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National Institute of Corrections

Jails Division

Large Jail Network Meeting

January 21-23, 1996

Longmont, Colorado

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National Institute of Corrections
Jails Division
Large Jail Network Meeting

January 21-23,1996 **Longmont, Colorado**

These proceedings present highlights of a meeting of NIC's Large Jail Network that was held in Longmont, Colorado, January 21-23, 1996. The meeting was attended by approximately 70 administrators of the largest jails and jail systems in the country. The meeting focused on issues surrounding deaths in the jail setting. Following is a brief summary of the panelists' presentations:

◊ *Opening Address: The Dilemma of Jail Deaths.* Dr. John Clark, Chief Physician, Los Angeles County Sheriffs Department, pointed to the importance of accurate reporting of jail deaths. He also summarized nine years' data on deaths of LA County inmates and identified measures taken to lower the risk of death from specific causes.

◊ *Overview of Dynamics of Jail Population.* Michael O'Toole, Chief of NIC Jails Division, discussed data on jails, highlighting the importance of using data that is appropriately disaggregated and based on the local context.

◊ *Preventing In-Custody Deaths.* Arthur Wallenstein of King County, Washington, cited the value of the National Commission on Correctional Health Care standards on health care in preventing in-custody deaths. John Alese described Pima County Adult Detention Center's successful suicide prevention program. Sudden in-custody death syndrome was discussed by Robert Conroy, who reported on Santa Clara County, California's approach to preventing such deaths. San Diego County's professional medical administrator has been responsible for significantly strengthening the jail system's mental health capacity, thus reducing jail deaths, according to Ben McLaughlin.

◊ *Resources Available for Dying Inmates.* David Owens, Camden County, New Jersey, described the variety of resources he has identified to provide assistance in dealing with dying inmates.

◊ *Community and Media Relations in the Context of In-Custody Deaths.* Mark French, Pierce County, Washington, presented a tongue-in-cheek lesson on how *not* to deal with the media. Multnomah County, Oregon's open and proactive approach to dealing with the media was described by Dan Noelle.

◊ *Coping with Staff Deaths.* Paul Cooper described San Joaquin County's program for responding to staff deaths, including an Employee Assistance Program, a peer support network, and the chaplaincy. Michael O'Malley of the Vermont Department of Corrections pointed to the importance of recognizing the impact of critical incidents on staff and of establishing a process to help them deal with their personal responses to deaths or other critical incidents. Michael Hennessey described San Francisco's unique law allowing transfer of sick or vacation benefits to other city or county employees with catastrophic illnesses.

◊ *The Crime Bill and Its Effect on Corrections.* Larry Meachum of the Office of Justice Programs, U.S. Department of Justice, described the provisions of the 1996 Conference Committee Version of Title II, Prisons: Violent Offender Incarceration and Truth in Sentencing Grants and their impact on corrections, especially local jail facilities.

Opening Address: The Dilemma of In-Custody Deaths

John H. Clark, M.D., M.P.H., Chief Physician, Medical Services, Los Angeles County Sheriffs Department

Inmates in correctional facilities today are more violent, sicker, older, and stay longer than in the past. All these qualities affect not only medical care, but also the morbidity and mortality of inmates. In-custody deaths:

- are stressful to both medical and custody staff;
- almost always result in a lawsuit;
- frequently are media events;
- often put staff at odds in terms of who is to blame;
- result in additional stress when appropriate discipline is administered.

It is important to be honest about the number of in-custody deaths that occur in our facilities. Some jurisdictions routinely contend that there were no in-custody deaths in the jail. In these jurisdictions, when inmates die in custody, they are always taken to an acute hospital or elsewhere to be pronounced dead. Although in-custody deaths are not something to be proud of, we must be honest about their occurrence in order to find ways to prevent some of those deaths.

In-Custody Deaths of Los Angeles County Sheriffs Department Inmates

An epidemiological review of nine years' data on in-custody deaths in the Los Angeles County Sheriffs Department indicated that the causes of inmate deaths were as follows (listed from most frequent cause to least):

1. Cardiovascular disease
2. HIV
3. Suicide
4. Unknown
5. Seizure disorders
6. Sepsis
7. Homicide
8. Cancer
9. Renal disease
10. Chronic pulmonary disease
11. Meningococcal disease
12. Pulmonary emboli

Measures Taken to Prevent In-Custody Deaths

One goal of doing an annual study of morbidity and mortality rates is to reduce the number of in-custody deaths. By analyzing the numbers and causes of deaths each year in the jail system, the Los Angeles County Sheriffs Department Medical Services has identified ways to prevent some deaths. For example:

- *The risk of death from cardiovascular disease*-- The department has significantly decreased deaths in this category over the nine-year period by recognizing that a 40-year old inmate is actually more like a 55-60-year-old in terms of physiology. Therefore, chest pains must be taken more seriously than it might be in a healthy 40-year old. A 27-year-old cocaine abuser must also be evaluated seriously if he is complaining of chest pain.
- *The risk of death from seizure disorders*-- The Medical Services Department has been able to affect such deaths by instituting a new staffing pattern in the inmate reception area. Since 1993, a physician has been located in the reception area to write prescriptions for incoming inmates with seizure disorders; the inmate is also given a three-day supply of needed medications to use until the prescription can be filled. Since 1993, the jail system has seen a decline in deaths from seizure disorders.
- *The risk of death from stricide* --Deaths from suicide are the most disturbing, because they are preventable. Los Angeles County does everything possible to prevent suicides. Specific rules and regulations define the suicide prevention tactics as well as disciplinary steps for staff negligence.
- *The risk of death from chronic pulmonary disease*-- The jail system went tobacco-free in 1991, which decreased deaths from chronic pulmonary disease among inmates.
- *Deaths from pulmonary emboli* -- A change in the policy on four-point restraints, which has incorporated monitoring and progressive restraints, has decreased the risk of death from pulmonary emboli.

Sudden In-Custody Death Syndrome

Sudden in-custody death syndrome is defined as “the unexpected death of a subject which occurs during arrest or while the subject is in the custody of law enforcement or corrections and is the result of several different external and internal factors acting alone or in concert.” Sudden in-custody death syndrome is also known as positional asphyxia, because the way in which the person is placed may result in a lack of oxygen or an increase of carbon dioxide in the blood, causing unconsciousness.

