed his face, he was ordered again to go to cover. When he did not respond, staff grabbed him by the shoulder and “took him to the ground.” The minor received seventy-two hours of room confinement. The staff reviewing the incident report observed that there was no indication that the minor was threatening during the incident; the report apparently was forwarded up the chain of command. (Exhibit 28.)

- A minor began verbally threatening another detainee. The minor began walking toward the dayroom, despite staff instructing her to return to her room. When the minor entered the dayroom, she was instructed to go to cover and staff sprayed her with an MK-9 canister. The minor was later strip searched and provided a suicide gown. (Exhibit 29.)

The above is a sampling of the many instances in which OC spray was used in response to a failure to follow instructions, verbal defiance, or other behavior that did not involve a serious and imminent risk of physical injury. The pervasiveness of such incidents demonstrates that staff at San Diego County juvenile detention facilities use OC spray as a method of behavior control, rather than as a last resort to prevent physical injury. Indeed, the slight provocation that led staff to use OC spray in some cases raises the question of whether OC spray is sometimes being used as punishment—a use of OC spray that is clearly unconstitutional, as discussed below.

DOJ has previously expressed concern when OC spray is used to obtain compliance with staff orders and in the absence of a threat of physical injury. In a findings letter detailing an investigation of the Indianapolis Juvenile Correctional Facility, DOJ highlighted an incident in which two girls were sprayed for failing to submit to orders to be handcuffed, noting that the
girls did not pose a threat. Similarly, in a findings letter discussing practices at the Terrebonne Parish Juvenile Detention Center in Houma, Louisiana, DOJ pointed to an incident in which staff sprayed a youth for refusing to proceed to the isolation unit.

C. The Use of OC Spray for Room Extractions

San Diego County uses OC spray to remove non-compliant detainees from their rooms. The following are summaries of several instances documented by staff involving the use of pepper spray for room extractions:

- A minor covered his window completely with wet pieces of paper in the morning and refused to remove it. At the beginning of the afternoon shift, staff asked the minor if there was anything they could do to help him; the minor replied that there was not. Staff told the minor that he should comply with the cover command, which he refused to do. Staff opened the door flap and sprayed OC “to gain compliance.” The “extraction team” then opened the door, pulled the minor out, placed him on his stomach, and handcuffed him. (Exhibit 30.)

- A minor refused to leave his room to go to recreation. The minor remained in his room, reading his rule book, despite being asked multiple times to leave. Staff called for the minor to cover, but he refused to. After staff called “cover OC” twice, staff sprayed the minor’s face with OC and closed the door for two minutes. The minor was handcuffed and removed from the room. Nothing in the report indicates that the minor was violent or threatening at any point during the incident. (Exhibit 31.)

- A minor covered his window with toilet paper and toilet seat covers and refused to remove them, urging other minors to do the same. Staff decided to extract him from his room and gave the “cover, cover OC” command. When the minor did not comply, staff sprayed OC through the door flap and closed the flap. When staff opened the door, they ordered the minor to cover. The minor refused and used profanity; staff entered the room, assisted minor to the floor, and handcuffed him. (Exhibit 32.)

- A minor was sent to his room after being sent out of the classroom. Staff decided to move him to a different unit. As the minor sat on the floor against the bed, staff yelled “cover” and the minor responded by cursing. Staff called “cover, OC” and sprayed OC at the minor’s face. The minor then moved into the cover position and was removed from the room. (Exhibit 34.)

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21 Findings Letter from Thomas E. Perez, Assistant Attorney General, to Mitch Daniels, Governor of Ind. (January 29, 2010) at 20.
22 Findings Letter from Thomas E. Perez, Assistant Attorney General, to Michel Claudet, President of Terrebonne Parish (January 18, 2011) at 11.
23 Please note there is no Exhibit 33.
• A minor apparently attempted to booby-trap her room and refused to take “cover” when staff ordered her to. Staff sprayed the minor and closed the door to her room. Staff sprayed again two minutes later, and then again two minutes after that, closing the door after each spray. The minor sat under her desk and covered herself with a blanket; staff again sprayed into the room and closed the door. Staff then entered the room and pulled the minor out from under the desk, pinned her shoulders, legs, and head to the floor, and slid her out of the room. When the minor refused to remove her arms from her clothing to be handcuffed, staff applied pressure to her “mandibular pressure point”24 twice to gain compliance and cut sections out of both of the minor’s sleeves. The minor was handcuffed and decontaminated while being held in shoulder control. The Watch Commander decided to place the minor in a suicide gown. Staff held the minor down and cut her clothing off. Staff covered the minor with a suicide gown before removing her underwear and strip searching her. The minor received seventy-two hours of room confinement. (Exhibit 35.)

• A minor covered his window and refused to uncover it. After speaking to him several times, staff decided to extract him from room. Staff opened the door and sprayed into the room. When the door was opened, the minor threw his blanket and pillow at staff and staff forced him to the ground. (Exhibit 36.)

• A minor who had been served dinner in his room refused to return his tray. Eight staff members convened at his door and called the minor to cover several times. Staff sprayed the minor in two bursts; three minutes later, staff sprayed two additional bursts. About five minutes later staff entered the room and removed the minor, who was standing on his bed holding the tray. (Exhibit 37.)

DOJ has previously expressed concern about similar uses. In a 2008 investigation of Los Angeles camps, DOJ noted that on one occasion, staff sprayed into a room and then shut the door.25 This is a common tactic when staff use OC spray in room extractions, and it is a tactic that is specifically permitted by the SDPD’s written policies regarding the use of OC spray. Although there were no reports that OC spray was used in a room extraction in either Kearny Mesa or East Mesa in 2013, the written OC spray policies continue to permit the use of OC spray in room extractions and to allow the door to the room to be shut to increase the effects of the spray. Accordingly, there is a well-founded concern that OC spray will be used in future room extractions in San Diego County.

We are concerned about the underlying concept of forcible room extractions in juvenile facilities as well as the use of OC spray to accomplish them. When a young person refuses to leave his room but does not present a threat to himself or others, force should not be used to

24 DOJ has found the practice of using pressure points on detained youth to be improper. Civil Rights Division, U.S. Dept of Justice, Investigation of the Shelby County Juvenile Court (Apr. 26, 2012) at 58.
remove that young person from his room – and the extreme measure of OC spray certainly should not be applied.

