U.S. Department of Justice
National Institute of Corrections

Proceedings of the Large Jail Network Meeting

NIC

Large Jail Network

February 2004

National Institute of Corrections

Jails Division

Large Jail Network Meeting

February 8–10, 2004

TABLE OF CONTENTS

MEETING HIGHLIGHTS

LARGE JAIL NETWORK MEETING

FEBRUARY 8-10, 2004

This document summarizes a meeting of NIC's Large Jail Network held in Longmont, Colorado, on February 8-10, 2004. Approximately 60 administrators of the nation's largest jails and jail systems attended the meeting.

The meeting focused on the following topics:

- Domestic preparedness and the impact on large jails;
- Preventing/containing contagious disease;
- The jail and its public health role;
- Jail evacuation, planning and implementation; and
- Update on legal issues for large jails.

HIGHLIGHTS OF MEETING SESSIONS

- **Domestic Emergency Preparedness and the Impact on Large Jails.** Sue Menser, Director of the Office for Domestic Preparedness, described the role of the Office. She offered some ideas to large jail administrators interested in seeking funding from the Department of Homeland Security for jail-related projects.
- **Discussion of Issues Important to Large Jail Network Members.** This session offered meeting attendees an opportunity to bring up interesting issues. The topics discussed included the Prison Rape Reduction Act of 2002, the new Bureau of Justice Statistics survey of jails, and ACA accreditation.
- **Role of the Jail in Public Health Policy.** Don Leach, Lexington, Kentucky, presented his perspective on the jail's role in public health policy, pointing to the ways in which the mission of jails has expanded. He focused on the resource decisions involved in the jail's taking on a public health role.
- **MRSA (Methicillin-Resistant Staphylococcus Areus).** Dennis Williams, Escambia County, Florida, provided information on MRSA and outlined how MRSA outbreaks in jails can be controlled.
- **Response by Jail and Public Health Officials to Contagious Disease Emergencies.** Following small group discussions of this issue, individual representatives of each group commented on a variety of issues related to this topic and to the two previous presentations.

- **Weapons of Mass Destruction Initiative: Jail Evacuation Planning and Implementation.** The National Sheriff's Association (NSA) sponsored this abbreviated version of an 8-hour seminar being provided to jurisdictions nationwide. Mike Jackson, Project Director, provided an overview of both the content and seminar activities. Sheriff Joseph Oxley, from Monmouth County, New Jersey, presented a video and discussion of how his jurisdiction tested seminar lessons through a jail evacuation exercise.
- **Legal Issues Update for Large Jails.** Bill Collins, Attorney at Law, Olympia, Washington, summarized and clarified recent changes in laws affecting large jails and responded to comments and questions from meeting participants on a range of important legal issues.
- **Presentation of Future Meeting Issues.** Richard Geaither led a discussion to select topics for the next meeting of the Large Jail Network, to be held July 11-13, 2004. The topics selected were Gangs and the Mental Health Population.

DOMESTIC PREPAREDNESS AND THE IMPACT ON LARGE JAILS

SUE MENSER, DIRECTOR, OFFICE FOR DOMESTIC PREPAREDNESS, DEPARTMENT OF HOMELAND SECURITY

Sheriff Grayson Robinson of Arapahoe County, Colorado, introduced Ms. Menser, who was formerly Director of Public Safety for Colorado.

BACKGROUND

I was a schoolteacher for 10 years and was hired by the FBI because of my Spanish skills. After retiring in 1998 from the FBI, I was appointed to the Columbine School review commission. I was then Colorado's Director of Public Safety for 3 years. Nine months ago, Secretary Ridge asked me to run the Office for Domestic Preparedness. A difficult job, it involves trying to pull 22 agencies together. I am impressed by Secretary Ridge, who truly cares about citizens' safety.

OFFICE OF DOMESTIC PREPAREDNESS

The Office for Domestic Preparedness is in charge of providing homeland security grants to both state and urban areas, where most threats are located. The '05 budget doubles the amount made available in 2004 for urban areas. It is nevertheless difficult to determine which states should get the funding and how best to spend it.

HOW TO SECURE FUNDING

Following are some suggestions for securing funding for your facility:

- Equipment is important, but there is likely to be a swing toward providing funding for training and exercises. Practice is crucial; if you don't exercise, you won't be ready. Because exercise becomes obsolete very quickly, you have to incorporate constant exercise into your plans.
- There will be an increased emphasis on a regional approach in funding. You should therefore think creatively about how to apply for money related to homeland security on a regional basis. Whatever funding your region acquires for homeland security will also help you understand the additional types of things for which you might seek additional funding.
- If you are part of an urban region and have not been included in the discussion of your state's strategy as it relates to jails, you need to find a place at the table or take part in information sharing with other state agencies.
- Information must also be shared with fire fighters, hospital workers, and EMS personnel. The Office for Domestic Preparedness needs to convey information to help those at the local level know what to do.

The Department of Homeland Security is a growing, evolving department. We are able to give more grants this year than last; in fact, money has been moved from other agencies to the Department.

STATE PLANS

Each state was required to submit a strategy for homeland security by January 31, 2004. A panel from each Homeland Security division will review each plan and either accept it, accept it conditionally, or return it to the state to be redone.

Remember that it is important to focus on a regional approach because terrorists are not bound by state, county, or city lines. We need to be able to work together across boundaries of traditional roles as well as geographical boundaries.

