National Institute of Corrections

# Proceedings of the NIC Chief Jail Inspectors Network Meeting, September 2015

***Program no. 15J2701***

**Meeting Topics:**

**Hospital Security Detail**

**Conducting Effective Audits/ Inspections**

**Objective Jail Classification**

**Legal Issues**

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**Aurora, Colorado**
**September 9–10, 2015**
**Program no. 15J2701**

U.S. Department of Justice
National Institute of Corrections

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## Introduction and Overview

Glenn Watson, Correctional Program Specialist, welcomed participants to the September 2015 meeting of the Chief Jail Inspectors Network on behalf of the National Institute of Corrections (NIC). The meeting took place at NIC's National Corrections Academy, in Aurora, Colorado.

Participants represented state agencies that have responsibility for inspection and auditing of local correctional facilities. Some agencies have oversight for juvenile as well as adult corrections or for any agency with sworn officers. The participant list is presented in Appendix A.

Guests at the meeting included:

- Mark W. Radcliff, Maryland Police and Correctional Training Division, who presented a session on security considerations during inmate hospital stays.
- Larry Reid, former Deputy Director with the Colorado Department of Corrections, presenting on security auditing and inspections.

BeLinda Watson, Chief of the NIC Prisons and Jails Division, spoke first to the group. She explained that NIC operates approximately 15 networks and is changing how they operate and share information on topics of shared relevance. Participants commented on the unique role of the jail inspectors in bridging the interests of several stakeholders and described recent efforts to identify more agencies that could join the network.

Participants and NIC staff also discussed difficulties experienced in registering for the program.

The agenda for the meeting is provided in Appendix B.

Appendix C provides includes presentation slides from the speakers.

# SESSION I: Hospital Security Detail: Scanning the Environment for "Events" and "Trends"

*Presenter: Mark W. Radcliff, Maryland Police and Correctional Training Division, Towson, Maryland*

Mark Radcliff noted that jail inmate escapes and escape attempts from hospitals are too prevalent nationwide. Radcliff is aware of at least 40 escapes/attempts in the U.S. during 2015 alone. Incidents may go unnoticed outside the affected agency and immediate community. Radcliff frequently speaks on this topic to raise awareness of specific indicators that agencies can use to train staff and reduce the chances of an escape attempt happening or succeeding.

Transportation outside the secure jail environment is inherently dangerous. Complacency can be fatal. No trip is "routine," because it's impossible to know what a detainee may be planning. Escape attempts most often occur in the hospital's emergency unit. The assailant typically has a gun or takes the officer's gun.

## Warning Signs

If an incident is predictable, it's preventable. Staff should be alert for inmates who show any of the following indicators or behaviors connected with transports and hospital stays.

- Long sentences, or charges with the potential for a long sentence
- Self-injury, perhaps inflicted specifically to prompt a transport for outside medical care
- History of violent behavior, particularly assaults on a police or other public safety officer
- Asking the medical staff unusual questions about medications and treatment
- Agitation, looking around for exits and where security officers are
- Asking repeatedly to use the bathroom
- Making demands
- Testing the officer and adherence to rules
- Attempting to engage the officer in personal conversation
- Asking the officer unusual questions, such as "Who is your relief?"

## Case Study

Radcliff presented findings from an incident review following a 2006 escape attempt from a Maryland hospital. It shows how indicators were overlooked and factors combined to create a "perfect storm" that led to the death of Officer Jeffery A. Wroten.

**Incident sequence**

- An inmate who had been receiving medical attention for several months for a pattern of self-injuries and abdominal pain was referred to the county hospital for an X-ray. A needle was found in his liver. He was aged 20 years and had an extensive adult and juvenile criminal history. Recently he had received a 30-year sentence for crimes in Virginia. He had three assault and battery charges on record, one against a police officer.

- He asked the nursing staff questions about the medication he'd be given during surgery; would it make him sleepy? Would he be able to leave the next day? He also told a nurse he was going to get out of the jail.

- Officer Wroten accepted the hospital assignment after having worked a 40-hour week plus voluntary overtime of an additional 20 hours.

- Wroten was the sole officer on duty with the inmate. It is unknown whether he received a verbal briefing from the officer he relieved. The inmate had tried but failed to engage the previous officer in personal conversation, and he refused three times to comply with orders to lie down for reshackling.

- The inmate repeatedly had been allowed to walk to and from the restroom alone and unrestrained, in violation of policy. He was also allowed to use the bathroom with the door closed, though policy required direct observation of the inmate at all times.

- Officer Wroten fell asleep several times and was awakened by nurses. His chair was out of the line of sight from the doorway. The nurses notified the jail, and the jail said it would send a relief. Meanwhile the inmate's IV unit repeatedly became disconnected, and the IV needle came out of his arm. Wroten did not object when the inmate asked the nurse to close the door partway.