D. Use of Pepper Spray on Medically-Contraindicated Youth

The ill effects of OC spray are especially pronounced for certain people, including individuals with respiratory and cardiovascular impairments and individuals who are taking psychotropic medication. For this reason, it is vital that individuals with such conditions are not exposed to OC spray, and that detention facility staff take measures to identify individuals with medical contraindications for the use of OC spray. This is especially true as individuals with medical contraindications, especially individuals using psychotropic medication, may be overrepresented in population of youth detained in juvenile facilities.

It is deeply troubling that the review of incident reports from East Mesa and Kearny Mesa from 2012 and 2013, including reports of incidents in which OC spray was not used, did not reveal a single instance in which OC spray was not used due to a detainee’s medical contraindication. Indeed, despite facility policies that call for youth with medical contraindications to wear yellow wristbands, the review did not find any incident reports that mentioned whether or not a minor was wearing a yellow wristband. This lack of documentation suggests that detention facility staff are not, in fact, making an effort to avoid deploying OC spray against youth with medical contraindications and likely are not adequately identifying such youth.

The review of incident reports documented at least one incident in which a young person with a medical contraindication was sprayed with OC. At the Kearny Mesa facility, a young man was sprayed after being involved in a fight. A medical addendum to the incident report states that after being sprayed, the minor requested his inhaler and took four puffs. Disturbingly, there is no indication in the incident report itself indicating that the minor had asthma, that staff took his respiratory impairment into account in determining whether to deploy OC spray, or that the minor was wearing a wristband identifying him as OC sensitive, as required by SDPD’s OC policies. (Exhibit 38.)

There are also documented incidents in which OC spray was used on individuals who were using psychotropic medication. In several of the incidents described above in which a young person on suicide watch was sprayed, the incident reports indicate that those minors were taking medication at the time of the incident.26 There is no indication that staff considered the fact that those individuals were using psychotropic medication before using OC spray or that the individuals were wearing OC-sensitive wristbands.

In another incident, a minor at intake was behaving erratically and mumbling to himself with “short spontaneous outbursts of laughter.” The minor also appeared to have a serious skin condition, as “[t]he minor’s skin was peeling from head to toe and had excessive ‘bumps’ and

26 Exhibits 3-5 and 18.
small sores spread over his body.” The minor refused to remove his clothing and threatened to fight staff if they took his clothes. Staff ordered the minor to cover and he refused. Without any concern regarding the minor’s skin condition, staff sprayed him in the face and closed the door. Staff then entered the room and pulled the minor to the floor. Eventually, staff cut off the minor’s clothing. Staff review determined that the use of OC was justified due to the minor’s “bizarre behavior.” (Exhibit 163.)

These incidents, combined with the lack of documentation regarding young people with medical contraindications, raises serious concerns that young people with such contraindications are being exposed to OC spray in San Diego facilities. DOJ has repeatedly expressed its disapproval of the use of OC spray on youth with compromised respiratory or cardiovascular systems or youth taking psychotropic medication. San Diego County does not adequately protect medically-sensitive youth from exposure to OC spray.

E. Use of Excessive Amounts of OC Spray and Overspray

Not only does San Diego County use pepper spray in situations in which it is manifestly inappropriate, the amount of pepper spray deployed is often extreme. After each incident in which OC spray is used, staff are required to record the change in weight of their OC canister in the incident report. The review of Kearny Mesa incident reports from 2012 and 2013 uncovered twenty-two instances in which more than eight ounces of pepper spray was used in a single incident. In five cases, staff deployed a pound or more of pepper spray. Although MK-9 OC spray canisters are designed for use in an open air environment and accordingly deploy larger quantities, the use of a pound of pepper spray is excessive – especially considering that in three cases, the incident involved only two minors. Further, staff sometimes use MK-9 canisters indoors, exposing detainees to an unsafe amount of spray.

Unsurprisingly, when staff use large amounts of pepper spray, the risk that minors not involved in the incident will be exposed to pepper spray (or “oversprayed”) is high. In at least six instances when large amounts of pepper spray were used, youth uninvolved in the incident were exposed to OC spray. In one instance, staff sprayed 17.4 ounces of OC spray, resulting in five youth being oversprayed.

However, the risk of overspray is not limited to situations in which staff deploy large amounts of pepper spray. The risk that youth not involved in an incident will nevertheless be sprayed with OC seems ever-present in San Diego juvenile detention facilities. The Kearny

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27 See Findings Letter from Ralph F. Boyd, Jr. to Yvonne B. Burke, supra note 18; Letter from Grace Chung Becker to Yvonne B. Burke, supra note 25, at 14-15; Findings Letter from Thomas E. Perez to Mitch Daniels, supra note 21.
28 Exhibits 41, 45, 47, 49, 52, 59, 62, 72, 73, and 147-159.
29 Exhibits 41, 62, 72, 73, and 155.
30 Exhibits 29, 39, 40, and 164 (“due to the intensity of the OC mist in A hallway, the whole unit was ventilated with fans. . .”).
31 Exhibits 41, 45, 49, 52, 72, and 73.
Mesa detention facility incident reports from 2012 and 2013 document at least thirty-seven instances of overspray, with at least thirty-seven youth receiving overspray in 2012 and thirty in 2013. In the East Mesa detention facility, there were at least thirty-nine documented instances of overspray in 2012 and thirty-three in 2013, with at least eighty-five youth oversprayed in 2012 and sixty-two in 2013. Indeed, the use of OC spray can add to the injuries suffered by assault victims. In at least six of the above instances documented at Kearny Mesa, the individual who was oversprayed was the victim of an assault by another detainee. Nor are other detainees the only people at risk of overspray – staff are also exposed to the effects of OC spray.

San Diego County’s justification for the use of pepper spray hinges, in part, on the principle that the use of OC spray helps prevent physical injury to detainees and staff. However, the pervasive pattern of overspraying demonstrates that the use of OC spray itself creates a significant risk of injury to young people who are not involved in the underlying incident and who would not have been exposed to the risk of injury but for the use of OC spray. The routine use of OC spray in these facilities creates an unacceptable risk of harm not only to the targets of the spray, but also to innocent bystanders.