QUESTIONS FROM PARTICIPANTS

- *How is an area designated a "high urban density zone"?*

  The designation is based on a number of factors, including FBI data on threat groups, population data density, and the critical infrastructures located in the state. Originally, 30 cities received the designation, but for Phase 2, there were 50 cities.

For additional information, contact Sue Menser, Director, Office for Domestic Preparedness, Department of Homeland Security, Washington, DC; Sue.mencer@homelandsecurity.gov

MEETING PARTICIPANTS' DISCUSSION OF ISSUES

PRISON RAPE REDUCTION ACT OF 2002

Art Wallenstein, Montgomery County, Maryland: Jim Gondles of ACA (American Correctional Association) and I attended a meeting on the Prison Rape Reduction Act, which has recently passed into law. It is strange legislation, and I knew nothing about it. The law will require correctional facilities to collect data on the sexual molestation of inmates, including not only rape but touching or being leered at. There is funding available to interview inmates on this issue in at least one prison and one jail in each state. There is no money to correct any problems identified, only money to collect data. It is hard to understand how this became law, but we should keep our eyes on it. There may be an opportunity to express our opinion, although we were not contacted prior to the legislation.

Dennis Williams, Escambia County: In 1986, legislation resulted in the interviews of inmates and those in health care environments who were victims of abuse because they were mentally impaired. The new legislation may be an outgrowth of that. I suggest that we flood ACA to ask them to lobby either to cut the funding or to redirect it to action.

Art Wallenstein: There will be a national policy board. We should keep checking newsletters and keep on top of the law. The corrections field was well represented at the meeting, but only after the legislation had already passed.

Jim Gondles, ACA: ACA is now trying to influence representation on the 9 member National Prison Rape Reduction Commission. The bill provides that 3 members are to be appointed by the President, 1 member by Senator Frist, 2 by Senator Daschle, 1 by Speaker Hastert, and 2 members by Rep. Pelosi. I will meet with a representative of the White House to see if we can get some people with knowledge of corrections on the Commission.

Richard Geaither, NIC Jails Center: Alan Beck of the Bureau of Justice Statistics reported on this legislation at the last Large Jail Network Meeting. He was looking for people to help develop test questions. I will follow up with him to see if he might bring us up to date on the issue.

BUREAU OF JUSTICE STATISTICS DRAFT SURVEY

Richard Geaither: The survey was sent out in early February. As Alan Beck made clear to us at our last meeting, the survey is actually a result of a request by this group several years ago.

Art Wallenstein: The Large Jail Network was really the genesis for this process. We had been discussing the fact that the yearly survey using average daily population data leaves out data on admissions and releases—which is what counts for jails. Upwards of 10 million people move through the country's jail systems in the course of a year, which is what matters—not 600 average daily population. This new survey establishes the correct perspective. We need to fill out the surveys so that data on admissions and releases is what is given to the public.

ACA ACCREDITATION

Dave Parrish, Hillsborough County, Florida: Only something over 100 of the 3300 jails in this country are ACA accredited. The Adult Detention Facilities Standards have just been revised, and all standards have been rewritten in a performance-based form. They may scare you when you see them because we are now required to gather additional statistics.

We would like now to get additional jails involved in some kind of accreditation by developing some "core standards." While I am at this meeting, I will met with Ginny Hutchinson, the NIC Jails Division Chief, to bring together a group to develop such core standards, which will address issues that any jail should meet, including such things as constitutional standards and life safety issues. We would then propose to ACA that a new category, such as "certification" rather than "accreditation," be developed. Certification would be an easier, less expensive, process than accreditation, but we hope that it would get more jail administrators involved in accreditation.

ROLE OF THE JAIL IN PUBLIC HEALTH POLICY

DON LEACH, DIVISION OF COMMUNITY CORRECTIONS, LEXINGTON, KENTUCKY

The perspective I am presenting today is the basis of the way we run the jail in Lexington.

Some things we all do because they are good for the country. But we sometimes need to sit back and say, "Do we need to do that"? Accreditation is an example; it is a great thing to do, but very expensive. Why should you subject yourself to an artificial standard that will cost money, when you don't have enough money to begin with? Therefore, I like the idea of some alternative to complete accreditation.

We also need a standard for defining Average Daily Population. The definition makes a big difference in contract costs, and it can vary within a single day. If I look at the population at 9:18 am, it is one number, two hours later, a different number. Does your contract with your medical provider define how you will calculate ADP? We were under a Federal order to cap our population, and the question was when to calculate the number. We agreed to calculate at 4 p.m. because that is when most people are released. If the judge had insisted on midnight, the population would be much higher. There should be a national standard.

All the agencies with which we have contracts, including the Bureau of Prisons, Bureau of Immigration and Customs Enforcement (ICE), and U.S. Marshals, have different policies. The U.S. Marshals won't allow us to identify the inmates we are holding. Our attitude is that the public has a right to know, so we refuse to hold people incognito. Contractual obligations also involve other things. We contracted with Correctional Medical Systems over 10 years ago and told them that we do not want to meet NCCHC standards. This decision saved us a quarter of a million dollars a year. We will give inmates constitutionally mandated treatment, but we will not respond to artificially inflated standards. NCCHC is in the business of making money. We need to remember that we are in a business, too.

The real world is what your taxpayers are willing to pay for , while the ideal world includes all the great things we would like to do in corrections. A few years ago, I met with a Dutch corrections official, who said we are "barbarians" for the way we treat those in jails and prisons. He said that in the Netherlands they rehabilitate offenders. I then visited an Amsterdam remand center and met with a jail administrator; he said that they didn't rehabilitate anyone. He did praise his inmate work programs, but in fact, Hennepin County has better programs, and the program in Holland was simply make-work. My point is that the Dutch ministry had an ideal vision, but the real world actuality was very different.