- At 4:45 a.m., the inmate asked to go to the bathroom again. While he was out of his restraints, a struggle ensued. The inmate got the officer's gun and shot him in the head at close range. Before the shot, the officer was heard using the inmate's first name to tell him to stop.

- A nurse on the floor called 911 to report that Officer Wroten had been killed and the inmate was still in the hospital. Her call was transferred to the police, who didn't answer. The 911 responder should have kept her on the line and should have asked her for a physical description of the inmate.

- A hospital security officer called 911 and said a patient had a gun but didn't identify him as a jail inmate. 911 got conflicting information on whether there was an active shooter.

- The three agencies that could have responded used different radio frequencies. 911 had to call each agency separately for dispatch. Each assumed one of the others was en route to assist, but none was. The first 911 call was made at 5:11 a.m., and the first responding officer arrived at 5:25.

- The inmate demanded car keys from a civilian visiting her daughter. When that failed, he exited via the stairway and commandeered a cab at gunpoint. A hospital security officer observed the departure and followed in the hospital's security vehicle.

- The hospital security officer called 911 to share the path of travel. A sheriff's deputy began to pursue, but his vehicle's siren didn't work, so he called for another unit.
- The cab driver ran the cab off the road, and the inmate ran to a FedEx dispatch lot, where he was confronted and controlled.
- Officer Wroten's supervisor took his duty belt from the crime scene and put it in his vehicle, where it stayed for more than 72 hours. This violation of chain of custody policy impeded investigators' ability to determine how the offender got the officer's gun. The holster was found to be intact and the officer's keys and handcuffs still attached.

**Observations**

- Officer Wroten had received law enforcement training from public safety agencies in two states, but there had been a failure to train him on Maryland standards.
- Officer Wroten had had only 3 days of training on defensive tactics; officers now receive up to 40 hours. He also had inadequate training on use of restraints and weapon retention. Training relied heavily on written packets instead of skills with physical performance.
- A lack of supervision allowed an informal culture to supersede formal, trained culture on hospital escorts.
- Officers on hospital duty had no radios or cell phones to request backup.
- The detention agency had no critical incident response team training.

**Recommendations**

Lessons learned have led to new policies in Maryland that other locations should consider adopting.

- On arriving at a hospital with a transported inmate, the officer should first check in with hospital security so their personnel know who is in the hospital.
- Policy should restrict inmates on hospital transport from using a public restroom and limit them to using a bedpan or portable toilet, unless a physician orders the use of a wall- or floor-mounted toilet for a medical reason. Inmates should be issued a two-piece jumpsuit for restroom access and should remain in their restraints at all times.
- Policy should provide for two officers in a hospital escort for maximum custody inmates.
- If an inmate is suspected of manipulating the medical system, an agency should launch two separate investigations: one from the custody perspective and a second from a medical perspective.
- Automated offender case management systems are recommended because they improve an agency's ability to identify patterns, such as self-injury, that are harder to detect in paper-based files.

- Hospital staff should receive training on inmate security concerns and procedures. They should know the jail's security policies. This eliminates confusion on why officers follow certain procedures, and it encourages nurses to report any violations. Nurses and officers should be trained together at the same time so everyone's professional concerns are understood. Hospital staff should be trained to run and hide if there is an incident while the security personnel respond. An incident is a felony in progress, not a medical situation.
- Policies should restrict offender movement in the last 30 minutes before a shift change.
- Training should cover how to apply restraints with different styles of hospital gurneys.
- Inmates who are convicted and given more time to serve should be reviewed for a higher security classification.
- Jail supervisors should make rounds at hospitals to confirm officers' adherence to policy and training.
- Officer training should emphasize that if an inmate grabs for an officer's firearm, it's a deadly force situation and the officer should respond at the appropriate level.

## Resources

Radcliff recommended sources for further exploration.

- Maryland's Model Guidelines for the Security of Prisoners for EMS and Hospital Settings. Available at https://www.campussafetymagazine.com/files/resources/Security-of-Prisoners-for-EMS-and-Hospital-Settings-FINAL.pdf
- For an example of a policy based on the Maryland guidelines, see "Patients Under Arrest - Detention Center Patients - Duty Officers," Anne Arundel Medical Center, https://devtogether.aahs.org/TwoColumn.pb.aspx?pageid=42&id=650
- From Research to Application: The Case for Learning and Performance. (NIC online learning program.) Information at http://nicic.gov/library/026893.