F. Use of Pepper Spray as a First Resort

The above examples demonstrate that San Diego County routinely deploys OC spray in situations in which it is manifestly inappropriate. These particularly egregious examples reflect a broader problem in the SDPD regarding the use of OC spray. Rather than using OC as a tool to address only those situations which present a serious and imminent risk of physical harm and where other interventions have failed, it appears that detention facility staff use OC spray as a default response, often without prior attempts to de-escalate. The review of incident reports raises concerns about the extent to which OC spray is a first resort in San Diego juvenile facilities, rather than an extraordinary – and rare – measure.

One primary area of concern is that SDPD staff appear to lack the tools to prevent or respond to fights in any other way than deploying OC spray. In incident report after incident report, the same pattern is repeated: two detainees begin to fight, a staff member yells cover, the minors do not cover, the staff member yells cover OC and sprays the minors. The sheer repetitive prevalence of such incidents demonstrates not only that OC spray is the default response to any physical altercation in a detention facility, but also that insufficient consideration has been given to other methods to end, or even prevent, such altercations. As DOJ has observed, “[i]n many cases, youth-on-youth violence and other out-of-control behavior can be

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32 Exhibits 41-74.
33 Exhibits 75-113.
34 Exhibits 114-146.
35 Exhibits 45, 47, 50, 57, 70, and 74.
36 Exhibit 93 (stating that the staff member became “overwhelmed with the OC spray”) and Exhibit 164 (stating that the OC spray impaired the staff member’s vision).
37 Even in instances where young people do not fight and OC is not used, there is a marked lack of de-escalation by staff. In many “near-fight” incidents, staff observe tension between minors and the only technique used to defuse the situation is calling the cover command.
prevented with proper behavior management techniques and sound verbal de-escalation skills.\textsuperscript{38} We are deeply concerned that a culture of “spray first” has replaced a thoughtful behavior management system that could reduce conflicts as well as harm to detained youth.

We are also concerned that detention facility staff do not give sufficient warning prior to deploying OC spray. San Diego’s policies require that warning be given prior to deployment of OC spray. Despite this policy, detention facility staff sometimes use OC spray without prior warning. We reviewed at least three incident reports in which staff used OC spray without giving a prior “cover OC” command.\textsuperscript{39} Even where the “cover OC” command is given, it is often unclear whether detainees are given sufficient time to comply before being sprayed. The failure to give adequate warning prior to deploying OC spray suggests not only that OC spray is sometimes used when less aggressive forms of intervention would have been sufficient, but also that OC spray is a reflexive staff response, rather than an extreme measure to be used only in limited circumstances.

The SDPD’s stated justification for the routine use of OC spray – and the use of OC spray in lieu of other forms of de-escalation or physical intervention – is to avoid physical intervention by staff and to end fights between detainees quickly. This rationale does not hold up to examination. Not only does the use of OC spray frequently fail to end fights between detainees, it also does not replace other physical intervention by staff, as staff often go “hands-on” even after deploying OC spray. The following are only a few examples of instances at Kearny Mesa in which the use of OC spray alone was insufficient to end an incident, with staff using physical interventions after deploying OC spray:

- When four minors began fighting, staff sprayed two of them in the face twice; once with an MK-9 canister. When the minors continued to fight, staff pulled one of them to the ground by the arm and shirt. OC spray failed to stop the fight, even though 15.3 ounces of spray were deployed. (Exhibit 54.)

- After a minor was sprayed in the face, he continued to stand, rubbing the OC off of his face. A staff member grabbed him by the right shoulder and took him to the ground, where staff pinned his shoulders and held his wrists. (Exhibit 28.)

- Two minors continued to fight even after being sprayed in the face twice from an MK-9 canister, with 14.8 ounces of OC spray dispensed. Eventually, staff pulled and shoved the minors apart, pulling one of them to the ground by his arm and shoulder. (Exhibit 158.)

- When two young women began fighting, staff sprayed them in three separate bursts. When the minors continued to fight, staff members grabbed them, pulled them apart, and “assisted” them to the prone position. (Exhibit 161.)

\textsuperscript{38} Findings Letter from Thomas E. Perez to Michel Claudet, supra note 22, at 9.

\textsuperscript{39} Exhibits 9, 158, and 160.
• Staff called “cover” when two minors began fighting. One minor went to the cover position and the other continued to assault him. Staff sprayed that minor to no effect and then pulled him to the ground by his shirt. (Exhibit 162.)

Again, these are only a few of the most recent examples from one San Diego facility. The review of incident reports uncovered a large number of similar incidents. It is clear that OC spray does not reliably end fighting between detainees or prevent staff physical intervention. Accordingly, there is no justification for the failure to use alternative, less harmful methods of conflict resolution. Further, it appears that if a young person can withstand the effects of OC spray, they can continue their assaultive behavior until they are overcome or until staff use a hands-on intervention. In this way, the use of OC spray rather than hands-on intervention may actually prolong an assault or fight.

In sum, we are seriously troubled by SDPD’s OC spray use in county juvenile detention facilities. Detention facility staff have used OC spray in manifestly improper circumstances, such as where a young person is demonstrating suicidal behavior, is merely failing to follow instructions, is a bystander in harm’s way, or has a clear medical contraindication for OC spray. Moreover, the high number of instances of OC spray use at these facilities point to a culture in which OC spray is the default response to disturbances, rather than a last resort. This use of OC spray as a first resort is improper.

III. San Diego Probation Department’s Inadequate Policies

As the above examples demonstrate, San Diego County uses OC spray as a first resort, as a means of controlling young people, and in situations where the use of OC spray is manifestly inappropriate. Not surprisingly, the San Diego Probation Department’s written policies regarding the use of OC spray are inadequate. Each juvenile detention facility in San Diego has its own policy regarding the use of pepper spray, but the policies are similar in most important respects. Each of the policies contain wording that purports to limit the use of OC spray to serious situations after attempts at de-escalation have failed. But that stance is consistently undercut by language that gives officers wide-ranging discretion to use spray without warning, without prior attempts at de-escalation, and in situations where there is no risk of physical injury to any individual. Because the limiting language is effectively swallowed by the discretion granted to individual officers, San Diego’s policy, in essence, is spray first and write a report later.