Internal and external factors working together may cause such deaths. These factors may include:

- Violent/bizarre behavior
- Use of force
- Use of restraints
- Cocaine use and toxicity
- Alcohol intoxication
- Obesity
- Intense physical activity
- Hypothermia
- Positional asphyxiation

Several of these factors may work in concert to cause sudden in-custody death syndrome. Although some individuals have suggested that tasers or pepper spray may cause such deaths, the way a person is restrained after use of force is the most frequently shared characteristic of these cases. The ACLU has identified 20-30 deaths possibly related to OC pepper spray, but the common denominator in all these deaths was that those who died had been placed in a position in which they could not breathe.

Recommendations

- Incorporate data on positional asphyxia into staff training.
- Have a physician in the booking area to treat problems as individuals are admitted into the jail (efficacy depends on the number of daily bookings and the degree of pathology that is identified).
- Eliminate smoking.

- Require staff to have an annual screening for tuberculosis.
- Endeavor to have dying inmates released through a "compassionate release" program, but only if the dying person has an appropriate place to go, such as a hospice.

For additional information, contact Dr. John Clark, Chief Physician, Medical Services, Los Angeles County Sheriffs Department, 213/974-0149.

Dynamics of Jail Population: An Overview

Michael O'Toole, Chief, NIC Jails Division

Background

Much of the data on jails comes from the Bureau of Justice Statistics, which completes a total census of jails every five years and an update annually. The full data set is available from BJS on CD-ROM. According to BJS data, the average daily population of jails in this country was at 490,000 in 1994; by now, this figure has just about passed the half-million mark.

It is important to be clear about the context of jail data and to disaggregate it appropriately. The tendency is to deal with overly aggregated data, which is not helpful in terms of policy development. Some examples of what an analysis of BJA data reveals:

- *Total Jails by Size*- 2800 of the 3304 jails in this country hold fewer than 250 inmates; this group of jails holds 2% of the nation's jail population. Thirty-three percent (33%) of jail inmates are in the 76 largest jails, and 53% of inmates are in the 200 jails with populations over 500.
- *Jail Occupancy* Rates-Small jails operated at 67% of their rated capacity in 1994. While staff and resources were a problem, small jails had enough beds. Between 1988 and 1993, there was considerable construction of medium-sized jails. Although there are crowded jails in both the small and medium jails, in the aggregate they are not operating at capacity. In jails with 500-1,000 inmates, there is significant crowding, which is being eased by construction. Among jails that hold over 1,000 inmates, however, crowding is a severe problem.
- *Jails by Region*- 1993 data shows the number and percentage of jails by region of the country and the percentage of inmates held in each region:
  - South-- 1,591 jails (48% of jails) holding 210,599 inmates (46% of population)
  - West-- 518 jails (16% of jail) holding 104,688 inmates (23% of population)
  - Northeast--228 jails (7% of jails) holding 73,871 inmates (16% of population)
  - Midwest--967 jails (29%) holding 70,646 inmates (15%)

Dr. Clark's presentation made clear the ways disaggregated data can be helpful in terms of policy development. By looking closely at specific aspects of data on inmate deaths, he was able to identify policy changes that could have a real impact in reducing the likelihood of inmate deaths from certain causes.

Static vs. Dynamic Ways to Look at Jail Populations

The static approach to describing jail populations is to say that the total average daily population in our nation's jails is 500,000. However, describing jail population dynamically is to point to the fact that there are 10 million commitments to jails each year. This is one difference between jail and

prison populations. While a prison and a jail may both have a rated capacity of 1,000 and an average daily population of 1,000, they differ widely in terms of new commitments. The prison would admit about 750 inmates annually, while the jail, whose population might turn over about 36 times, would admit a total of 36,000 inmates during the same period.

Jails and prisons are alike in important ways, but what is really is important is the ways in which they differ. These differences account for the major misunderstandings that inevitably create difficulties for jails. The static population figure of 1,000 might suggest that prisons and jails have the same problems. However, when you look at the number of individual offenders involved in both, it is clear that the 1,000 bed prison deals with 7,750 individuals, while the 1,000 bed jail deals with about 36,000.

This misunderstanding was apparent in an NIC-funded study of jail suicides. It is important to make clear whether rates of jail suicide are based on the static 500,000 average daily population or on the 10 million who actually move through the jail. If the jail suicide rates are based on the ADP, they are 10 to 15 times higher than in the general population, but if they are based on the 10 million, the suicide rates are actually lower than in the general population.

The figures on diagnosable serious mental illness can also be misleading. About five years ago, it was estimated that 6 to 8 percent of jail inmates were seriously mentally ill. Eight percent of 500,000 people is only 40,000--hardly enough to constitute a national crisis. What was really at stake was the 10 million total jail admissions, which would have revealed a problem on the magnitude of 800,000 individuals.

Average Length of Stay

Inmates' average length of stay is another area in which aggregated data can cause misinterpretations. Jail populations turn over approximately 36 times a year, which creates the inference that the average length of stay for inmates is 10 days. However, 85% of inmates are released within 96 hours. There is really a bimodal distribution at work. Inmates stay fewer than four days or more than 30--which creates the IO-day average.

This recognition means that jails should not be designed as 10-day facilities. The misunderstanding about average length of stay has affected aspects of jail design and operations, including the way booking rooms are designed and the types of programs provided. In addition, jails have three very different functions taking place under one roof booking, inmate holding, and detention. It is also important to recognize that jails differ significantly in terms of size, purpose (sentenced or pretrial), and inmate population profiles (who goes to jail, why, and how long they stay). Local custom is important in determining the profile of the inmate population.

Conchsion

Rather than using national averages, it is important to use local, disaggregated data to analyze a local jail. Instead of using national data or other people's data, jail administrators need to develop local data and to use it in making policy decisions addressing a range of significant issues.

For additional information, contact Michael O'Toole, Chief NIC Jails Division, 303/682-0639. Copies of figures derivedfrom BJS data are in Appendix A.

Preventing In-Custody Deaths

Arthur Wallenstein, King County, Washington

Importance of Reporting Jail Deaths

The Bureau of Justice Statistics' annual report, *Jails in America*, lists in-custody deaths, but if jails do not report 100% of the deaths, the report will not be accurate. Because the issue of in-custody deaths is value-laden and likely to result in a lawsuit and media attention, there is a natural reluctance to report all deaths.

The Large Jail Network can be a critical link in ensuring that inmate deaths are reported accurately, because our facilities account for 37% of the nation's total jail population. If we are going to learn about how to deal with some of the causes of in-custody deaths, then we must report 100% of deaths. We must count all deaths that occur in the hospital or ambulance to inmates in our custody.

The Element of Luck

To some extent, luck plays a part in the number of deaths in our facilities. For example, the release of very sick persons before their malady is known or before they die may be a result of luck.