## SESSION II: Conducting an Effective Audit/Inspection

*Presenter: Larry Reid, Deputy Director (Retired), Colorado Department of Corrections, Cañon City, Colorado*

This session covered ways to ensure that the results of security audits are translated into improved performance. As an experienced facility auditor, Reid commented that in every state he's visited, there are security systems that aren't up to speed. The core question is what each agency needs to examine in order to be comfortable with its own safety and security.

### Indicators

In the first half of the session, participants broke into groups to discuss indicators of what's working as intended, or not, in detention, hospital duty, courtroom, and transport assignments.

#### Detention

This group identified its essential indicators as follows.

- Inmate counts
- Proper use of video equipment; are the cameras working?
- Appropriate performance of officer tours of tiers/housing units
- Checks of new admission processing, such as timely mental health screenings
- Fire safety
- Training, particularly new officer training including on-the-job training.
- Direct observation of a housing unit, and asking the officer questions
- Asking the control unit officer questions, such as, "Why does that panel show the door is locked if it's not?"
- Reviewing testimony on the system breakdowns that led up to an incident
- Review of video evidence: handheld video with audio is more useful than wall mounted cameras that create only the visual record.

The group agreed that, in addition to body-worn video cameras, agencies need a handheld camera to document an incident from a few steps away from any altercation. Video recordings are exempt from public record access while the incident is in investigation. Some officers have been initially concerned that body cameras could be "Big Brother"-esque. Once in use, cameras have helped de-escalate situations, and use of force drops. More often than not, the video record resolves the "he said/he said" problem of conflicting statements between inmates and officers.

**Transport**

This group suggested several items necessary for safe and secure inmate transports.

- Sound policies are necessary before you can train.
- Before you go, do you know who you have? The inmate's security background, physical description, and photograph should travel with him/her.
- Awareness of timing is important; transport officers should keep in touch on expectations for time away and call in if any delays occur.
- Agencies should provide a checklist for emergency protocols during travel: whom to call for vehicle emergencies, etc.
- Escort protocols should be in place for special situations, such as PREA cases.
- Quality assurance often is lacking, so teams should self-assess. This prevents teams from creating their own shortcuts.
- Transport packets should include instructions for medical staff. For example, if medical personnel want restraints removed, they can be instructed to call the officers' supervisor.
- Log book records should be complete.
- Relief should be in place for staff to allow for meals and bathroom breaks.
- There should be a record of whether the transport vehicle has been searched, whether the gas tank is full, and whether the inmate has been searched.
- Hospital administrators and staff need to understand the jail's needs. Why are restraints necessary? Why are two officers needed for transport? Why are officers concerned about physical contact with the patient? Why should nurses let the inmate rub on their own lotion?
- Training for non-jail personnel should be provided freely on request.

**Hospital escort**

This group identified significant points for planning and/or review.

- Knowledge of policies and laws
- Inmate manipulation potential
- Limitations on contracted services
- Physical plant constraints/security levels supported by the building
- Communicating about who is being transferred for care and their relative flight risk
- Ensuing the inmate has an ID card and photo

- Photo IDs for medical staff
- Radio access
- Union contract limitations on hours worked and bidding processes
- Location of hospitals and expected travel time
- Public relations concerns: keeping restraints, badges, and guns out of sight and reducing disruption; it was suggested jails should call the hospital ahead of time to get a space ready.
- Being prepared for instances in which inmates select and pay for their own provider
- Mutual understanding with clinical care and security personnel
    - Making hospital personnel aware of all the potential weapons they have on their persons and in their pockets
    - Differences in medical staff security knowledge when a jail uses more than one hospital
    - Getting input from medical staff: are they comfortable working with inmates? Can they tell when jail officers are following security protocols correctly?
    - Getting input from hospital security staff: what are the security vulnerabilities in the building?
- Input from inmates after they receive treatment; cross-referencing staff reports with inmate statements may uncover discrepancies.

**Courtroom security**

This group discussed several key factors for reviewing safety and security.

- Training for all courtroom personnel: deputies, bailiffs, transporting officers, judges, recorders. Ask them, “Is our total security communication effective?”
- Communication on how an individual should be managed: what restraints are needed? Will staff be armed or unarmed? Will the victim or victim’s family be allowed in the courtroom? Is this inmate agitated?
- If a judge prohibits the use of restraints, it is still the responsibility of the transporting agency to advocate for restraints if and when needed. From an insurance perspective, the agency is liable for damages.
- Transport officers should identify any blind spots in the surveillance systems and know where an accomplice could leave an item for the inmate.
- Officers should be aware of what articles in the courtroom could constitute a weapon—chairs, pens, etc.

- Officers should have a plan for food and bathroom breaks and recesses. What are the steps? When will the inmate stay in the courtroom and when will he/she leave?
- Officers should have a plan for dealing with the news media.
- Officers should anticipate their options for protecting courtrooms from gang member threats, such as having the judge close the courtroom, using restraints, or utilizing video arraignment.