THE JAIL AND PUBLIC HEALTH

Does the jail have a role in public health policy? Should we do things that might better be left to the local public health department?

As jail administrators, we must deal with certain realities, including the fact that there are state laws we must follow as well as constitutional minimums. Nothing can supersede constitutional law, of course, but if there are state standards, we also try to follow them. We must also keep political considerations in mind.

MISSION-BASED MANAGEMENT

Mission-based management is an administrative methodology for managing the risks associated with operating a modern detention facility based on an agency mission and articulated goals and objectives intended to measure accomplishment of the mission. Businesses usually have a mission and articulated goals, and we need to be clear about our mission as jail administrators. In Kentucky, the jail is run by bureaucrats. Our mission should not be confused with law enforcement.

The jail mission is to protect the public and institutional safety through the incarceration of adult offenders in institutions that meet statutory and constitutional standards of care and provide program opportunities intended to reduce re-incarceration.

My concept of "program opportunities" means keeping inmates busy because this keeps operational costs down. I know of a jail in Pennsylvania in which television and books, except for religious materials, were not allowed. They then wondered why there was a 68% turnover among staff. The jail administrator got smart and, behind the backs of the prison board, rolled TVs in as rewards for good behavior and also passed out magazines. This approach helped him gain control of the jail.

CORRECTIONAL RISK MANAGEMENT GOALS

Correctional risk management goals are:

To Protect:

- Public Safety
  - Threat of Violence
  - Threat of Escape
- Institutional Safety
  - Threat of Violence
  - Threat of Escape

To Provide

- Constitutional Level of Care
  - Medical
  - Mental Health
- Programs to Reduce Recidivism
  - Educational
  - Vocational
  - Rehabilitative
  - Spiritual

IMPLEMENTING THE OBLIGATIONS

Meeting our obligations to protect involves separating predators and prey via objective jail classification, imposing protocols and structures to prevent escapes, and developing methods to block contraband entry. To provide constitutional levels of care and programs

to reduce recidivism, we must identify the immediacy of need for medical and mental health care and create programs to modify offender behavior.

MISSION CREEP AND JAILS

Mission creep is the process by which an organizational mission's methods and goals change gradually over time. In military terms, mission creep describes a common phenomenon in which forces are committed to achieve a *limited* objective, but then find themselves drawn into expanding both the size and the nature of the intervention, supposedly to support the original objective. Mission creep is also a common occurrence in public education.

Over the past 20 years I have been in corrections, I have seen significant mission creep. Sometimes you know that it is happening, sometimes you don't. Mission creep has occurred in jail history as follows:

1. House offenders until punished.
2. House offenders as part of punishment.
3. Provide for immediate medical needs.
4. Provide for immediate mental health needs.
5. Provide for rehabilitative needs.
6. Provide public health functions.

In our jurisdiction, we look at the "immediacy of needs." We do no 14-day assessment, and we do not take on the chronic care of inmates. Instead, inmates do not see a doctor unless they are sick. We let them tell us about it if they need care.

As part of mission creep, jails have become mental health institutions. Beginning in the 1960s through the '80s, there was de-institutionalization of the mentally ill, putting them into community-based treatment. However, there was insufficient funding for community-based treatment, so it was not really possible. The result was that, by July 2002, there were more mentally ill in jails and prisons than in hospitals. The L.A. County Jail is the nation's largest mental health institution. Is that part of the jail's mission?

Serving as the community's mental health institution has the following implications:

- Increased need for mental health separations;
- Increased mental health staffing;
- Increased length of stay;
- Increased costs of psychotropic medications, especially "designer drugs"; and
- Increased costs associated with a new mission.

Our obligations are increasing, but our budgets are diminishing. In short, anything can be done for a dollar. Are you willing to pay for it?

JAIL AS A PUBLIC HEALTH AGENCY?

The argument for the jail as a public health agency focuses on the following:

- The jail is a microcosm of the local community.
- Most inmates have had minimal contacts with medical care providers.
- Jail inmates are a captive public health population.
- Offenders will eventually be released from the jail back into the community.
- Jail populations have a high incidence of contagious diseases: tuberculosis, sexually transmitted diseases, Hepatitis B, HIV/AIDS, MRSA, influenza, and SARS.

Taking on the public health role is really a question of money. Although it might be a good thing to do, it is really a resource decision. There are practical issues, including:

- Jails have a high turnover in population.
- There are a large number of repeat offenders.
- There is a lack of follow-up on release; we don't do long-term transitions.
- Resource expenditures continue to grow—for physical plant, staff or service providers, supplies and equipment, and unfounded mandates.

We are being told to cut medical costs. In this context, how do we manage resources based on the core mission of the jail?

OUR CURRENT PRACTICES

In Lexington, our medical practices include the following:

- Intake triage
- Booking screening
- Medical assessments
- Sick call requests
- Immediacy assessments
- Isolate carriers
- Provide treatment
- Referral to external providers

An inmate can be in our jail and never see a medical provider. We cannot afford to do more because we continue to be hit with unfunded mandates. There is funding for law enforcement, but not for corrections.

FUTURE PRACTICES?