Luck is also related to suicides, as the number of suicides is very small compared to the number of suicide attempts. We can prevent most suicides--though not all--through proactive policies and procedures, but luck is also involved. The jail population size has no impact on the number of suicides. In fact, the larger the jail, the less amount of time is likely to be spent on proactive screening. The smaller the jail population, the greater the time available for screening and triage.

King County Inmate Deaths

Through a research project being conducted with the University of Washington, King County has reviewed inmate deaths from 1975 to 1995. The medical examiner reviewed the data and found a total of 33 deaths during that period, an average of 1.5 deaths per year. An analysis of that data shows that since 1991, as bookings have gone up, deaths have gone down dramatically.

The year 1990 was a watershed year in which the jail saw six inmate deaths as well as the departure of senior managers, medical directors, jail health managers, and others. Some of the deaths were clearly related to inadequate processes in the jail. What has made the difference in the decreasing number of inmate deaths in King County is accreditation.

National Commission on Correctional Health Care

Jaye Anno's 1992 NIC publication on correctional health care established the focus, the ground work, and the case for accreditation. It represents the finest work ever done on how to establish a quality correctional health care program. It is available through the NIC Information Center.

By following the guidelines for NCCHC accreditation, King County has been able to reduce the number of inmate deaths radically since 1991.

Of the 3,300 jails in this country, only 158 are accredited by the NCCHC. It is possible that a higher percentage of large jails than of small or medium jails are accredited, but accreditation has still not caught on. Nothing supersedes good policy on health care, and nothing is a better guide for the proactive review of a facility's health care policies than going through the accreditation process. NCCHC provides detailed prescriptive packages for every important issue, including:

- Intake;
- Triage;
- Testing;
- 14 day physicals;
- Sick call;
- Inmate reporting of medical concerns;
- Recordkeeping and documentation;
- Medication protocols;
- Health care protocols;
- Restraint protocols;
- Peer review;
- Security staff-health care interface;
- Training in universal precautions;
- Intensive external review of operations.

Following these guidelines is the best way to lower the number of inmate deaths. No other technique currently exists that has been so carefully developed within corrections. King County is absolutely dependent on following NCCHC accreditation guidelines.

Few studies have been done on deaths of jail inmates, but in reviewing them, King County found that its jail system differed from virtually all other counties in that it had a higher suicide rate. The point of studying in-custody deaths is to see if there are ways to identify physical maladies that could have been identified earlier to intervene and prevent death. Right now, King County is focusing on preventing suicides through the intake and the booking processes.

My point again: Nothing substitutes for rigid adherence to the national NCCHC standards which correctional facilities helped to develop.

For additional information, contact Arthur Wallenstein, Director, King County Department of Adult Detention, 500 5th Avenue, Seattle, WA 98104, 206/296-1268.

John Alese, Pima County, Arizona

Background: Pima County Adult Detention Center

Pima County's three direct supervision facilities are very crowded. Originally designed with a rated capacity of 1144, they currently hold as many as 1651 inmates. In 1995, 22,000 persons were booked into the facilities. The inmate population is constantly changing; the greatest turnover is within 96 hours; most inmates are held one to three days. Because of this large and transient population, suicide prevention is a high priority. Following two suicides in 1993 and another three in 1994, officials focused on the need for a specialized suicide prevention program.

Pima County's Suicide Prevention Plan

Pima County staff determined that the suicide prevention plan should emphasize the following:

- Promoting maximum staff and inmate interaction in the critical first 48 hours of incarceration;
- Providing a higher level of crisis intervention availability to new inmates;
- Intervening during the inmate's initial 48 hours in custody, a critical period for new inmates, to reduce traumatic effects of incarceration and possible actions of self-harm.

The action plan developed to accomplish these goals proposed the following:

- Assign an additional corrections specialist with mental health training to the intake pod, booking, and other intake areas on four-day, ten-hour shifts.
- Adjust the work hours of corrections specialists assigned to the intake pod to provide maximum availability to the new inmate population.
- Provide specialized in-service training to corrections officers assigned to the intake pod to enable them to interact with new inmates more effectively and train them to evaluate new inmates' potential for self-harm.
- Modify operations in the intake pod to encourage inmates to remain the dayroom area to make it easier for officers to observe them and to promote additional interaction with officers. This change makes it easier to evaluate the inmate's state of mind and observe possible signs of depression or suicide tendencies.
- Conduct initial classification interviews and evaluations during the inmate's first 16 hours in the intake pod. The purpose of this change is to make an in-depth determination of each inmate's risk factors for potential suicide and self-harm on a timely basis.
- Ensure that supervisory staff encourage a team approach to suicide prevention and suicide risk evaluation by having formal and frequent interaction and information

exchange through Operations, Support Services, and Administrative Services. Meetings are conducted weekly or bi-weekly to evaluate system deficiencies and to develop appropriate remedies.

- Begin offering outdoor recreation to inmates in the intake pod for one hour per day in order to increase inmate activities, encourage socializing among inmates, and increase inmate interaction with staff
- Institute a modified staffing pattern for the intake pod to support the goals identified above. The staffing was based on the matrix management scheme already in effect throughout the facility. One specially trained correctional sergeant was made responsible for intake and suicide prevention, and staff trained in suicide prevention are assigned to the intake pod.

None of these changes cost additional dollars. Because of the high priority placed on suicide prevention, Pima County recommitted existing resources to implementing this plan.

Maximum Observation Strategies

1. Booking, identification, and Intake Pod staff became a team, overseen by a sergeant.
2. A form documenting staff observations during intake was initiated. The form travels with the inmate through the intake process and lists any factors that could be indicators of a high risk for a suicide attempt.
3. Observation of inmates in the intake pod was maximized. On arrival in the Intake Pod, the inmate's "Contact Information Form" is reviewed by the pod officers. Intake staff conduct an inmate orientation on the facility rules, regulations, and behavioral expectations. They answer inmate questions about court procedure and arrest charges. Inmates are provided maximum dayroom time to make phone calls and socialize in the pod.
4. Sufficient uniformed staff are assigned to the Intake Pod to allow the officers to interact frequently with the inmates, observe their behavior, and make regular observation rounds throughout the unit.
5. Three crisis management trained counselors are assigned to the unit, giving coverage for the unit for the majority of the calendar day. In addition to their general counseling and evaluative duties in the unit, their priority "target population" for evaluation of the potential for suicide attempts are white males 18 to 24 years old. This is based on national statistics indicating that the highest number of suicides/attempts are in this segment of the inmate population. Inmates of all races falling into the 18 to 24-year-old category are interviewed/evaluated by the specialist first.
6. The team holds regular meetings to discuss problems, potential improvements to the system, and discusses recent changes in policy, procedure, and other administrative or operational actors which may affect unit functioning.