## The Security Audit Process

A security audit is a "process of evaluation and analysis of security systems, policy, procedures, standards, and practice combined for a safe and secure environment." Its goal is to identify and correct security deficiencies.

Reid reviewed the "Three Ps" of the security audit: 1) Physical plant: does the building match the mission? 2) Programs: what does the jail do that has measureable outcomes? 3) People: is their job performance great, good, or so-so? Even if a jail has a poor physical plant and its programs aren't strong, a great staff can manage it safely and effectively.

The three objectives within an audit are:

- First, to assess policy and procedure. An agency can overlook policy and procedure because it's familiar, but an outside auditor will see it fresh eyes. Standards can be cited in policy, and policy can be written to meet a standard.
- Second, to heighten security awareness and proficiency among all staff.
- Third, to strengthen the overall security operation.

A successful audit relies on skillful communication techniques, both for eliciting and for sharing information. The auditor should present a non-threatening demeanor. The auditor and the agency are on the same team, though people may be reluctant initially to share information. Asking the jail staff about their own concerns is a good approach.

Findings should be presented in terms of what the agency can do to improve on deficiencies and challenges: this is how auditing becomes useful to the staff. The audit report can state that an agency is working to accomplish a goal rather than failing to meet a standard.

The audit report should present the answers to five basic questions.

1. What are the current conditions?
2. How should conditions be, based on specified criteria and policy?
3. Why is this important?
4. How did this come about?
5. How can the jail correct the problem?

Causation can be hard to pin down. A problem may need more attention to human factors, or to a systems issue, or to finding money to solve it. Most of the auditor's time is spent developing

recommendations and in identifying priorities. High priority items are those most closely tied to safety and security.

For example, a jail may have some cells with older locks that are no longer working well. The auditor may notice whether officers reported the problem and whether the supervisors reinforced their responsibility to do so. The audit report will then document the issue for action, even if a $14 million investment isn't likely to be approved overnight. The audit report can call for the jail to create a plan of action to replace the locks, so the agency can operate according to policy and ensure the safety of inmates and staff. Options to mitigate risk in the meantime might include taking some cell groups offline until the locks are repaired.

## Priority Focus

Going into breakout groups, participants ranked basic facility elements in terms of their importance for safety and security. Averaging responses from all groups, the net ranking was:

1. Procedures
2. Training
3. Staff performance
4. Equipment
5. Facilities/physical plant
6. Monitoring/internal auditing.

### Discussion

- Expensive facilities and equipment aren't essential. A participant commented, "Good staff can supervise an inmate in a cardboard box."

- Jail managers often claim they need more staff to meet certain requirements or goals. Administrators may not see it that way. The auditor's role is to look at the system and evaluate accordingly. Too many duties may be assigned to one post. Some jails could use civilians instead of uniformed officers to perform administrative tasks.

- Auditors should take time during a site visit to simply watch. You'll see the good habits and the bad habits.

- Staffing is not static. An audit report can suggest making a plan for bringing in new staff a few at a time to reduce pressure. On the other hand, hiring more people sooner may be necessary to meet minimum staffing standards for hourly well-being checks, etc. It depends partly on what other duties the officers are assigned and whether critical position duties are being met first.

- The jail's options can boil down to hiring, using more overtime, or outsourcing inmates to another facility. Otherwise the jail's liability rises and it may lose its insurance or pay more for coverage. If one jail is kicked out of the state's insurance trust, other agencies will pay more or the trust is less solvent. County commissioners serving on insurance panels may be less likely to raise rates according to risk.

- Jails get positive feedback for having inmate work crews. Cutting back on crews is a visible way to demonstrate the need for more staff positions.

Reid said that inspectors play a critical role in corrections. Inspectors provide a link between the "boots on the ground" and the financial decisions made at the top of the organization. There's an art to recognizing deficiencies that can have life or death significance before an incident happens. Inspectors document their concerns and let the people who receive the documentation fight the battles.

## SESSION III: Objective Jail Classification

*Presenters: Shannon Herklotz, Assistant Director, and Jackie Semmler, Inspector, Texas Commission on Jail Standards, Austin, Texas*

The Texas legislature passed a statute in 1997 requiring all jails to use objective jail classification (OJC) for inmate housing decisions. Before 1997, Texas jails were separating inmates based on their misdemeanor or felony charges, and sometimes by race or age.

Texas started out using a "point additive" instrument. The point additive model is more difficult for staff to use, because staff need to know (or look up) the severity level of some 2,500 criminal charges, and the number of charges is increasing. If the severity level isn't correct, inmates can be housed unsafely, potentially leading to assaults, injuries, and liability for the jail.