Are we going to resort to as little physical contact as possible, including the use of face masks, gloves, fluid impermeable uniforms, and self-contained breathing apparatus? If we assume that the risk of contagious diseases is that serious, we will need all these things. Any

time there is contact, there is a chance of contagion. How will we cut down exposure? If we take on a public health role, we have to acknowledge exposure to our staff and ourselves.

ACQUIESCE TO MISSION CREEP?

In addition to protecting public safety from the threat of violence and the threat of escape, will we also protect it from a threat to public health? Will we take on another role? If so, who will pay for the services?

For additional information, contact Donald Leach, Administrative Officer, Lexington/Fayette Urban County Government, 600 Old Frankfort Circle, Lexington, KY 40510; 359-425-2612; donl@lfucg.com

MRSA (METHICILLIN-RESISTANT STAPHYLOCOCCUS AREUS)

DENNIS WILLIAMS, ESCAMBIA COUNTY, FLORIDA

DEFINITIONS

MRSA (Methicillin-Resistant Staphylococcus Aureus) is a type of Staphylococcus Aureus (staph) infection that has become resistant to the class of antibiotics, such as methicillin, frequently used to treat staph. Staph are bacteria commonly carried on the skin or in the noses of healthy people.

The nature of bacteria (including staph) is that they evolve. Bacteria have their place, but some bacteria happen to be pathogenic to humans. You cannot get rid of MRSA; you can only control it.

WHAT MRSA IS NOT

- It is not a spider bide. (Spiders are timid creates who are more afraid of people than people are afraid of them.)
- It is not the result of a bite by any type of insect.

MRSA

MRSA appears as an abscess, which starts as a small pimple or lesion that becomes red, hot, inflamed, and painful. It is transmitted easily to others.

Persons in hospitals or health care facilities often get MRSA, as do persons living in crowded settings (such as college dormitories or jails and prisons) and those who share contaminated items.

A lack of understanding is fueling the concern about MRSA. We need to remind people of the issue constantly and educate them about it. It can become very serious.

HOW IS MRSA TRANSMITTED?

Virtually anything you touch can transmit MRSA. It is transmitted from person to person by:

- Contaminated hands;
- Sharing towels, personal hygiene items, and athletic equipment;
- Through close-contact sports; and
- Sharing injection drug use equipment.

In correctional settings, MRSA outbreaks have been linked to poor inmate hygiene, the sharing of contaminated personal items, and participation in unsanitary tattooing practices.

HOW TO CONTROL MRSA

- First step: Good hygiene. Post "wash your hands" signs everywhere. We saw a 75% reduction simply from communicating the importance of good hygiene.

- Second step: Analyze the culture of abscesses. What bug are we dealing with? What is it sensitive to?
- Third step: Catch it early. MRSA becomes resistant to normal antibiotics. Advise all medical personnel that if an inmate has an abscess, the doctor wants to know about it immediately. Treat it with antibiotics right away.
- Fourth step: Incise and drain any large unchecked abscesses.

ANTIBIOTIC TREATMENT

Use the broadest spectrum and the cheapest antibiotic, such as Doxycycline, Septra, Clindamycin, and Rifampin. However, MRSA can quickly become very resistant to Doxycycline.

When possible, use a 5-day regimen instead of a 10-day one. (If the abscess is gone in 2 days, continue the antibiotics for 3 more days, just to be sure.) Because resistance can develop if a drug is used too long, get the patient on and off the antibiotic as soon as possible.

Use Doxycycline until you notice a resistance, such as an additional red spot on the body. Then begin cycling drugs:

- Completely discontinue use of Doxycycline and begin using Septra;
- When resistant to Septra, go to Clindamycin;
- When resistant to Clindamycin, go to Rifampin.

There are benefits to cycling drugs. For example, you may be able to return to Doxycycline because the MRSA has forgotten it and is no longer resistant to it. Moving to the next effective antibiotic is moving to one with a higher cost, but you may then be able to return to a cheaper antibiotic.

In our case, there were some instances in which Doxycycline did not quite work, so we used a combination of Doxycycline and Septra beginning on the same day, with Doxycycline used for 5-10 days and Septra for 4 days.

PREVENTION

Preventing MRSA requires the following precautions:

- Shower once a day.
- Wash hands with soap and water:
    - At least 3 times a day;
    - When in contact with any material from nose, mouth, or ears;
    - When in contact with other people (handshake); or
    - When they feel dirty.
- Change into fresh clothes whenever possible.

- Notify medical staff when a pimple (small lesion) is noticed. Do not squeeze it or pick at it.

WHY NOT START EVERYONE WHO COMES INTO JAIL ON DOXYCYCLINE?

- Because MRSA becomes smart and resists Doxycycline;
- MRSA could become a "super bug"; and
- Super bugs are resistant to *all* antibiotics, which is a very real concern.

THE FINESSE OF MEDICINE

- Know when to start antibiotic treatment.
- Know how long to keep a patient on it.
- Know when to get a patient off of it.

OUR EXPERIENCE

Within 30 days of implementing this strategy, we reduced the number of new cases of MRSA by 75%. We have maintained that level for the 10 months since implementation (2 or fewer cases every month).

REASONS FOR DECREASE IN ABSCESSES

- Increased surveillance by medical staff for the early onset of any lesions;
- Appropriate antibiotic treatment;
- Education of staff and inmates; and
- Posted notice on washing hands: "Hand washing is the single, most effective method of preventing the spread of infection/diseases. Please wash your hands."