A preliminary problem is that SDPD’s written policies authorize staff to carry OC spray while on duty. This stands in stark contrast to the predominant practice of those few juvenile facilities using OC spray of requiring spray canisters to be stored in offices. An annual survey of juvenile correction administrators conducted by the Council of Juvenile Correctional Administrators demonstrated that 71% of juvenile facilities do not use OC or other chemical agents, that only 12% of agencies surveyed permitted staff to carry OC spray in secure facilities, and that agencies that permit staff to carry OC spray “have adopted an overall more punitive and
adult-corrections oriented approach to managing youths in facilities.  When officers are armed with OC spray, it is small wonder that a climate develops in which OC spray is seen as a tool for managing behavior, rather than a weapon to be used only in the most extreme situations.

A second basic problem with San Diego’s OC spray policies is that they permit OC spray to be deployed before other conflict resolution methods have failed. San Diego’s use of force policies state that force, including the deployment of OC spray, should be used only when less restrictive methods have failed. However, despite this seeming restriction of the use of OC spray to situations in which less restrictive methods have been tried and failed, the policies actually grant significant discretion to individual officers to use OC spray before trying other methods of de-escalation. Indeed, the policies explicitly state that individual officers need not actually progress through lower levels of force; instead, officers may use a higher level of force first.

Another fundamental problem with the written policies is that they do not limit the use of OC spray to situations in which there is a substantial risk of physical injury. San Diego’s OC spray policies state that the spray is to be used “to assist officers in dispersing large disturbances, in moving threatening persons from rooms, buildings or vehicles, for personal defense against violent persons and to reduce injuries to officers and detainees.” Other sections of the policies indicate that OC spray may be deployed to prevent injury not only to people, but also to property or the institution. Further, the policies specify that spray may be used in the case of verbal threats where “the person has the apparent ability to carry out the threat” and is ready to do so. Therefore, the policies explicitly contemplate the use of OC spray even in situations where there is no risk of physical injury to staff or detainees or where a young person’s resistance is merely verbal. These defects in the policies have certainly contributed to the multiple situations described above in which staff deployed OC spray in situations in which the minor was merely being verbally defiant or failing to follow instructions.

Another situation in which OC spray is used in the absence of a risk of physical injury is in relation to room extractions. As recounted above, San Diego County Probation officers have used OC spray in room extractions, even when the target of the spray was not physically violent or threatening. Such OC spray use is specifically authorized in the OC spray policies of East Mesa, Kearny Mesa, and the Girls’ Facility. Those policies permit the use of OC spray where a detainee in a sleeping room refuses to comply with instructions and the refusal to comply constitutes a danger to the detainee or officers. The policies also provide that if the detainee continues to be non-compliant, officers may close the door for up to two minutes to “allow the

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40 CJCA, supra note 11.
OC to become more effective.43 The policies state that the use of OC in room extractions must be approved by a supervisor. However, as with many other apparent limits on the use of OC spray, the requirement to seek supervisor approval is immediately undercut, as the policy also grants discretion to officers to act without supervisor approval if they judge that waiting for approval would threaten the life of an inmate.

This pattern of placing an apparent limit on the use of OC spray, while at the same time undercutting that limit by granting individual officers discretion to ignore it, is repeated throughout the OC spray policies. When limits on the use of OC spray are allowed by officer discretion in an individual case, it increases the likelihood that OC spray will be used in inappropriate situations. Without clear guidelines, officers are left with insufficient guidance as to when OC spray is permitted under the policy, virtually guaranteeing that some officers will use it incorrectly.

Finally, San Diego’s OC spray policies do not sufficiently address the health effects of OC spray or the use of OC spray on youth with medical contraindications. There is no indication in the written policies that OC training encompasses the potential long-term effects of OC spray use or the potential negative effects on individuals with medical contraindications. Although the policies suggest that officers take reasonable efforts to avoid spraying detainees with medical contraindications “whenever possible,” they specifically state that there are situations in which OC spray may be used on OC-sensitive individuals. The policies themselves do not suggest alternative methods for de-escalation to be used with OC-sensitive individuals. Further, the OC spray policies do not identify any affirmative steps to examine young people for medical contraindications.

These appalling practices are being perpetrated primarily on youth of color in a system that is supposed to provide care and treatment for them in accordance with their individual needs. Given the pervasive culture of OC use as a behavior management tool and longstanding failure to adopt a more sparing use despite repeated complaints, we do not believe that anything short of barring the use of OC spray will be sufficient to protect youth detained in San Diego’s juvenile facilities.

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IV. Reasons for Investigating

A. The Use of Pepper Spray Violates Youths’ Constitutional Rights

The above-described policies and practices in San Diego juvenile detention facilities demonstrate that the use of OC spray in these facilities has created an unconstitutional condition of confinement under the Fourteenth Amendment. The routine use of OC spray in San Diego County juvenile facilities violates the constitutional rights of all youth detained in those facilities.

Treatment of children in the juvenile justice system is based on the fundamental premise that children are less mature and responsible than adults and should not be held to the same standards of behavior. Young people adjudicated in California’s juvenile justice system are not considered to have been convicted of crimes, and the purpose of the institutional confinement of children is rehabilitation, rather than punishment. Accordingly, the standards for evaluating conditions of confinement in juvenile institutions differ from those used to analyze conditions in adult facilities. Conditions of confinement in juvenile facilities violate the Fourteenth Amendment where those conditions “amount to punishment” or represent a substantial departure from accepted professional judgment. Courts have found that the use of chemical agents in juvenile facilities violates the Constitution except in situations where an imminent and serious threat of harm persists after less drastic methods have been tried and failed.

San Diego’s use of OC spray violates the Constitution under either the Bell or Youngberg standard. The use of OC spray in situations where the youth involved did not pose any threat to staff or detainee physical safety strongly suggests that OC is being applied not for safety reasons, but as a form of punishment. Further, as discussed below, the routine use of OC spray in juvenile facilities represents a substantial departure from not only best practices in the juvenile correctional field, but also from the current practices of a wide majority of juvenile detention systems. As demonstrated above, the SPDF routinely uses OC spray in situations in which there is no imminent and serious threat to physical safety and without engaging in prior attempts at de-escalation.