Factors Contributing to Jail Suicides

Arrest/incarceration may result in fear of surroundings, feelings of loss of freedom, feelings of loss of personal control, feelings of anxiety, severe depression, and suicidal ideations. Other factors include intoxication, drug use, emotional state, and the nature of the crime. The most critical period for suicide prevention is the first 48 hours.

Essential Elements of Suicide Prevention

1. Trained staff -- Staff are trained in crisis intervention and observation.
2. Screening interview--A screening interview form follows inmate during the entire time he/she is in the facility.
3. Identification of high risk individuals--The focus is on those 18 to 24 years old.
4. Observation--Staff are maximized in the intake area and on late swing shifts.
5. Prompt intervention--Specially trained counseling staff interview all newly arrested offenders.
6. Timely transmittal/sharing of information--Regular meetings of staff identify problems in the system.
7. Inmate orientation--Intake staff orient inmates to the rules of the facility.

Success of the Suicide Prevention Program

Since the program was implemented, there have been no inmate suicides or suicide attempts in the facility. In addition, staff morale in the intake unit is very high, because the staff recognize that they are contributing to an important effort within the organization.

For additional information, contact Captain John Alese, Pima County Sheriff's Department, P. 0. Box 951, Tucson, AZ 85702. A copy of Pima County's "Jail Suicide Prevention Plan" is available from the NIC Information Center.

Robert Conroy, Santa Clara County, California

Background

Santa Clara County, located about 50 miles south of San Francisco, has about 1.5 million people. At any given time, there are 4,500 jail inmates and another 1,000 on various types of programs. The jail had 69,000 bookings last year.

Sudden In-Custody Death Syndrome

Santa Clara's facility is overcrowded, which increases the likelihood of sudden in-custody deaths. In Santa Clara, any death involving officer force draws media attention and political backlash. Administrators are therefore very interested in preventing sudden in-custody deaths, defined as "the unexpected death of a subject which occurs during an arrest or while the subject is in the custody of law enforcement or corrections and is the result of several different external and internal factors acting alone or in concert."

Positional Asphyxia

The most common cause of sudden in-custody death syndrome is positional asphyxia, an impairment of the respiratory system in which oxygen is decreased and carbon dioxide is increased. Positional asphyxia often results from what was previously a common practice of confining subjects in a maximally restrained position, hog-tied and prone. This position can lead to positional asphyxia as it can cut off air flow to the lungs. When someone is placed on their abdomen, the lungs and diaphragm are not able to contract as needed. When a violent struggle ensues, the contractions need to increase. Moreover, when someone is struggling, in our business the tendency is to put pressure on the person's back--which exacerbates the problem.

Certain factors predispose someone to positional asphyxia, including obesity; alcohol or drug abuse, or an enlarged heart.

The recommended response to positional asphyxia is-- immediately on gaining control of the subject--to roll the person over on his side or place him in a seated position. Never hog-tie anyone. If the person seems to be suffering positional asphyxia, get immediate medical attention.

Santa Clara County's Approach to Preventing Sudden In-Custody Deaths

- Training--Intake staff, medical, and mental health personnel are being trained to recognize those predisposed to positional asphyxia.
- Intake screening--Intake screening has been changed to facilitate better identification of potential candidates for positional asphyxia. The intake form has been revised to ask questions about the use of force or any physical trauma.
- Requiring additional things of the arresting agency--The arresting agency must now fill out a form to address questions about use of force. We will no longer take anyone who

has been hog-tied without a medical clearance.

- Updating use of force policy--The use of force policy does not now address sudden in-custody deaths. We are using the restraint chair as an option to other forms of restraint.

One impetus for these changes is that we currently have an inmate in a vegetative state as a result of our actions. Positional asphyxia possibly contributed to his state. We tape violent incidents as often as possible, and, when viewing the tape of the incident in which this happened, it is obvious that staff were not being malicious, but they were not concerned about the safety of the inmate. We are trying to prevent other such incidents in the future.

For additional information, contact Robert Conroy, Santa Clara County Department of Corrections, 180 West Hedding St., San Jose, CA 95110-1772, 408/299-4005.

Ben McLaughlin, San Diego County, California

Background

Until 1989 the San Diego Sheriffs Department could not get the attention of the county to help deal with mental health problems. However, in 1989, tier the County of San Diego paid $2 million for medical and psychiatric-related lawsuits in addition to being sued for not having a women's psychiatric unit in the county jail system, the county took notice. As a result, the sheriff was given permission to hire a professional medical administrator to oversee all medical and mental health services in the jail system.

Jail Deaths, 1989-1995

The county saw a significant drop in the number of deaths in the jail system from 1989 to 1995; in 1989 there were 13 deaths, none from suicides; in 1995 there was one death, a suicide. During this period, the average daily population increased from 3,900 to 5,200. The medical administrator, hired in 1990, deserves credit for helping to reduce the number of deaths. One thing that the medical administrator found was that, in addition to suicides, many other deaths in the jail were related to mental health problems. Staff interventions with these individuals had sometimes resulted in a death.

Mental Health Facilities in the San Diego County Detention Services Bureau

Today, the San Diego County Jail system has the largest mental health facility in the county. It includes:

- A psychiatric security unit for men at the 1600-bed facility
  - This is the largest mental health facility in the county. It includes a 24-bed acute care facility, and a 200-bed non-acute unit. It has an average daily population of 300 under psychiatric care and includes 40 mental health providers. In 1995, the facility handled 15,400 cases
  - At present, the mental health staff are employees of the county's mental health division, and the sheriff provides all security support services.
- A psychiatric security for women at Las Colinas
  - This small mental health unit includes twelve mental health providers serving 25-30 women, on average, receiving psychiatric care. There is a 12-bed voluntary treatment facility on site, and five acute care beds are reserved at the county mental health facility.
  - Mental health staff are employees of county mental health, and the sheriffs department provides security support services.

Screening for Mental Health Problems at Intake

San Diego now screens for medical and psychological problems at receiving in every jail. Inappropriate answers indicating mental health problems trigger an immediate referral to a psychiatric security nurse or psychiatrist. Appropriate placements are made immediately to a safety cell, the psychiatric security unit, or the county mental health facility. Security staff are also trained to recognize potential psychiatric cases. These steps have all made a difference in the number of deaths in the facility, and they can all be attributed to having a trained medical administrator.