DISCUSSION BY LJN PARTICIPANTS

- *Have your policies related to MRSA been well accepted at the line level?*

  No, not initially. However, we developed committees of line staff and gave them the opportunity to respond. We opened lines of communication and used email extensively. Initially, everyone was convinced that MRSA was related to spiders. There was a great deal of initial resistance, and it took about 45 days to overcome that hurdle. Staff are now more willing to understand and accept what we tell them.

For additional information, contact Dennis Williams, Director, Detention Division, Escambia County Sheriff's Office, P.O. Box 17800, Pensacola, FL 32522; 850-436-9822; dwilliams@escambiaso.com

RESPONSE BY JAIL AND PUBLIC HEALTH OFFICIALS TO CONTAGIOUS DISEASE EMERGENCIES

DISCUSSION

Meeting participants met in small groups to discuss issues related to the jail and public health. Reporters from individual groups summarized these discussions:

- Anything that is touched in the jail can potentially pass on MRSA. It is important to educate our staff, and we plan to return to tell them that MRSA is more of an issue than we had realized. We have to educate them slowly, and we also have to give them resources, such as rubber gloves, so that they can protect themselves.
- Since 9/11, jails have necessarily had a change in their mission, including an increasing overlap with the world of public health, as well as fire fighting and law enforcement. The linkage between public health and corrections is necessary because we have the population that has the public health problems. We now understand that alcohol is also a public health issue that jails must take into account. There is, in fact, a natural relationship between corrections and public health. One solution to the funding problem is to develop a solid partnership with a public health agency that puts them with us at funding hearings rather than making the argument alone. The public health problem is huge, and mission creep is necessary. The stronger the relationship with public health, the better. If we work closely with them, other county departments will step forward to make clear that we do not have the resources to address these problems alone.
- The Bureau of Justice Statistics survey does not address public health. The public does not understand the relationship between public health and jails, so it should be included in the survey.
- It is important to generate data on health and mental health costs to develop information to take to the people in charge of our budgets. We can't just say, "We are having a problem." We need actual numbers to support our position.
- How do we know, short of accreditation, that we are getting our money's worth for medical services? How do we measure the services we are supposed to get for what we are spending? One answer is to pay for an outside consultant to work with the administrator to analyze health care and how it is being managed. It is important to put money up front for consulting services to evaluate what we are getting. As we take on more public health roles, we must do this analysis. Another approach is to hire a contract monitor who was previously on the provider side.
- In Alaska, we do zero-based budgeting, which requires us every year to review what we need to provide and what we do not. The public are shareholders; the question is, are they willing to pay for what they want? Statistics do help. In Alaska, native corporations wanted us to do testing for sexually transmitted diseases and agreed to pay for education and testing on the issue. We responded that they must provide it for all inmates through a multicultural approach, which they have done. When you are talking about partnering, there are clearly some implications. We also had a big

issue surrounding "spider bites," but we don't have spiders in Alaska. Our proactive medical director figured out that the problem was really MRSA, and we implemented the same changes Dennis suggested.

- A comment on future Large Jail Network meetings: I suggest that we provide some time in the meetings for point and counterpoint perspectives on an issue. The conflict that emerges at the tables is one of the most interesting aspects of the meeting, and it would be useful to have it integrated into the meetings as a whole.

NATIONAL SHERIFF'S ASSOCIATION: WEAPONS OF MASS DESTRUCTION INITIATIVE:

JAIL EVACUATION PLANNING AND IMPLEMENTATION

MIKE JACKSON, PROJECT DIRECTOR, NATIONAL SHERIFF'S ASSOCIATION

BACKGROUND

The brief seminar being presented at this Large Jail Network meeting is a very abbreviated, 4-hour, version of the complete seminar, which runs for 8 hours. The complete seminar has been pilot tested at several sites: Culpepper County, Virginia; Hillsborough County, Florida; Orange County, California; and Wilson County, North Carolina.

MODULE I: GOALS AND OBJECTIVES OF THE SEMINAR

Goals

1. Increase awareness of the need to plan for a jail evacuation in response to a hazardous incident.
2. Increase knowledge of potential threats to jails and possible responses to hazardous incidents.
3. Increase knowledge of planning required to execute a jail evacuation in response to a hazardous incident.

Seminar Objectives

1. Define potential threats to a jail that would require evacuation.
2. Provide information concerning how to obtain current threat information.
3. Establish procedures for developing plans, policies, and exercises for a jail evacuation.
4. Provide information on activities required in the first hours following hazardous incident.
5. Establish procedures for a jail evacuation in response to a hazardous incident.
6. Provide information concerning necessary coordination at site to which inmates will be evacuated.
7. Establish procedures for returning to the jail facility.

Reasons for Attending

1. Jail evacuation is not high on a community's priority list for an emergency.
2. There are no relevant requirements or standards.
3. Evacuation plans of many jails are outdated.
4. The jail has changed, in terms of classification, population, and/or reduced staff.
5. The current plan does not move inmates far enough away to avoid contamination.
6. There are possible legal repercussions from a failure to evacuate.
7. A jail is less likely to be sued if a plan for evacuation is in place.

MODULE II. TERRORISM AND WEAPONS OF MASS DESTRUCTION

Definitions of Terrorism

- USC Title 22, Section 2656f(d): "Premeditated, politically motivated violence perpetrated against noncombatant targets by sub-national groups or clandestine agents, usually intended to influence an audience."
- U.S. Department of Justice: "A violent act or an act dangerous to human life, in violation of the criminal laws of the United States or any segment to intimidate or coerce a government, the civilian population, or any segment thereof, in furtherance of political or social objectives."
- The Federal Bureau of Investigation (FBI): "The unlawful use of force or violence against persons or property to intimidate or coerce a government, the civilian population, or any segment thereof, in furtherance of political or social objectives."