41 In re Aline D., 14 Cal.3d 557, 567 (1975) (“Juvenile commitment proceedings are designed for the purposes of rehabilitation and treatment, not punishment.”).
43 Youngberg v. Romero, 457 U.S. 307, 321-22 (1982); see also Alexander S. v. Boyd, 876 F. Supp. 773, 796-99 (D.S.C. 1995), aff’d in part and rev’d in part on other grounds, 113 F.3d 1373 (4th Cir. 1997), cert. denied, 522 U.S. 1090 (1998) (determining that Youngberg analysis is appropriate in juvenile correctional setting and that Due Process Clause of Fourteenth Amendment, including Bell decision, is appropriate standard for reviewing conditions at juvenile facilities); Gary H. v. Hegstrom, 831 F.2d 1430, 1432 (9th Cir. 1987) (finding that the appropriate standard for evaluating conditions at juvenile facilities is the Due Process Clause).
44 Alexander S., 876 F. Supp. at 786 (finding that indiscriminate use of CS gas was unconstitutional; “gas should be used only when a genuine risk of serious bodily harm to another exists and other less intrusive methods of restraint are not reasonably available.”); Morales v. Turman, 364 F. Supp. 166, 173-74 (E.D. Tex. 1973) (finding that the use in juvenile facilities of “chemical crowd control devices in situations not posing an imminent threat to human life or an imminent and substantial threat to property” is unconstitutional).
45 See notes 45 and 46.
46 See infra Section IV.C.
B. The Use of Pepper Spray is Harmful

OC spray poses significant health risks to all those exposed to it. These risks may be exacerbated by medical contraindications, mental illness, insufficient air circulation, and repeated exposure—all conditions that exist in juvenile facilities. In addition, there has been little research on the effects of OC exposure on young people. These factors suggest that OC spray should be used sparingly, if at all, in juvenile facilities. The regular use of OC spray in San Diego County juvenile detention facilities poses an unacceptable risk to the health and safety of youth detained in those facilities.

The principal active ingredient in pepper spray is Oleoresin Capsicum (OC), an oil extracted from hot peppers, at varying levels of concentration depending on the commercial manufacturer. Contact with OC spray creates a number of acute physiological effects including intense burning, swelling, redness, occasionally blistering and exacerbation of allergic reactions and allergy-related dermatitis. Individuals with compromised respiratory systems, such as those suffering from asthma or bronchitis, may be at particular risk for respiratory arrest resulting from OC spray exposure. Chronic exposure to OC spray may result in chronic respiratory ailments.

OC spray has a number of gastrointestinal effects when ingested and also affects the cardiovascular and neurological systems. The risks involved in using OC spray may be exacerbated where the person exposed has an existing cardiovascular or respiratory problem, or where an individual is under the influence of psychotropic drugs.

Researchers have also expressed significant concerns about the use of OC spray on individuals who are mentally ill, suggesting that the use of OC spray can exacerbate mental health issues and may be ineffective in any event. This is especially troubling in the context of juvenile facilities, where the population contains a disproportionate number of youth with mental health issues. Where a young person’s mental health problem is based on past trauma, the use of OC spray can exacerbate existing mental health issues. Young people involved in the juvenile

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51 Smith, supra note 50.
52 Id.
53 Id.
56 Pinney, supra note 54 at 5-6.
justice system have experienced trauma and resulting mental health issues at disproportionate rates. A longitudinal study of youth detained at the Cook County Juvenile Temporary Detention Facility in Chicago, Illinois found that 92.5% of youth had experienced a traumatic event and that 11.2% had experienced posttraumatic stress disorder in the year prior to being interviewed.  

A number of effects of exposure to OC spray are exacerbated by preexisting conditions or medications, a fact which is especially concerning in the context of juvenile institutions. Many young people incarcerated in juvenile facilities are prescribed psychotropic medication that can increase the risks of OC spray. Further, young people may have undiagnosed cardiovascular or respiratory conditions that can exacerbate the risk of repeated exposure to OC spray. A young person, who has a diagnosed cardiovascular or respiratory condition that makes the use of OC spray especially dangerous, may be unaware of the existing diagnosis or the exacerbating effects of OC. Even where a young person is aware of her diagnosis, that information might not be communicated effectively to staff. Given the multiple points at which communication about a medical contraindication for the use of O.C. spray may break down, the use of OC spray is inherently risky, even for young people without an identified medical contraindication.

There are numerous documented cases of deaths following the use of OC spray. Between 1993 and 1999 there were over seventy in-custody deaths following the use of pepper spray. Although a review of fifty-six of those cases did not determine that OC spray was a precipitating cause in any of those deaths, there is reason to believe that in at least some cases, OC spray was not adequately considered as a potential cause of death. In addition, in many cases, deaths resulted where the individual involved was suffering from a condition, such as cardiovascular or respiratory disease, that could increase the risks involved in the use of OC spray.

Although the known effects of the use of pepper spray are serious standing alone, there is a further reason to be wary of the use of OC spray on adolescents. There has been little or no research on the long-term effects of exposure to OC spray, the effects of repeated exposure to OC spray, the effects of exposure to OC spray on adolescents, or the effects of OC when used in locked institutions with limited air circulation. Despite the limited research, however, there is some reason to believe that the repeated use of OC spray in locked juvenile facilities may be especially harmful. OC is known to lead to the degeneration of nerve terminals, which can lead in the long-term to desensitization to pain and temperature changes. A 2009 literature review indicated that the effects of pepper spray are exacerbated in confined areas and areas with poor ventilation, two characteristics of many juvenile facilities. At least one study indicated that repeated exposure to OC spray may increase its harmful effects.

58 Smith, supra note 50 at 272.
59 Id.
60 Id.
Because of the gaps in the research and the lack of clarity surrounding the long-term effects of repeated exposure to OC spray as an adolescent, the serious physical and psychological effects of OC spray, and the risks to youth with medical contraindications, OC spray should be used only sparingly, and ideally not at all, in juvenile facilities. San Diego County’s routine use of pepper spray in its juvenile detention facilities poses significant health risks to all youth detained in those facilities.

C. The Use of Pepper Spray Represents a Substantial Departure from Accepted Professional Practice

Not only is the use of OC spray physically and mentally dangerous for young people, it is also unnecessary and contrary to best practices in juvenile detention facilities. In permitting line staff to carry and deploy OC spray, and in relying heavily on OC spray to resolve incidents ranging from fights to suicidal behavior, San Diego lies far at one end of the national bell curve regarding OC spray use. Further, the routine use of OC spray is both unnecessary for maintaining a safe facility and counterproductive, as it creates an atmosphere of distrust and resentment among both staff and detainees.

