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July 12, 2011

Mr. Larry Rollins
Harnett County Sheriff's Department
P.O. Box 399
Lillington, NC 27546

RE: Inmate Brandon Bethea Death

Dear Sheriff Rollins,

On June 22, 2011 Jail Inspector Chris Wood and I visited the Harnett County Detention Center to gather information about the conditions of confinement that were present at the detention center on March 15, 2011. This is the day that inmate Brandon Bethea was involved in a use-of-force incident that ultimately led to inmate Bethea's death, according to the NC Chief Medical Examiner's Office. This investigation was conducted in accordance to G.S. 153A-222 and was a follow up on the "Report of Death" that the Construction Section received from the Harnett County Sheriff's Department on March 18, 2011. The investigation was performed by interviewing staff, reviewing documentation and observing video of the incident.

Upon reviewing all available information, this office has determined that the procedures the staff followed on March 15, 2011 should immediately be reviewed. The following items represent my observations and interpretations of what transpired on March 15, 2011 between Harnett County Detention staff and inmate Brandon Bethea. Many of the items include questions that should be answered and/or addressed in facility policy and procedure.

1. According to statements, detention staff recognized that inmate Bethea may be a security problem before he ever left the facility on the morning of March 15, 2011.
2. It became clear that inmate Bethea was a security problem after he was reported to have flooded a holding cell at the court house.
3. According to staff statements, inmate Bethea made threatening statements towards staff as he was brought back into the jail. According to staff statements, inmate Bethea made specific threats towards staff and challenged them if they took his restraints off.
4. It was ordered by the shift supervisor to place inmate Bethea into the "padded cell". This order implies that the inmate was a special threat and could not be put back into the general population.
5. It is unclear why the shift supervisor found it necessary to take off inmate Bethea's hand restraints. (especially considering the threats he had made).
6. The techniques used by the detention staff to remove restraints from a potentially dangerous

inmate were not sufficient for the situation. Staff should consider kneeling, prone, and chest to wall techniques.

7. According to staff statements, the inmate made threats during the handcuff removal procedure, yet the staff member continued to remove the hand restraints.
8. In a correctional setting mechanical restraints are used for two reasons:
    a) To protect staff and the general public from the potentially dangerous inmate.
    b) To protect the inmate from harming himself.

    Why was the order given to keep the leg restraints on yet take the hand restraints off? What would this action accomplish?
9. Typically, non-lethal weapons are used to cause temporary incapacitation of a combative subject so that officers can gain control of the subject. Normally, the first step in gaining control of the combative subject after using a non-lethal weapon is to place the subject in mechanical restraints. In this case, when the officer initiated the first taser discharge the inmate immediately fell to a face down position on the floor of the cell. Inmate Bethea appeared to be unresponsive and he exhibited no physical or verbal threats.
10. Considering the number of officers present, why didn't they attempt to restrain the inmate at this point? According to staff statements, inmate Bethea was ordered several times to roll over but inmate Bethea did not respond. What may be important to note is that officers were not issuing orders such as; "quit resisting", or "stay down". According to staff statements, the officer tased inmate Bethea two additional times because he would not roll over, however, it was not reported that inmate Bethea was exhibiting any type of overt refusal. Why didn't staff place hand restraints back on the inmate after the use-of-force? What was the ultimate goal?
11. Was Pepper Spray available, and if so, how does staff determine which weapon to use?
12. A contributing factor to this event is the fact that the padded cell does not contain a security wicket, (food trap). I voiced my concern about this deficiency approximately six months before the jail opened when I participated in a tour. It is not mandatory that cell doors have security wickets so I could only make a recommendation. I am again recommending that the administration consider installing an approved door that contains a security wicket due to the nature of the type of inmate that is normally placed in a padded cell.

In summary, this event constituted an "anticipated use-of-force". This gave staff the opportunity to consider all alternatives. It is my opinion that the best alternative would have been to simply put inmate Bethea in the cell and leave all the restraints in place. This option seems like the most logical decision due to the fact that inmate Bethea had just flooded a cell and he continued to make threats against the staff. It is also my opinion that staff should carefully study what constitutes "control" when force is used on an inmate. Staff must recognize the difference between taking control of an inmate and changing the behavior of an inmate.

This office will review all Harnett County Detention Center standard operating procedures within the next thirty days. We will make an appointment with the Jail Administration in the near future. If I can be of further assistance, Please contact me at the email address or telephone number listed below.

Sincerely,

John P. Harkins, Program Administrator
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