Common elements of terrorism include the following:

- Violent illegal actions;
- To further political or social objectives;
- Influence or intimidate a target population; and
- Intended to coerce a government or its civilian population.

Terrorists and Terrorism

Domestic Terrorism includes right-wing terrorism; left-wing terrorism; special interest terrorism; splinter groups; and lone perpetrators.

International Terrorism includes state-sponsors of terrorism and lone perpetrators.

Types of Targets

- Primary targets—most critical or valuable to terrorists: people, infrastructure, or property.
- Secondary targets—specific overall importance, but not the main focus of effort; ancillary damage.
- Targets of opportunity—when primary target is inaccessible, this is another target that will get notice.

Weapons of Mass Destruction

Legal definitions:

- Poison gas;
- Any weapon involving a disease organism;
- Any weapon designed to release radiation or radioactivity at a level dangerous to human life;
- Any destructive device as defined in Section 921 of Title 18USC.

Routes of exposure include inhalation, ingestion (eating), absorption, and injection. *Reducing exposure* is related to the distance you are away, whether you are uphill or upstream, and how shielded your location is. The further away you are, the better are your chances of not being exposed.

Persistent v. Non-Persistent Agents

- Persistent Agent
  - The lethal concentrations will last in target areas for more than 12 hours.
  - Hazards from both vapor and liquid may exist for hours, days, or, in exceptional cases, weeks after dissemination of the agent.
- Non-Persistent Agent
  - Lethal concentrations will not last in the target area for more than 12 hours.
  - Hazards are predominantly posed by vapor, will exist for minutes or, in exceptional cases, hours after dissemination of the agent.

Categories of Weapons of Mass Destruction

- Biological Agents—Bacteria, Virus, Rickettala (Q Fever), and Toxins
- Nuclear Weapons—Fission devices, radiological dispersal devices, or disrupting water supply at facility
- Chemical Agents—Nerve gas, blister, blood, chocking, or irritant
- Incendiary Devices—The most WMD commonly used by domestic terrorists
- Explosives—Approximately 70% of domestic terrorist incidents involve explosives; examples include vehicle bombs, pipe bombs, and satchel charges.

Key Concept: Detection Delay

Detection delay is the time it takes after deployment to detect a weapon of mass destruction. Explosives are detected within a second and incendiary devices within an hour. Nuclear materials and chemical agents may take from an hour to a month to detect; and biological agents are usually detected in less than a week to more than a month.

MODULE III: THE THREAT

The Jail as a Target

The jail might be selected as a primary or secondary target or a target of opportunity.

- **Some reasons for selecting the jail as a primary target:**
  - There would be mass casualties;
  - It would create disruption of local government;
  - It is appealing as a symbol of government control;
  - It would create fear in the community; or
  - There may be terrorists being held in the jail.
- **Some reasons for the jail as a secondary target:**
  - The jail may be connected to the courthouse; or

- It may be in proximity to other targets such as industrial plants or warehouses.

- **Some reasons for the jail as a target of opportunity:**
  - Perimeter security may not be in place;
  - The delivery/sallyport door is not secured; or
  - A fuel truck refueling or emergency generator facility may be close to the building.

Types of Threats to the Jail

- Contaminating water (easier than contaminating the entire county's water);
- Explosions/bombing of building;
- Gases and poisons (both from the attack and from an accident);
- Biological incident (from inside or outside, from inmates or staff.)

Facility Vulnerability Assessment

Key Assessment Areas

- Location of the facility;
- Facility description
  - Floor plan
  - Entrances and other access points (how well are they monitored?)
  - Windows
  - Utilities
  - Security systems
  - Lighting
- Communication systems (how will you talk to one another? What is the back-up arrangement?
- Emergency equipment
- Duress or emergency codes
- Logistical and resource concerns, including how you will handle food and water, transportation, and medical supplies if you have to move inmates away from the facility.

Mini Threat Assessment

- What are the principle threats to your facility?
- What other buildings, not under your control, affect your facility?
- What are the important utilities for the facility and who controls access?
- Who are the emergency responders and what is the estimated time of arrival of each?
- What is the surrounding terrain that might affect the security of your facility?

Threat and Incident Information

- General information can come from the media and national emergency management agencies, such as the Department of Homeland Security.
- Specific threat information in your area can come from local law enforcement agencies, a joint terrorism task force, NCIC, state police, or inmates who might be terrorists.

Sources of Jail Intelligence

- Booking and Intake
    - From the arresting/transporting authority
    - Intake is a good source of information. Intake officers should be skilled communicators, and inmates' personal property can also yield clues, as can outward signs such as scars, tattoos, clothing, jewelry, etc.
- Classification
    - The primary function of classification is gathering and coordinating information. Trained and skilled interviewers should be able to interpret both verbal and non-verbal communications. This is also another opportunity to look for scars and tattoos.
- Housing Officers
    - Housing officers have the most contact with and access to inmates. They need to be trained to keep an eye on mail, telephone, visitors, and cellmates. Housing officers are usually the ones to develop "sources," which can sometimes provide valuable information to share with other agencies.