Although OC spray is a common law enforcement tool and is used in many adult detention facilities, use of OC spray in juvenile facilities is rare nationally. A 2011 national survey of correctional administrative staff by the Council of Juvenile Correctional Administrators (CJCA) revealed that only 12% of agencies surveyed authorized staff to carry pepper spray in secure facilities and only 29% of agencies authorize the use of chemical restraints at all.64 California is one of only six states that permit staff to carry OC spray on their persons.65 Of the 200 facilities participating in the CJCA’s Performance-Based Standards program, only fifteen, or 8%, used chemical restraints in a given month.66 In a survey of youth in residential placement conducted by the Office of Juvenile Justice and Delinquency Prevention, only 7% of youth reported that pepper spray had been used on them.67

Not only is pepper spray rarely used, it is also contrary to best practices in the field. The Annie E. Casey Foundation’s Juvenile Detention Alternatives Initiative’s standards call for policies that prohibit the use of chemical restraints, including pepper spray.68 Even if OC spray is not barred outright, San Diego’s policy of using OC spray as a first response deviates radically

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Pierre-Nicholas Carron & Bertrand Yersin, Management of the Effects of Exposure to Tear Gas, 338 British Med. J. 1544, 1556 (2009)).

63 Id. (citing Marita Broadstock, What is the Safety of “Pepper Spray” Use by Law Enforcement or Mental Health Service Staff?, 14 New Zealand Health Technology Assessment Tech Brief Series (Sept. 2002)).

64 CJCA, supra note 11.

65 Id. at 2.

66 Id. at 3.


from accepted professional standards. The CJCA’s Performance-Based Standards for Juvenile Correction and Detention Institutions call for chemical restraints to be used only as a last resort.\textsuperscript{69} It is clear that in many cases, San Diego uses OC spray where there is no risk of serious injury, such as when OC is deployed based on a failure to follow instructions or in room extractions.

This general rejection of the use of OC spray in juvenile facilities has a sound operational basis. Beyond the physical and mental health effects of OC spray, the use of OC spray can have serious effects on the relationship between youth and staff. The CJCA has noted that over-reliance on chemical restraints can harm relationships between youth and staff and that the states authorizing the use of chemical restraints tend to have adopted a more punitive, adult-corrections-like approach to juvenile detention.\textsuperscript{70} A survey conducted by CJCA demonstrated that where OC spray is used, staff and youth fear for their safety more than average.\textsuperscript{71}

At the very least, the use of OC spray does not improve either youth or staff’s sense of safety, and at worst, it may even decrease it. As the court in \textit{Alexander S.} observed, the use of tear gas is counterproductive, as it “causes more anger in the juveniles toward the adults who are supposed to be caring for them. The use of gas as a form of punishment teaches the victims to inflict pain as a method of controlling others and makes the juveniles more volatile, more aggressive, and less likely to respond properly to authority figures.”\textsuperscript{72} A task force appointed by the U.S. Attorney General has likewise recognized that young people involved in the juvenile justice system are likely to be survivors of violence and trauma, and that it is vital to “maintain safety without relying on practices that are dangerous and that compromise the physical and mental well-being” of detained youth.\textsuperscript{73} The fact that dehumanizing practices are being perpetuated primarily on youth of color is all the more reprehensible.

The purpose of the juvenile justice system is rehabilitation. Using OC spray runs counter to that purpose and contributes to a punitive environment in which young people and staff both fear for their safety. Carrying out a rehabilitative mission in an environment where young people do not trust staff is virtually impossible.

In light of the national trend toward reduced use of chemical restraints and the deleterious effects of OC spray on detainee-staff relations, the use of OC spray should be seriously curtailed, if not eliminated, at juvenile detention facilities. Safety is better guaranteed through other measures, including increasing staffing, training staff on crisis intervention and de-escalation, increasing and improving the programming offered to youth, and improving the classification system used to determine where youth are housed.

\textsuperscript{69} CJCA, \textit{supra} note 11, at 4.
\textsuperscript{70} \textit{Id.} at 1.
\textsuperscript{71} \textit{Id.} at 3.
\textsuperscript{72} \textit{Alexander S.}, 876 F. Supp. at 786.
D. Other Troubling Conditions in San Diego Juvenile Detention Facilities

In addition to the SDPD’s policies and practices on the use of OC spray, the review of incident reports uncovered a number of other troubling conditions at San Diego juvenile facilities.

1. Routine Use of Solitary Confinement/Isolation

In the incidents described above, when a youth is pepper sprayed, he or she is also disciplined by being given locked room confinement, often two or three days in length. In addition, the disciplinary policies of San Diego juvenile detention facilities permit the use of administrative segregation. When a young person is on administrative segregation, they are not allowed to leave their room when other detainees are present and are restrained in wrist chains, handcuffs, and leg chains when they do leave their rooms — even when they are showering. Youth on administrative segregation are not permitted to attend school and are required to do all school work in their cells. Although education staff “may” sit outside the cell to work with youth, there is no requirement that youth on administrative segregation receive any form of instruction beyond independent study. It is unclear whether youth who are on administrative segregation receive any mental health services.

There is growing concern about imposing solitary confinement on juvenile detainees. The American Academy of Child and Adolescent Psychiatry has observed that the “consequences of prolonged solitary confinement ’are well recognized and include depression, anxiety, and psychosis’”; juveniles are at particular risk of suffering those consequences. The Academy has issued a policy statement opposing the use of solitary confinement in juvenile correctional facilities. The routine imposition of lengthy room confinement and isolation violates accepted professional standards. The Annie E. Casey Foundation’s Juvenile Detention Alternatives Initiative’s standards state that room confinement should be a temporary response to behavior that threatens harm, should not be imposed as discipline or for a fixed period of time, and should not be used for longer than four hours.