The County of San Diego, with a population of two and a half million people, has only 30 acute care mental health beds. What happens is that many people needing mental health beds are in the community but are not being treated. Inevitably, they land in the jail. This perpetuates the view that the jail is the bottom line mental health provider in the county.

Summary of San Diego's Current Issues and Concerns

- There is an escalating demand for mental health services; over the past five years, the number of mental health patients has grown proportionately faster than the inmate population, and all indications are that this trend will continue.
- County dollars are not going far enough to provide mental health services in the community. San Diego County has 30 acute care mental health beds for 2.5 million people.
- The cost of mental health services is increasing.
- Community mental health services shrink as county dollars flow to the jail system. As more money flows to the jail, the idea that the jail is the bottom line mental health services provider for the county is perpetuated.

For additional information, contact Assistant Sheriff Ben McLaughlin, San Diego County Sheriff's Department, 9621 Ridgehaven Court, Box 429000, San Diego, CA 92142-9000/(619) 974-2240. Copies ***of*** *a document describing San Diego County's mental health services arc available from the NIC Information Center.*

Resources Available for Dying Inmates

David Owens, Camden County, New Jersey

An HIV-positive inmate in Camden County was recently given six months to live. As his health began to deteriorate, the county put $265,000 into treatment. Unfortunately, the individual died. The county is now being sued by his family, who are saying that the Camden County Correctional Facility didn't do everything we could to prolong his life.

The question is how can we best manage our resources to respond to dying inmates. No one in the community wants to assume responsibility for dying inmates. Historically, the local health department has distanced itself from the problem. However, if the dying individual were not being held in a correctional facility, the health department would have full responsibility to provide care. Private nursing homes do not want to take dying inmates, either.

Resources for Dying Inmates

Camden County Corrections petitions the court to release most dying inmates. However, it is impossible to obtain the release of individuals charged with capital crimes or sexual assault. Those inmates will therefore continue to be managed within the corrections system. The following options are being explored for caring for dying inmates:

- Working with the local health department--Owens has discussed with health department administrators about how the two agencies can work together and share resources for caring for dying inmates.
- Contracting with the local hospice--The county has signed a contract with the local hospice to house dying inmates. This was difficult to achieve, as the hospice was willing to come in and work with the dying inmate but was initially reluctant to make its own facilities available to these individuals.
- Developing a special management unit--A special unit for caring for these seriously ill inmates has been set aside in the facility.
- Obtaining a catastrophic insurance policy--Under such a policy, if costs to the county exceed $125,000, insurance would pick up the costs. This is an exciting possibility, as it provides the possibility of a hedge against exorbitant costs. The most recent estimate is that such a policy would cost about $65,000 a year; we are hoping we can obtain one for less.

Other Suggestions

- One solution may be to develop separate, regional facilities for dying inmates.
- The managed care concept offers another useful approach

For additional information, contact David Owens, Jr., Warden, Camden County Correctional Facility, 330 Federal Street, Camden, NJ 08103, 609/225-7632.

In-Custody Deaths: Community and Media Relations

Mark French, Pierce County, Washington

"How to Lose with the Media and Community in Managing Custody Deaths without Even Trying"

A correctional administrator, sheriff, or public official is assured of failure with the media, the community, and perhaps their employees after an in-custody death or other crisis even if they follow my nine-step prescription. It is easy, and it works.

1. Don't establish in advance of the death rapport or trust with the editor, police beat reporter, or community leaders--especially the minority community. Why bother? We are busy executives who don't have the time to get to know the people who have the power to shape our agency's image and future. Meet them for the first time during a crisis. That way, suspicion and distrust will abound. Everything you say will be on the record, even if you don't want it that way.

2. Don't prepare in advance for a press conference or a meeting on the crisis event. Why let preparatory activities decide the success or failure of your contact? Just fly by the seat of your pants. Lots of people do. Who needs the confidence and comfort that preparation brings, anyway? If you do not prepare, you will have a chance to display your depth of knowledge on the myriad of subjects that will come up during the interview or meeting because you didn't limit the topics in advance. Come to think of it, you won't have to spend valuable time becoming acquainted with the circumstances surrounding the death, the history of similar incidents, the facts supporting or weakening your position, or in formulating answers in advance. You won't have to think about key points you would like to make.

3. So many people are inconsiderate of your schedule that you should not be considerate of theirs. Let the media, family members, or community leaders work around your schedule rather than you around theirs. Make their lives difficult. Have the media view you and your agency as a hindrance to complete news coverage. You will really endear yourself to them. You might even hinder your public relations officer's ability to get his/her job done by restricting the possibility of generating favorable publicity for your agency or about the event.

Speaking of department spokespersons, use several different ones after the death. The resulting official version inconsistency will send mixed messages to the community and give your under-worked staff more work duplicating one another. If you come from a multiple media outlet or a large community, you can create more work for your staff by not holding a press conference or public meeting. Your staff can spend their time responding to repetitive, redundant, superfluous, and duplicative questions about the same issues instead of doing other, less important things.

4. During press conferences, interviews, or public meetings, get into arguments with reporters or citizens. Take offense at their questions and, if necessary, lose your temper. Be curt with persons who are trying to express their reality to you. That way, you won't have to spend time listening to community concerns about or priorities for your jail. Embarrass those who ask dumb questions. You'll make a lasting impression. If you hold a press conference, don't hold it in an area in the jail similar to the one in which the death took place. We have security to consider. This way, the media will be more inclined to speculate as they report the information you gave them.

In dealing with the media, treat them all the same. Ignore the fact that radio, TV, and the newspaper use different communications methods to reach their audience. This will add to their frustration and change their view of you.

Who knows, from this or other post-incident responses to the community or media, maybe you will become the evening news story instead of the death. Your family and friends will enjoy your new-found publicity. So will the voters if you are an elected official.

5. Now comes my most valuable piece of advice: When things go wrong, *as they invariably do*, be evasive, unavailable, silent, reticent, cover up, stall, or say "no comment." If necessary, lie. You won't have to take the time trying to include information favorable to your jail in the story. Another person, such as the decedent's next of kin, their attorney, or your inmates will get their version of the death reported instead. You will increase the likelihood that some reporter will get an exclusive story with prominent play in the evening news. Visions of Pulitzer Prizes will be dancing in their heads. The story will "get legs," or a life of its own because of you. It will play out, bit by bit, for days, perhaps weeks or months. Won't this be good for your jail? The reporters covering the story or your political opponents will love you for providing them with so much ink. You and your jail's credibility and image will reach unprecedented levels.