MODULE IV: PLANS, EXERCISES, AND CONTINGENCIES

Plans

Proper planning includes:

- Developing and maintaining a jail evacuation plan;
- Carrying out exercises to test the plan's effectiveness and documenting the exercise; and
- "War-gaming" possible contingencies.

Each agency should have a plan, which it may be able to adapt from its state-mandated Disaster Preparedness Plan or from model plans. The plan should be reinforced by policy and amplified by Standard Operating Procedures. There should be a schedule for periodic updating.

Issues that must be addressed in the plan include:

- Short term vs. long-term relocation. How would they be different?

- Multiple remote site possibilities, including different types and in different areas and different sites for different custody levels.
- Staffing, including extra security concerns, medical and other support staff. There must be enough security personnel to secure the facility and a remote site and to provide armed personnel for transportation.
- Mutual aid agreements should cover: Who's coming? What can they bring? How long can they stay? Who's paying for it?
- Documentation of all occurrences. It is very important to designate "scribes" at key activity locations to track what happens and at what time. This will be useful for court challenges as well as financial reimbursement requests.
- The plan must address:
    - The use of force, including informing mutual aid agencies and, if applicable, inmates;
    - A communications plan (who will use what channel or device), and
    - The possible release of low custody/low risk inmates. This will require written agreements with the courts and written instruction for return when the jail reopens.
    - Security equipment, including waist and/or gang chains and flex cuffs;
    - Protective equipment, including airpacks for staff and escape hoods for inmates;
    - Movement of records or access to administrative and medical records;
    - Transportation, including secure and special needs vehicles, sources outside the agency, decision about who moves first, and the security of routes.
    - Resource needs at remote sites:
      --Food preparation and distribution
      --Drinking water
      --Bathing and restroom facilities
      --Equipment and supplies housing (secure space for armory, medications, etc.)
      --Classification and separation needs—male/female/juvenile, protective custody, custody levels
      --Location of nearest medical facilities from each site

Exercises

- All personnel should have initial training; train in small pieces, a part at a time, including at roll call and in-service.
- All personnel must be trained in protective equipment.
- There should be specific training for specified groups.
- Exercises are a good place to check coordination.
- Training should be followed by tabletop exercises.
- Planning and training should culminate in a full-scale evacuation exercise.

Types of Exercises

- *Table Training Exercise (TTX):* Uses scenarios to evaluate plans, command and control, and coordination. Can also evaluate whether necessary resources are available.
- *Situational Training Exercise (STX):* Similar to TTX but with some limited play by field personnel. Evaluates logistics (communications, routes, etc.), clarifies roles of personnel, determines if plans can be implemented in reality, and assesses capabilities of personnel.
- *Field Training Exercise (FTX):* Full-run exercise using all necessary personnel, logistics, and resources. Inclusion of inmates as a part of the exercise is possible with careful pre-planning. The most realistic exercise will yield the most realistic results, but inclusion of inmates, even at the lowest custody level, involves some degree of risk.

JOSEPH OXLEY, SHERIFF, MONMOUTH COUNTY, NEW JERSEY

MODULE IV: PLANS, EXERCISES, AND CONTINGENCIES (CONTINUED)

We planned to offer the full version of this course in Monmouth County, New Jersey, in 2001. However, September 11 occurred two weeks before the program was scheduled. Ultimately, we went ahead with the program, which had standing room only.

The 9/11 attacks took a toll on Monmouth County, including the death of many county residents that day. Then, shortly after that, we received an envelope with white powder. At our staff meeting, we talked about "what if." Although we screened mail at that point, we took it to the pod and opened it in front of the inmate. We realized that approach would make a biohazardous site of the entire jail, so now we screen mail outside the perimeter. Just after that, there was a threat to a judge. Although it turned out to be a hoax, it alerted us to the need to take a look at our plans. As part of testing those plans, we did an exercise involving evacuation to a remote site.

This NSA program helps you to do the necessary brainstorming in a controlled environment. The pilot programs have gone very well. In terms of stretching your training dollars, this is a phenomenal opportunity. The program gives you the opportunity to create a policy or review your existing policy, if you have one, and improve it. As part of the grant, NSA will bring in instructors and provide breakfast and lunch. You just announce the program and bring the group together.

The 9/11 attacks provided a wake-up call for us. We have an obligation to keep our communities as safe as possible. I want to re-emphasize how valuable the NSA training is.

DISCUSSION

Following presentation of a video on Monmouth County's evacuation exercise, meeting participants were given the opportunity to ask questions.

- *Did you invite media representatives to the evacuation exercise?*

  No. We did not want it to become a media event, so we told them that we would be doing a "small training exercise." We had a pre-printed media release, but the plan also included a designated area for the media. We have a good relationship with the media, and professionals have no problem being told where they are allowed to go.

- *Were there disciplinary outcomes for staff after the exercise?*

  No, this was a training exercise designed to give everyone an opportunity to learn from the experience.

- *Was the local community involved?*

  We did not notify the neighborhoods, but we should have done so. We set up a meeting after the exercise and will involve local areas next time.

- *Do you have contingency plans for events that might occur in your region, including New York City?*

  Many of our officers wanted to go to Ground Zero, but no additional help was being requested. Our primary responsibility is in our own community.

MODULE V: RESPONSE AND EVACUATION

MIKE JACKSON, NATIONAL SHERIFF'S ASSOCIATION

Training Scenario

Participants in the full NSA training program are given 20-30 minutes to respond to the following scenario:

"You have just been notified that a WMD incident has occurred near the jail. You have 2 hours to completely evacuate before the contamination reaches the facility. In 15 minute increments, map out what must be done to accomplish this successfully."