The Attorney General has also taken special notice of this issue. Recently, the Attorney General condemned the excessive use of solitary confinement in juvenile facilities, stating that isolation should be used only in a limited way to protect staff, other detainees, or the detainee himself from harm. The Attorney General’s 2012 report, Defending Childhood, specifically calls for youth in juvenile facilities to receive treatment that is free from the use of coercion, restraints, seclusion, and isolation, and that is designed specifically to promote recovery from the adverse impacts of violence exposure and trauma on physical, psychological, and psychosocial

75 Id.
76 Annie E. Casey Foundation, supra note 68, at 177-178.
development, health, and well-being. The report places special emphasis on the “damaging impact” of solitary confinement, pointing out that “juveniles experience symptoms of paranoia, anxiety, and depression even after very short periods of isolation” and calling for juvenile systems to “[a]bandon juvenile justice correctional practices that traumatize children and further reduce their opportunities to become productive members of society.”

2. Youth with Mental Health Issues

The treatment of mentally ill youth and youth who engage in or threaten self-harm in SDPD facilities is also deeply concerning. As discussed above, young people threatening or engaging in self-harm have been pepper sprayed by San Diego detention staff. However, even where OC spray is not used, detention facility staff threaten suicidal and self-harming youth with OC to gain compliance. For example, in one instance staff attempted to strip search a young woman who had bitten her finger, drawing blood. The minor stated, “I do not feel safe; I am not taking off my clothes,” and initially refused to assume the cover position. Staff then called, “cover OC,” and the minor complied. (Exhibit 165.) Staff proceeded to hold the minor down and cut her clothing off, including her underwear. In another incident, a minor who was self-harming by banging her head against the wall was told that she could either walk to the clinic or be sprayed with OC and placed in a restraint chair. The minor was given seventy-two hours of room confinement for having bitten a staff member earlier in the incident. (Exhibit 166.) OC spray should not be used on suicidal and self-harming youth; neither should threats of OC spray be used as a method of extracting compliance from such youth.

Another troubling practice is the use of administrative segregation, extended isolation, and room confinement as discipline for a youth’s behavior while on suicide watch. In a number of incidents in which OC spray was used on suicidal youth, the minor was given a forty-eight hour room confinement as discipline. Isolation is also used as discipline even where OC spray is not deployed. For example, a minor who was on suicide watch was placed on administrative segregation for two days and given seventy-two hours of room confinement for kicking a staff member in the calf and spitting on another staff member. The nurse who visited her after the incident noted that the minor was rocking back and forth with her arms folded and crying. (Exhibit 167.) In another incident, a young woman was found tightening a sweater around her neck. She resisted staff attempts to remove the sweater and to take her to the suicide watch room. When staff began cutting her clothing off, she began to spit. The minor was given a forty-eight hour room confinement and was placed on disciplinary removal status for twenty-four hours. Another minor was placed on temporary administrative segregation and given a 120 hour room confinement for combative behavior after being placed on suicide watch. (Exhibit 169.)

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78 OJJDP, Defending Childhood, supra note 73, at 177-78.
79 These are not the only instances in which young people on suicide watch were given disciplinary room confinement. See Exhibit 170, (forty-eight hours); Exhibit 171, (seventy-two hours); and, Exhibit 172, (forty-eight hour room confinement and twenty-two hour disciplinary removal).
In some cases, room confinement is imposed as discipline based on youth’s response to staff’s attempts to remove their clothing. For example, a young woman who was on suicide watch refused to remove her clothes and began cursing. When staff succeeded in stripping and searching the minor, she began to threaten staff members. The minor was given forty-eight hours of room confinement for the threats, “serious verbal misbehavior and major not following instructions.” (Exhibit 173.) In another incident, a minor was given a forty-eight hour room confinement and a twenty-two hour disciplinary removal after resisting staff attempts to stop her from self-harming and to cut her clothing off. (Exhibit 174.)

There is a strong consensus that the use of administrative segregation and isolation is extremely harmful to youth with disabilities and suicidal youth. In a 2012 report, the ACLU and Human Rights Watch documented the detrimental effects of solitary confinement on disabled youth, stating that solitary confinement can exacerbate mental illness and interfere with mental health treatment.80 In his May 2014 statement, the Attorney General observed that solitary confinement is “particularly detrimental to young people with disabilities” and called to reduce “the overreliance on seclusion of youth with disabilities.”81 Perhaps most troubling, a national study of juvenile institutional suicides has confirmed that 75% of successful suicides involved youth confined in single occupant rooms, and that approximately 50% of those were youth being subjected to disciplinary confinement.82 The routine use of disciplinary segregation on suicidal and self-harming youth in San Diego County juvenile detention facilities may be exacerbating mental health issues and placing young people at increased risk of suicide.

The review of incident reports also revealed that detention facility staff sometimes place youth in restraint chairs in response to self-harming behavior or threats. For example, in one instance, a young man was placed in a restraint chair for about two hours after repeatedly banging his head against the wall and threatening to kill himself.83 The minor was later given a seventy-two hour room confinement for an earlier fight. The use of restraint chairs violates accepted professional standards. The Annie E. Casey Foundation’s Juvenile Detention Alternatives Initiative’s standards call for the use of restraint chairs to be barred at juvenile facilities, and the American Bar Association’s Standards for Juvenile Justice state that it should not be necessary for mechanical restraints to be used inside a juvenile facility.84

This examination of the treatment of mentally ill and disabled youth has been confined to the context of incident reports documenting the use of force and crisis situations. The grave mismanagement of suicidal and self-harming youth documented in these reports is troubling in

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81 Eric H. Holder, Jr., supra note 77.
83 Exhibit 175. The incident report describes the minor’s continued use of profanity and threats of self-harm as the minor “contin[u]ing with his attitude.”
itself. However, it also raises broader concerns about the adequacy and appropriateness of mental health care and treatment at San Diego County juvenile facilities. We urge DOJ to investigate these instances of inappropriate use of force, restraint, and isolation against youth with mental health issue as well as the treatment of mentally ill and disabled youth at these facilities more broadly.

3. Non-Compliance with PREA

Finally, we are concerned about PREA compliance issues that emerged from the review of incident reports. Youth on suicide watch were asked to disrobe by staff of the opposite gender. 85 Also, staffing ratios at San Diego County juvenile facilities are routinely higher than the minimum required staffing ratios under the Prison Rape Elimination Act. 86 Although facilities have until October 1, 2017 to achieve compliance with this aspect of PREA, the failure to meet these minimum requirements likely impacts both the use of OC spray and disciplinary policies more broadly in San Diego facilities. Improving staffing ratios would improve staff and detainee security and reduce the perceived need for the use of harmful restraint, force, and disciplinary practices.