6. Diminish the death's importance or display callousness, insensitivity, or disregard for the decedent, especially to their next of kin. After all, they are only family. Smile or grin when dealing with them. Let them know that you have little use for criminals, including the decedent. Don't meet personally with the family or express condolences to them. Don't identify with their loss as one parent to another. You certainly don't want to keep them informed about the case status or offer them assistance, such as your chaplaincy program. Why should we be concerned about their parental guilt, sense of loss, and anger? These behaviors work well, especially with disenfranchised members of the minority community in cases in which force was applied. People will trust you and believe that what you tell them about the death is the truth, the whole truth, and nothing but the truth.

7. Do not investigate the death or do an inadequate investigation. You know, meeting or exceeding every reasonable investigative standard is a lot of work anyway. If you can avoid an investigation and there is a coroner's inquest, criminal prosecution, or a lawsuit, you can reconstruct the scene and relocate the released inmate later. If there

wrongful death action to discover. Nor will there be any documents you will have to waste time reviewing to refresh your memory before your deposition or court testimony.

Whether you have an investigation or not, publicly state that you did everything by the book and don't intend to change one procedure, even with the benefit of hindsight. Don't review the death from the human perspective or of how to avoid a recurrence. Since everything is according to procedures, even when the procedures don't make sense or are outdated, you are off the hook. This attitude will inspire public confidence in your managerial skills. The community and media will know that your department is in tip-top shape and cannot be improved upon.

8. Who needs peer support teams, pastors, paid administrative leave, or critical incident stress debriefings for staff? Can't they be stronger and more insensitive? They don't really have feelings, do they? Why do officers who have unsuccessfully administered CPR or cut down hanging suicide victims suffer from guilt or depression. It wastes time and energy!

9. My last tip: Don't adequately train your personnel, especially booking staff, on issues invariably related to in-custody deaths, such as the use of force, positional asphyxia, suicide prevention, mental illness, acute alcohol or drug intoxication, or the like. It is so costly, and we are so busy trying to run overcrowded jails, comply with court orders, attend NIC training, and supervise staff. Who has the time?

In closing, if you follow my nine-step media and community relations plan, you are assured of several things. First, you will get a lot of ink and camera, especially on the op-ed pages and call-in talk shows. Maybe Mike Wallace and the "60 Minutes" crew will pay you a visit. You will be the featured guest at many community meetings about the death. Your internal and external competitors will love you! Your family will hear your name talked about like never before. Media coverage and community concern will last for some time. You will become better acquainted with the prosecuting attorney, risk manager, and your boss. Your career will most certainly advance, too.

Dan Noelle, Multnomah County, Oregon

The state of Oregon has a broad public records law, which means that if you operate in the public arena, anything may be under public scrutiny. Even in a criminal investigation, you can protect only what you must to prosecute your case. I am in favor of the public records law because I believe in the importance of providing accurate information to the media and the public.

Three things can cause the media sharks' feeding frenzy:

1. Official misconduct involving sex or violence;
2. Any issue involving animals or kids;
3. Any attempt to hide information or obstruct access to the facts.

Dealing with the Community and the Media: Multnomah County's Approach

- The chaplaincy program--As soon as it is determined that someone in the jail is seriously ill, the inmate is assigned a chaplain. The chaplain tries to contact the inmate's family while the inmate is alive. If someone dies who has not been ill, the chaplain helps with notification of the family. The chaplain can also arrange with the Salvation Army to house the family. A small service is held prior to burial, whether there is family or not. The chaplain has access to everyone in the facility and to the medical examiner and can therefore answer any questions that come up, either immediately or later.

- Lessons from policing--In police shootings, it is important to deal with the community's immediate concerns. Similarly, if there is a death in the jail, it also helps to hold a neighborhood meeting to explain what occurred. In Multnomah, in cases of any unusual death involving an inmate, detectives and the district attorney are immediately assigned. This makes it clear that an outside entity is dealing with the death. It is also important to get autopsy findings as quickly as possible in order to provide credible information to the media and community. All information is made available, except what might be involved in a criminal case; if the media want to see the scene, jail administrators should make this possible.

  The second week I was in the corrections department, an inmate was raped by a corrections deputy. The supervisors immediately got the inmate to the hospital. A DNA analysis was done, and the district attorney was involved with the case. We immediately told our staff what was happening in the investigation, which helped to offset inmates' rumors. When we told the media we had terminated the corrections deputy, the story got virtually no news coverage.

- Potential for litigation--There is always the potential for litigation when an inmate dies. If the corrections agency errs, it should be on the side of more, rather than less, information. Everything will come out in any case, so it is important to disclose as much as possible. We sometimes overestimate the damage that can result from releasing information.

- Call the media first--When an inmate death occurs, call the media immediately. It is better if they find out about the death from you than from an outside source. In most cases, the media will work with you. Even if you do not have all the details, be the first to notify the media of problems.

For additional information, contact Dan Noelle, Sheriff, Multnomah County Sheriff's Office, 12240 N. W. Glisan Street, Portland, OR 97230, 503/251-2400.

Coping with Staff Deaths

Paul Cooper, San Joaquin County, California

Causes of Staff Deaths:

It is important to have policies in place in advance to deal with all types of staff deaths:

1. On the job--deaths in the line of duty
2. Unexpected, off the job--presumptive suicides or accidents
3. Long-term illness or terminal prognosis

Some Components of San Joaquin County's Program

- Management Involvement and Support
  - + Management support is crucial to the program. It is important for management to be involved in the development of written policies and to support them. When an incident occurs, managers must not be judgmental. Field any questions from staff and provide affirmations of your support.
- Employee Assistance Program
  - + Employee Assistance Programs (EAP) deal with many issues other than staff deaths. Such programs are the most cost-effective ways to help employees. It is possible to start an EAP as a pilot, by working with other county or city agencies.
  - + The first step in establishing an EAP is to identify the problems of employees which the program will need to address. It is important to provide services to families as well as to employees. Funding can be a difficult issue, but it is less expensive than eliminating an employee every time a problem arises. Comprehensive programs covering the whole county can be the least expensive alternative. Some agencies charge a nominal fee for EAP services. If starting a program, it is sometimes best to contract for services from county or private mental health providers and therapists.
  - + San Joaquin County's EAP program started as a pilot in 1978. The first year the program dealt with 75% alcohol and drug abuse problems and 25% other kinds of problems; in the second year, these proportions were reversed. The program was mandated for all employees and dependents. The program now provides services to employees of other county agencies and of the U.S. Post Office.