By contract, the "decision tree" model is easier to learn, but it also takes training. It stands up in court, because the chance for errors is low. Staff answer yes/no questions on topics such as current charge, past violent charges if any, and length of time at current residence. The form used in Texas has aggravating factors and mitigating factors on opposite sides of the classification form. The form yields a result: placement in minimum, medium, or maximum security housing.

Compared to the additive point instrument, the decision tree model directs more inmates to medium and minimum security housing, which gives the agency more latitude on where to place them.

Jail policies should define a range of time for reassessment after initial classification. The OJC tool puts the burden for an upward or downward custody decision on the tool, not the staff's discretion. During audits, inspectors should confirm whether inmates are actually moved in response to 30- and 90-day reassessments.

### OJC Training

The Texas Commission on Jail Standards (TCJS) supports local agencies staff in understanding and using OJC properly. Texas jail standards require 4 hours of training on objective classification before officers can begin making housing determinations. Auditors have found this wasn't happening consistently. Staff who lacked training were making subjective decisions on who should be in maximum instead of using reliable and valid criteria to make housing decisions.

TCJS faces some challenges in ensuring all jails have staff who are trained on objective classification and meet other state training requirements. About 70% of Texas jails have fewer than 100 beds. Jails with a small staff find it difficult or almost impossible to send staff to training in Austin, and travel and lodging are costly. High turnover in all jail positions is another factor.

Recently TCJS partnered with the Texas A&M Engineering Extension Service (TEEX) to develop an online jailer school that includes objective classification training in the basic jailer certification program and in a stand-alone course. Training covers both initial classification and reclassification assessment.

TEEX helps new jail staff to get their minimum training hours for a temporary license and to meet other training requirements. Staff without a computer at home can use the local library's connection. A user's first TEEX course is free. Any agency can take the OJC training via TEEX at https://teex.org/Pages/Program.aspx?catID=278&courseTitle=Corrections. The Texas Commission on Law Enforcement (TCOLE), the licensing agency in Texas for peace officers, grants 4 hours of educational credits for completing the TEEX online OJC training.

## OJC in Use

The OJC training focuses strictly on the classification tool. It does not connect classification outcomes to housing plans and decisions on exactly where to place inmates, which depends on a jail's housing plan. Herklotz recommends designing jail spaces for maximum security, so a unit can be used with any custody level.

The presenters offered additional recommendations and comments.

- Staff should avoid OJC overrides, because they take away from the objectivity of the assessment. Overrides should fall below 10% to 15%.
- All overrides must have supervisor approval.
- Any overrides should be based on institutional behavior patterns. If a repeat offender has been in jail 20 times but is a model inmate once he's there, that's a legitimate reason for a downgrade.
- Overrides may be more frequent when a jail is housing many gang members.
- Staff should steer away from overrides during initial classification and wait until the inmate has been in the jail a few weeks and behavioral information is available.
- If an inmate is rated as minimum custody and the jail's only available bed is in maximum, don't override to put him in maximum.
- For original classification or a reassessment, staff should always write down a specific reason for an override. Noting "trusty status" is not enough: noting that the inmate has had no disciplinary reports is meaningful.
- Reclassification may be advised after sentencing, when inmates may be more likely to make an escape attempt.

# Session IV: Legal Issues

*Presenter: Carrie Hill, Attorney, Hennepin County Corrections, Minnesota*

## Strategies for Reducing Liability

Attorney Carrie Hill observed that the law does not require perfection from jails, but it does require agencies to do something about known risks. Hill discussed several things jail inspectors can encourage local jail officials to do to manage jails more safely and reduce their liability.

- Promote objective jail classification. OJC is an asset for jails in their duty to protect. In a lawsuit, attorneys will look at classification: what did the jail know, and was it deliberately indifferent to known risks? Jails should use *Turner v. Safley* to justify their classification criteria.

- Promote use of *Turner v. Safley* standards in other areas of policy. *Turner* identified four factors for evaluating a possible violation of First Amendment rights: 1) a rational connection to a legitimate governmental interest for every policy: in safety, security, order, control, and/or discipline; 2) availability of alternatives, if the agency is denying a privileges or accommodation; 3) the potential repercussions if the agency were to accommodate a request; and 4) whether the agency's response is exaggerated.

- Promote updating of state jail standards and local policy to reflect the elements addressed in cases heard by the U.S. Supreme Court.

- Promote after-incident reviews and follow-up on failure to train or supervise. Encourage face-to-face interviews with officers instead of relying only on paper reports.

- Reinforce that an agency should always file criminal charges against the accused perpetrator of an assault. This shows that the jail was making an effort toward change and facility safety.