V. Relief Requested

We request that DOJ thoroughly investigate the policies and practices regarding the use of OC spray in San Diego County juvenile detention facilities and all other practices and conditions of confinement implicated in this complaint that may violate the rights of young people detained in those facilities. Given SDPD’s well-demonstrated inability to meaningfully address these issues over a period of many years, we strongly urge that SDPD be required to adopt policies that eliminate the use of OC spray in its juvenile facilities, with a timeline and detailed plans with respect to the staffing, training, and program development needed for

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85 Exhibits 2, 3, and 11; 28 C.F.R. § 115.315. It is unclear from the incident reports whether cross-gender staff were present when staff cut off these youths’ clothes and conducted strip searches.
86 The minimum staffing ratios for secure juvenile facilities under PREA are 1:8 during waking hours and 1:16 during sleeping hours. 28 C.F.R. § 115.313(c).
implementation. We also urge DOJ to impose specific, strong relief with respect to each and all of the other issues identified in this complaint and through its investigation.\textsuperscript{87}

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Description of Complainant Organizations

Youth Law Center is a national public interest law firm that works to protect the rights of children in the foster care and justice systems, and to ensure that they receive the necessary support and services to become healthy and productive adults. Since 1978, Center lawyers have worked across the United States to reduce unnecessary incarceration; ensure safe and humane conditions when youth are removed from their homes; keep children out of adult jails; and secure equitable treatment for children in the child welfare and juvenile justice systems. Youth Law Center attorneys are nationally recognized experts on the legal rights of children in institutions, and have engaged in extensive institutional litigation, drafting standards and regulations for juvenile facilities, and training juvenile system professionals around the country on conditions
law. The Center advocates for increased accountability of the juvenile justice and child welfare systems, and champions professional and public education.

**California Rural Legal Assistance, Inc.** (CRLA) was founded in 1966 as a nonprofit legal services program. Its mission is to strive for economic justice and human rights on behalf of California's rural poor. Today, CRLA has 21 offices, many in rural communities from the Mexican border, including San Diego County, to Northern California. Each year, CRLA provides more than 40,000 low-income rural Californians with free legal assistance and a variety of community education and outreach programs. Half of CRLA's resources are committed to multi-client cases that grapple with the root causes of poverty. The impact of CRLA's litigation has touched the lives of literally millions of low-income individuals, improving conditions for farm workers, new immigrants, single parents, school children, the elderly, people with disabilities, and entire communities. It has also been necessary to bring CRLA's advocacy to a national audience in order to maintain its ability to address the more political and controversial issues found in rural communities.

**El Grupo** is a coalition of community-based organizations, advocates for children and youth, civil rights organizations, student groups, public interest law firms and individual residents of San Diego County that work together to address issues related to the political, educational, social, and economic equality of Latinos and other disenfranchised groups. Some of the issues addressed by El Grupo include: advocating local law enforcement agencies to hire more Latino and Spanish-speaking officers, to educational issues such as the Latino and other minority group drop-out rate, to monitoring local/county/state government in their adoption of new laws and ordinances impacting the Latino and other minority communities.

**NAACP**'s principal objective is to ensure the political, educational, social and economic equality of minority citizens of the United States and eliminate race prejudice. The NAACP seeks to remove all barriers of racial discrimination through democratic processes. This mission is accomplished by seeking the enactment and enforcement of federal, state and local laws securing civil rights, and by informing the public of the adverse effects of racial discrimination. From school desegregation, fair housing, employment and voter registration, to health and equal economic opportunity, the NAACP is working successfully with allies of all races and plays a significant role in establishing legal precedents in order to improve the quality of life of America’s downtrodden.

**Border Angels** was founded in 1986 and is a non-profit organization supporting humanity. The organization consists of extraordinary volunteers who want to stop unnecessary deaths of individuals traveling through the Imperial Valley desert areas and the mountain areas surrounding San Diego County, as well as the areas located around the United States and Mexican border. The high percentage of unnecessary deaths has been results of extreme heat and cold weather conditions, in addition some have sadly been the results of racial-discrimination crimes.
Latinos Organizing for Action (LOFA) is a grassroots collective of volunteers dedicated to organizing Latinos in our communities around demands for comprehensive and human immigration reform, opposition to intimidation of low-income and Latino community members, and encouraging Latino participation in the political process.

Alliance San Diego is a community empowerment organization that works to change policies so that all people can achieve their full potential in an environment of harmony, safety, equality, and justice. Alliance San Diego works with community members to identify the change needed, create solutions, prepare community members as leaders, and mobilize people to bring about change.

CSA San Diego County is one of San Diego County’s oldest and most respected civil and human rights organizations. Long an advocate for fair housing and tenant/landlord mediation, CSA San Diego County addresses many other issues as well-including hate crimes, the civil rights violations experienced by newly-arrived immigrants, human trafficking, youth alienation and poverty. Through direct client services, field outreach and public education CSA is able to reach those persons who have been underserved in their areas of need. Participation in regional, state and national policy work has enabled CSA to become even more effective in helping those looking to us for assistance and leadership.

American Friends Service Committee (AFSC) is a Quaker organization devoted to service, development, and peace programs throughout the world. In San Diego, AFSC promotes human rights through leadership development of migrant-led organizations. Its work is based on the belief in the worth of every person, and faith in the power of love to overcome violence and injustice.

San Diego La Raza Lawyers Association (SDLRLA) is the Latino Bar Association for San Diego. It is an affiliate of both La Raza Lawyers Association of California and the Hispanic National Bar Association. SDLRLA's purpose is to advance the cause of equality, empowerment and justice for Latino attorneys and the Latino community in San Diego County through service and advocacy. SDLRA is dedicated to promoting diversity on both the bench and bar. SDLRA’s membership include current and former state and federal court judges, magistrates, referees, law professors, State Bar committee members, county bar board directors, government officials, elected officials, lawyers practicing in all specialty areas and law students.

Kali Konnect is a community based organization dedicated to supporting young men and women, consistent with the Five Pillars of Islam, to live their lives in peace and justice.