- Peer Support
  - + Peer support coordinators are trained in a variety of issues and have well-developed interpersonal skills. Their responsibilities have included developing policies and procedures for the peer counseling team, setting up a training program, serving as contacts for outside agency requests, and, along with psychologists, developing guidelines for peer support teams. A peer support program allows staff the opportunity to counsel their peers. San Joaquin County assigns a psychiatrist with experience in law enforcement to its program.
  - + Those interested in serving as peer counselors are chosen through a letter of interest, an interview, and an evaluation of their attitudes. Team members are trained and are reviewed periodically for stress or burnout. Peer counselors provide support for staff problems, but if they learn of anything involving criminal conduct, they must divulge it.
  - + Counties are possible funding sources for peer support programs, especially because statistics have shown how much money such programs can save a county. San Joaquin County has found the program to be of immeasurable assistance in responding to staff problems. The deputy sheriffs' association (the union) has designated a contact person available at all times and has been helpful in training and recruiting members to be with families during difficult times, such as when a death occurs.
  - + San Joaquin's program is voluntary. Peer counselors provide assistance on their own time.
- Chaplaincy
  - + Chaplains have been very helpful in terms of family support and death notification. They are often seen as the most neutral and accessible source of support. They are non-political. Spiritual counseling is often the most calming type of counseling during a trauma.
- Other support
  - + Other support for survivors handle such things as insurance issues, funeral arrangements, survivors' benefits, and distribution of funds. This kind of help is very useful, but it doesn't exempt the department from dealing with these concerns.

These programs are linked together, and all have a necessary function at the time of staff death. The final question, however, is whether your staff see that you are supportive of these efforts. Every incident that occurs under your command gives you an opportunity to show your support. Your presence may not be needed, but it sends an important message. If you only show up during times of crisis, it gives the message that someone has to die to get your attention.

For additional information, contact Paul Cooper. San Joaquin County Sheriff's Department, 7000 Michael Canlis Boulevard, French Camp, CA 95231, 209/468-4310.

Michael O'Malley, Vermont Department of Corrections

Critical Incidents' Effects on Staff

It is important to have rituals for dealing with death and other critical incidents in our lives. A critical incident is any incident that forces one to face his/her vulnerability and overwhelms the ability to cope.

Whenever there is a critical incident it can affect a staff member's ability to perform his or her duties. Critical incidents include not only a death, but also such things as a car accident or a near suicide. Such incidents in a correctional setting can raise issues of personal and professional failure, create moral dilemmas, and cause personal traumas on the part of staff. At the same time, there will be internal and external investigations, as well as media attention that will provide additional pressures.

Staff need to have a parallel response to a critical incident. That is, they must deal with it both professionally and personally. Someone may be able to deal with such incidents professionally but may have trouble on a personal level.

Incident Reporting System

If you plan for critical incidents, things can be in place when someone dies. It is important to be proactive, to have a process in place that incorporates mental health issues into the incident reporting system. For example, in the Vermont DOC, whenever there is an incident requiring a one-hour notification, there is a requirement to determine if everyone is dealing with mental health issues.

It must be a value, a principle, of the organization that there is an inherent worth in life. It is much easier to deal with deaths and other critical incidents issues if this is a norm of the organization.

You need to have a formal plan so that everyone knows what will occur in the case of a critical incident. It is also important to deal with the employee's family as well as the employee. The earlier you deal with mental health issues and the lower the level at which you address them, the fewer problems you will have when an incident occurs.

For additional information, contact Michael O'Malley, Vermont Department of Corrections, 103 South Main Street, Waterbury, VT 05671-1001, 802/241-2316.

Michael Hennessey, San Francisco, California

Background

The AIDS epidemic has hit San Francisco hard. In spite of public knowledge about the spread of the disease, about two people a day die of AIDS in San Francisco. Many city employees are gay. Since 1983, the Sheriffs department has lost 19 deputy sheriffs to AIDS. Of course, employees have become seriously ill and/or died from other causes, as well, including breast cancer, liver cancer, Hodgkin's disease, and crohn's disease. With advances in medicine, sick people live longer. The consequence is that a long-term illness can often lead to financial ruin and loss of medical coverage for a seriously ill or dying employee.

San Francisco's Catastrophic Illness Law

In 1988, after trying to help a dying employee, the department asked the county controller if other employees could donate unused sick leave to this person. Although they were told at that time that such a practice was impossible, employees started a lobbying campaign, which resulted in a new law. Since 1990, San Francisco has had a catastrophic illness law that allows a city or county employee to transfer sick and vacation hours to another city or county employee who has a catastrophic illness.

Eligibility for Benefits Under the Law

The definition of catastrophic illness in this program is "a life-threatening illness or injury that prevents work for at least 30 days." To qualify for benefits under the law, the ill person must have exhausted all sick, vacation, and camp leave. In addition:

- The employee's physician must certify that the person meets the definition;
- The department of public health has the right to review all documentation;
- The department head of the ill person's workplace must also certify that the employee meets the definition.
- If the benefit is denied, there is an appeals process.

The staff member contributing sick or vacation leave:

- Must retain at least 64 hours of his/her own sick leave;
- may not revoke any donated time;
- Can donate a maximum of 80 hours at a time and a maximum combined total of sick and vacation leave of 480 hours in one calendar year;
- Must, if married, have his/her spouse's agreement to donate the hours.

Because the ill employee continues to earn sick and vacation leave, whatever benefits the employee earns must be used first. The maximum number of hours an ill person may receive is 3,120 hours,

or 380 work days. There is also a rule prohibiting employees from selling donated hours and a rule against coercing the donation of hours.

Advantages of the Program

- The ill person stays on the payroll and continues getting benefits.
- Medical insurance stays in place.
- Because the city has "use it or lose it" rule on vacation time of more than 1,040 hours, employees who have accumulated this many hours often donate hours.
- Employees who donate sick leave have the opportunity to make a contribution to their coworkers.

Disadvantages

- Because the person is still on the payroll, he/she continues to fill a position in the department even though not at work or likely to return;
- Credits are irrevocable. If the person wins a disability claim after receiving the catastrophic illness benefit, they may accumulate a very large number of hours;
- It is often hard to get employees to accept these benefits, as they are reluctant to receive charity. Peer counseling is used to convince them to do so.

Impact

The ordinance took effect in 1990. Since then, there have been 405 approved recipients city-wide, about 70 per year. About 15 Sheriffs Department employees have received these benefits. In 1995, Sheriffs Department employees donated about 5,000 hours to those with a variety of illnesses. The program has helped seriously ill people to live with decent health care and benefits and allowed them to die with dignity.

For additional information, contact Michael Hennessey, Sheriff San Francisco County Sheriff's Department, Room 333, City Hall, 400 Van Ness Avenue, San Francisco, CA 94102, 415/554-7225. Copies of San Francisco's ordinance authorizing transfer of leave to catastrophically ill employees and departmental policies arc available from the NIC Information Center.