- Encourage the submission and review of inmate grievances. Grievances provide a barometer of the facility and can help identify a custom, policy, or practice of doing something incorrectly. If one officer has a lot of grievances, it may not indicate a problem; the officer may be doing his/her job correctly.

- Ensure that intake officers ask all of the questions on the booking sheet, even if the inmate declines to answer them. The agency is then on record as having tried to elicit the information.

- Promote excellent report writing. Reports should use language that reflects Supreme Court concerns. Officers should clearly state the legitimate governmental interest behind their actions and cite related agency policy. They should write a clear narrative of the exact actions taken by both staff and the inmate/detainee. Writing that an inmate was "uncooperative" or "combative" does not provide enough information for a strong legal defense. Writing that he was reaching for the officer's Taser or biting the officer is more specific, accurate, and effective.

- Encourage jails to ensure that supervisors will not sign off on an incident report unless the rationale for specific actions is articulated and complete.
- Per *Sandin v. Connor*, reinforce that policies are guidelines. Staff can step outside established policy if there is a good reason.
- Convey that the *Florence* decision established that "substantial deference" should be given to a corrections agency, but the rationale for an action or policy must be clear.
- Ensure that officers are aware of bystander liability as per *Kitchen v. Dallas County*, which established that deputies who observe inappropriate use of force are liable for damages.
- Encourage jails to "close the loop" after an error or incident by identifying what it will do to discipline those responsible, update its training, acquire new radios, etc.
- Remind jails conducting after-incident reviews of video evidence to also look at details in the background. Are windows covered, trash receptacles left in the hallway, or officers standing too close to inmates or with their hands in their pockets? These issues also need follow-up.

**Guidance from audits**

Hill provided points on sharing guidance with agencies after an inspection.

- Even in a jail that technically meets standards, the auditor may have other observations that can be shared in an out-briefing.
- Being out of compliance with a standard is not necessarily a constitutional violation.
- A preliminary draft audit report can include recommendations for mitigating risk or coming closer to full compliance, and the agency can respond in writing to identify its limitations and/or efforts to compensate.
- Issues that relate to security can be identified in a separate letter to the sheriff to preserve the confidentiality of the information. The preliminary findings report could be discoverable, but it also may be possible to redact sensitive security information.
- The audit report can state a recommendation to review practices in a given area. Florida audit reports distinguish between "recommendations" and "suggestions"; recommendations are specific to standards violations and require action; suggestions are less formal.
- Jail administrators may appreciate receiving documented recommendations they can pass up to funding decision-makers. For example, if a facility has towel hooks that pose a suicide risk, the report can recommend they be changed out, starting in the special management area and continuing as funding permits.

**Incident response**

Inspection agencies are notified when an incident occurs and may provide administrative review, opening them to requests for comment from the media though actual investigations are continuing elsewhere. The response to the media can state that it would be premature for the inspection agency to respond while the investigation is not yet complete.

Hill suggested that the inspection agency might appropriately provide input from its own internal review directly to counsel, without creating exposure to the jail. After investigations are complete, the inspection agency can raise with county commissioners and sheriffs its concerns about inconsistencies in compliance with standards.

Paper or digital records examined in connection with an incident are owned by the agency for which the inspection agency develops its report. Destruction of material after the review is completed should be in incompliance with the state's public disclosure rules.

## Current Topics

### Prison Litigation Reform Act

The Prison Litigation Reform Act (PLRA) requires plaintiffs to exhaust administrative remedies before filing suit. If each state would enact its own PLRA equivalent, agencies would have a chance to respond to issues before a federal suit is filed. Agencies could take corrective action at the lowest possible level, and there would be fewer lawsuits and fewer frivolous suits.

Agencies can reject grievances that address more than one issue at a time, that do not address a grievable topic, or that do not meet the filing deadline. Per *Woodford v. Ngo*, failure to meet timelines does not equate to exhausting administrative remedies. Per *Albino v. Baca*, an inmate cannot claim he didn't know about grievance forms and process; jails should make grievance forms readily available.

After an inmate submits a grievance, the jail must provide a written response that includes instructions for appeal.

### Inmates and same-sex marriage

Per the 2015 Obergefell decision making same-sex marriage legal in all states, jails should review their policies on visitation, housing, and inmate marriages. Jails already can prevent marriages of two inmates on grounds of inappropriate fraternization. Jails should treat gay marriage partners the same as any other family member.

If a jail has both marriage partners in custody, it has no obligation to let them communicate directly. The rationale is that a spouse may be manipulative or may try to influence testimony. If two men who are married to each other are admitted to jail, they should be housed separately on the same principle used for housing other family members.

If a same-sex couple (one or both of whom is an inmate) want to be married, the jail should not deny it, unless length of stay is potentially relevant. The jail need not allow the marriage partners to touch. A marriage can be accommodated within normal visitation hours and with the partners' own clergy. The jail may assist with process, as with any other marriage, such as by transporting the inmates to appear personally at the clerk's office for a marriage license.

### Religious observance

Inmates can sue jails in connection with their right to free exercise of religion or the establishment clause, which prevents government from promoting a religious faith.

- In *O'lone v. Shabazz*, the Court upheld the jail's decision not to create a separate work crew for Muslim inmates.

- In *Lamb v. Arpaio*, the Court okayed the all-day playing of holiday music in the jail.

- Religious volunteers cannot visit inmates cell to cell. Jails can't pass out religious materials on behalf of religious groups, but items can be placed on a cart that circulates. Inmates have to request to talk to a religious adviser; advisers can't proselytize.

- "God Pods" likely will be shut down by the courts on grounds that residents are getting extra privileges.

- For any programming that has religious tones, such as AA and NA, the jail needs to be prepared to provide an alternative if a grievance is filed. The Court has found that AA/NA language referring to a "higher power" is religion-based.

- Inmates who obtain certification as a pastor cannot assume they can have a pastoral role in the jail. The jail can decline the offer, as well as offers from outside volunteers, based on a lack of requests for care.

- Jails should check the credentials of clergy who volunteer to provide services in jail. Credentials might include certifications, college diplomas, the address of the congregation they represent and any facilities where they have ministered before, and a federal tax-exempt ID. Jails should require a background check, security and PREA training, and signed agreements to adhere to the jail's rules and regulations. Privileges for clergy are not the same as for attorneys. If services are denied, the jail should state that the person is not prohibited from communicating with inmates in a personal capacity.

The Religious Land Use and Institutionalized Persons Act (RLUIPA) established the most difficult test in corrections. An agency's rationale for preventing the full exercise of religious beliefs must be "compelling," and the policy must limit practice in the least restrictive means possible. Any denial must be tied to safety and security, not to what religion is involved.

- Head coverings may be disallowed on the rationale of contraband, weapon, identity concealment, and self-injury concerns. A jail can provide its own head coverings, conduct checks in a private space with a same-sex officer, allow head coverings in the cell, and remove the privilege if the head covering is used for anything other than its intended use.

- Under *Resnick v. Adams*, a jail can evaluate the inmate's sincerity in a religious conversion. It is acceptable for a jail to say that, for purposes of attending services or requesting a special diet, inmates can't change their religion more often than every 3 or 6 months. Forms for requesting special diets and articles can acknowledge the inmate is requesting a privilege that can be removed if the inmate is inconsistent in his or her religious behavior. A minor slip-up isn't grounds for removing the privilege.

- *Holt v. Hobbs* found that Arizona could have done more to accommodate a request to allow a Muslim inmate to grow a short beard.

- A request for peyote can be denied because inmates have access to several other ways to exercise their faith.

- Vegetarian meals are not necessarily kosher.

It was suggested that jails or jail inspection agencies could provide briefing sessions or "cheat sheets" for county commissioners on the legal issues and caselaw that jails need to accommodate to avoid liability risk. State sheriffs' associations and association of counties could be an ally. In Indiana, a sheriff sued a county commissioner successfully for deliberate indifference. There have been cases where commissioners refused to fund jail construction and were sued for jail crowding.

**Use of force**

The law on use of force is different in jails than it is on the street and during an arrest, and it's currently different for pretrial vs. sentenced inmates. Jail inspectors can help apprise sheriffs and other local officials on the differences. *Graham v. Connor* applies in situations leading up to arrest and is familiar to sheriffs. *Kingsley v. Hendrickson* applies to pretrial jail inmates. For convicted offenders, the standard is through *Hudson v. McMillian* and *Whitley v. Albers.*

*Whitley v. Albers* established that the deliberate indifference test did not apply to use of force; the standard is whether force was applied maliciously to cause harm or in a good faith effort to restore order. *Farmer v. Brennan* is then the leading Supreme Court decision for guidance. *Hudson v. McMillian* established a five-part test to evaluate the reasonableness of the use of force: 1) the threat perceived by the officer; 2) the need for use of force; 3) the amount of force used in relation to the threat; 4) the effort made to temper forceful response; and 5) the extent of resulting injury.

The *Kingsley* case established a seven-part test for reasonableness: combining the five-part test from *Hudson* and two elements from *Graham*: 1) severity of the situation under way; and 2) whether the inmate is actively resisting. Cases concerning a convicted inmate will cover the *Hudson* five elements, and cases with pretrial inmates will cover all seven elements. Agencies should have their officers cover all seven factors in their reports. Sheriffs' deputies on the street should use the same format as well.