The Crime Bill and its Effect on Corrections

Larry Meachum, Office of Justice Programs, U.S. Department of Justice

There are four different versions of the Crime Bill and there is talk of amending it again, so it is difficult to know which version to work from. The goal of the Violent Offender and Truth in Sentencing section is to restore integrity to the criminal justice system by making sentences real. Truth in sentencing gives the public confidence that serious offenders are locked up.

The 1994 act omitted a definition of violent offenders, which caused confusion because states had varying definitions. Some states had changed their statutes based on unreasonable expectations of eligibility for a proportion of the total $10 million originally authorized, not all of which was appropriated. In another example of how aggregated data can be misleading, many states got less than one percent of the total, based on their violent crime rate. The Violent Offender and Truth in Sentencing Act is now very different.

Provisions of the 1996 Conference Committee Version

The 1996 Conference Committee Version of Title II, Prisons, Subtitle A-Violent Offender Incarceration and Truth in Sentencing Incentive Grants has the following provisions. The bill:

- Defines indeterminate sentencing;
- Defines Part 1 Violent Crimes as "murder and non-negligent manslaughter, forcible rape, robbery, and aggravated assault as reported to the Federal Bureau of Investigation for purposes of the Uniform Crime Reports;"
- Authorizes grants to build or expand correctional facilities for confinement of violent offenders;
- Authorizes grants to build or expand facilities for non-violent offenders and criminal aliens on military bases, prison barges, and boot camps;
- Under special rules, specifies that each state "shall reserve not more than 15% of allotted funds to counties to construct, develop, expand, modify, or improve jail facilities." These funds are available only to states that fit definitions of truth in sentencing or violent offender provisions.
- States are eligible for *either* a general grant or a Truth in Sentencing (TIS) grant. TIS grants are now based on 2/3 of the available moneys and general grants are based on 1/3.
- A state that qualified under the Crime Control Act of 1994 is eligible under this Act only for the first year, after which they must qualify under the new bill.
- Eliminated certain provisions:
    - + Comprehensive planning is no longer required;
    - + Needs and rights of veterans are no longer addressed;

+ Crimes of serious drug offenders are not addressed;

+ Discretionary or reverted funds were eliminated;

+ Rules and regulations are not required;

+ Provisions for technical assistance are not spelled out;

+ States can no longer receive funds for assurances; action is required;

+ There are new criteria for qualifying for general funds; Since 1993, a state must have increased the percentage of persons convicted of part 1 violent crimes who are sent to prison; increased average time served by part 1 violent offenders, and increased average percentage of sentence actually served for part 1 violent crimes;

+ Indeterminate sentencing states must have increased sentences for part 1 crimes and increased time served for murder, rape, and robbery;

+ Allows governments to make exceptions for geriatrics and for those who no longer pose a threat to the public.

The intent is to lock up violent offenders and keep them longer. Funds to county jails are designed for jurisdictions in which state prisoners are backed up in county jails. The bill will allow local programs but only if states expand space to hold violent offenders for a longer period. The bill adds "integrity to the system" through truth in sentencing, but it may actually increase prison crowding. In effect, the Crime Bill ignores other impacts.

For additional information; contact Larry Meachum, Director, Office of Justice Programs, U.S. Department of Justice.

Final Session: Planning for Next Meeting

Meeting participants recommended that the next meeting of the Large Jail Network focus on the topic of juveniles in adult jails. The meeting will be held in Longmont, Colorado, on July 7-9, 1996.

APPENDIX A

Meeting Agenda

U.S. Department of Justice
National Institute of Corrections

LARGE JAIL NETWORK MEETING

Longmont, Colorado — January 21-23, 1996

RAINTREE PLAZA CONFERENCE CENTER

Final Agenda

SUNDAY, January 21, 1996

6:00 PM - 8:00 PM — *Informal Dinner*

Welcome . . . . . **Larry Solomon, Deputy Director**
National Institute of Corrections

Introductions an Program Overview
. . . . . **Richard Geaither**

Opening Address:

Presentation

The Dilemma of In-Custody Deaths
. . . . . **John H. Clark, M.D., M.P.H.**
Chief Physician, Medical Services
County of Los Angeles, CA

MONDAY, January 22, 1996

7:30 AM — **BREAKFAST**

8:30 AM — **Overview of Dynamics of Jail Population**
. . . . . **Michael O'Toole, Chef**

MONDAY, January 22, 1996 (cont.)

Large Jail Network

9:00 AM *Discuss effective approaches related to the prevention of in-custody inmate deaths or the management of the circumstances which contribute to them.*

. . . . . **Arthur Wallenstein, King Co., WA**

. . . . . **John A. Alese, Pima Co., AZ**

. . . . . **Benny McLaughlin, San Diego, CA**

. . . . . **Robert W. Conroy, Santa Clara Co., CA**

Group discussion

10:30 AM **BREAK**

10:45 AM *Discuss methods or procedures related to the management of resources available for the maintenance of dying inmates.*

. . . . . **David S. Owens, Camden Co., NJ**

Group Discussion

12:00 NOON **LUNCH**

1:15 PM *Discuss community and media relations which must be given consideration in preventing and managing the circumstances contributing to in-custody deaths.*

. . . . . **Donald E. Watts, Wayne Co., MI**

. . . . . **Mark P. French, Pierce Co., WA**

. . . . . **Dan Noelle, Multnomah Co., OR**

Group Discussion

2:45 PM *Discuss approaches in developing employee assistance efforts for addressing the issue of coping with staff deaths.*

. . . . . **Paul Cooper, San Joaquin Co. CA**

. . . . . **Kenneth W. Berry, Harris Co., TX**

. . . . . **Michael O'Mally, Vermont DOC., VT**

. . . . . **Michael Hennessey, San Francisco Co., CA**

Group Discussion

5:00 PM ADJOURN

6:00 PM DINNER

TUESDAY, January 23, 1996

8:30 AM **Let's discuss the Crime Bill and its effect on the nations Large Jails!**

. . . . . **Larry Meachum, Director**
Office of Justice Programs
U.S. Department of Justice

10:00 AM **BREAK**

10:45 AM **Presentation of Future Meeting Issues**

11:00 AM RECAP AND CLOSEOUT . . . . . **Richard Geaither**

APPENDIX B

Meeting Participants

LARGE JAIL NETWORK MEETING

January 21-23, 1996 Longmont, Colorado

Final Participant List

Mr. Tim Ryan, Division Commander
Alameda County Sheriffs Department
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