Deference goes to the officer who wrote the report. Incident reports must state the inmate's actions, any background on the threat perceived by the officer (the inmate's size, behavioral history, stance, weapons, active resistance, etc.), and why the officer did what he or she did. Latitude is allowed to account for the fact that deputies need to make split second decisions on the basis of what they know at the time. Each individual strike or tactic used by the officer ideally should be explained. If the inmate is injured and he is referred for medical care, that is all the officer's report should say.

The first draft version of an officer's report may need improvement. Reports should stay in draft status all the way up through the review process. Sergeants should not sign off on the report until all the information needed to evaluate the action has been included. This does not constitute asking the officer to change the report; it is requiring them to fully complete it. Often, a deputy doesn't know exactly what should be included and what is significant.

Factual and complete reporting is essential. No one can anticipate what will be relevant 3 years later as a lawsuit moves forward. A participant gave the example of a report stating that an officer took hold of a resisting inmate's hair so his head would not hit the floor when he had to be taken down. The protective gesture otherwise would have been overlooked in the video evidence.

A checklist can be useful for structuring use of force reports, but there also needs to be a narrative that covers all the incident evaluation criteria. The agency's after-action review should cover the same seven elements.

### Searches

Hill recommended that agency policy should define the terms "arrestee," "strip search" (using language from the Supreme Court), and "pat search." *Bell v. Wolfish* defines case criteria as the need for the search, the intrusiveness of the search, the manner in which it is conducted, and place where it is done. Probable cause never is an adequate reason to search a jail inmate as it is on the street. The *Florence* decision established that jails don't need reasonable suspicion to search arrestees entering the jail's general population.

The term "general population" also should be defined with the help of legal counsel. Hill favors language such as "any area of the facility where the inmate may have substantial contact with one or more inmates, including but not limited to the booking area, general housing, administrative segregation, and the infirmary."

Hill cautioned agencies against strip-searching arrestees returning from a court appearance who are about to be released. They can be housed separately while their record is checked for other detainers.

### Miscellany

- Hill cautioned the group against honoring detainer requests from the U.S. Immigration and Customs Enforcement Division's Priority Enforcement Program (PEP). The detainers lack judicial authority, and honoring them may violate detainees' rights.

- Agencies should talk with county counsel about inmate access to newspapers. Coverage in a local paper may put an inmate at risk. Hill recommends that jails subscribe to a national newspaper instead. Counsel can advise on whether inmates should be allowed to have their own subscription to a newspaper. A rationale for newspapers not to have privileged status is stated in *Pell v. Pecunia*. When material is considered privileged, jail officials should find out why and document the rationale.

- Cell phones in an inmate's possession on arrest may not be searched without a warrant. A phone found in a jail is contraband and can be searched. It could be connected with criminal activity.

## Session V: Network Activities

In the final session of the meeting, project leaders provided updates on their activities.

Network members have conducted research to identify more agencies responsible for inspecting secure facilities in U.S. states and territories. Information collected includes the name of the inspecting entity, its location, its statutory authority, its responsibility for adult and/or juvenile facilities, the agency's size, etc. In some locations, the American Jail Association or the American Correctional Association are the only entities that provide inspections or audits.

Participants discussed topics for a future meeting of the Chief Jail Inspectors Network. The meeting was then called to a close.

## Appendix A

## Participant List

| | |
|---|---|
| J. Sterling Penix | Arkansas Criminal Detention Facilities Review Committees |
| Allison Ganter | California Board of State and Community Corrections |
| Isaiah Dennard | Florida Sheriffs' Association |
| Cindy Malm | Idaho Sheriffs' Association |
| Mike Funk | Illinois Department of Corrections |
| Kenny Whipker | Indiana Department of Correction |
| Delbert Longley | Iowa Department of Corrections |
| Kirstie Willard | Kentucky Department of Corrections |
| Ryan Anderson | Maine Department of Corrections |
| Howard Ray | Maryland Commission on Correctional Standards, Department of Public Safety |
| Jennifer Gafney | Massachusetts Department of Correction |
| Timothy Thompson | Minnesota Department of Corrections |
| Jim Muskovitch | Montana Association of Counties |
| Felix Martinez | New York City Board of Corrections |
| Steve Engen | North Dakota Department of Corrections |
| John Adams | Ohio Department of Rehabilitation and Correction |
| Tom Grieshaw | Pennsylvania Department of Corrections |
| Shannon Herklotz | Texas Commission on Jail Standards |
| Jackie Semmler | Texas Commission on Jail Standards |
| Kristi Dietz | Wisconsin Department of Corrections |

# Appendix B

# Meeting Agenda

# Appendix C

## Speakers' Presentation Slides