Most participants respond with some of the following steps:

- Establish control/command post;
- Ensure accountability of staff and inmates;
- Secure facility from outside attack and inside disturbances (sometimes inmates react badly to being locked down);
- Get protective equipment to staff and inmates;
- May begin to release less serious inmates;
- Initiate a plan to move;
- Begin to acquire transportation, including school buses, other county buses, military vehicles, or commercial buses;
- Ensure the safety of staff and visitors;
- Assign roles and responsibilities to security and movement personnel, transport vehicles, and escort vehicles; and
- Coordinate resources at remote site.

Making the Move

- Personnel are assigned and in place:
    - Everyone knows where to go and the routes to follow;
    - The advance team is in place at the remote location;
    - Lines of authority are clear.
- Logistics are determined for special needs, medications, records, and other equipment.
- Transportation is in place, gassed up, and ready to go.
- All inmates are accounted for.
- Security of convoy (from both inside disturbances and outside attacks) is ensured.
- Any special needs or equipment such as wheelchairs or the evacuation of infirmaries are taken into account.

MODULE VI: ACTIONS AT THE REMOTE SITE

Training Scenario

Participants at the full NSA training program are then given the following scenario, to which they respond with a report to the group:

"What type of actions need to be taken to reestablish operations once personnel and inmates are at the remote site?"

Typical responses include the following:

- Decontamination; who will conduct it?
- Run-off containment;
- Weather concerns addressed;
- Inmate verification and headcount;
- Medical facilities area designated;
- Relief schedule determined;
- "Normal routine" (visitors, media, attorneys);
- Intake area and procedures for new arrestees; and
- Release dates honored.

MODULE VII: RETURNING TO THE FACILITY

Returning to the facility can be more dangerous than moving out, so it is important not to be complacent. In many cases, the inmates are not anxious to return. Be sure you know the route you will take. As other agencies will not be helping on the way back, you need to be sure the route is secure.

"What actions are necessary during each of the phases: at the remote site, at the jail facility, and upon completion of the move?"

Seminar participants tend to cite the following:

- Time is on your side for the return.
- The return is more risky than the evacuation.
- Ensure that all inmates are moved and accounted for.
- Check the facility for contraband.
- Perform the required clean-up.
- Return the remote site to normal operations.
- Complete decontamination has been verified.
- Know ahead of time who has the authority to certify the return.
- The transitional team is in place.

- Secure the facility.
- Check for contraband.
- Make sure doors and other security devices are all in good working order.
- Ensure that staffing levels have been re-established.

After-Actions

- Review the process.
- Update polices and procedures
- Perform a cost analysis, e.g., on non-agency vehicles, decontamination costs, equipment losses, and mutual aid resources.
- Address funding; it may be necessary to ask the county government for additional funding. You may be able to apply for funding from the Federal Emergency Management Act, but you will have to meet the agency's requirements. It would be useful to find out in advance what is reimbursable.

Conclusions

Managing WMD incidents is a continuous process that involves constantly doing the following:

- Planning
- Exercises
- Evaluating
- Monitoring for Changes
- Identifying the Terrorist Threat
- Assessing the Threat

For additional information or to arrange for this training program in your region, contact the National Sheriff's Association at 1-800-424-7827 or Mike Jackson, 1450 Dule St., Alexandria, VA 2234; 571-238-2605; mjackson@sheriffs.org.

You may also contact Sheriff Joe Oxley, Monmouth County Sheriff's Office, 50 East Main St., Freehold, NJ 07728; 732-431-7139.

BILL COLLINS, ATTORNEY AT LAW, OLYMPIA, WASHINGTON

ANNOUNCEMENTS

I have done a book for the American Jails Association on legal issues in prisons and jails, with a focus on jails, and it will be out in the next few months. I have also published a similar book through ACA.

I plan to send all Large Jail Network members an announcement of my two-day seminar on legal issues to be held in Oregon in October.

LEGAL ISSUES TO BE COVERED

Today's session will cover the following legal issues:

- Contagious Diseases, officers' "right to know," and inmate medical confidentiality
- Your contract provider has been sued…
- The violent mentally ill inmate and involuntary mental health treatment
- Arrestees, "clothing searches," and general population
- Sanitation and the "acting out" inmate
- Who is in the second bunk and how does he/she get there?
- "Stump the Chump"

MEDICAL INFORMATION AND THE RIGHT TO PRIVACY

This issue emerges in two common questions, one from a correctional officer, who says "We have a right to know what inmate has what disease, especially who is HIV+. If you know an inmate has AIDS or is HIV+, you should tell us." The second question, from medical staff, is "Under what circumstances can or should medical staff share medical information with custody staff?"

There are two groups responding to these questions: NCCHC (the National Commission on Correctional Health Care) and the courts.

- NCCHC says that medical records are confidential and should not be accessible to correctional officers, or, in most situations, to the agency director. On the other hand, NCCHC standards recognize that some information can be shared. Medical staff have a right to information from custody files and, more significantly, officers have right to information from a file when it involves the health and safety of inmates. This is true only on an exceptional basis, not routinely, which probably does not suggest that officers should be notified if an inmate is HIV+.

  It is in the best interest of the medical staff to become partners with custody staff in some circumstances. It is important for medical purposes that some information go to custody staff. For example, it might be important for custody staff to know that

an inmate is on medication that might result in a problem. In short, presumptively, medical information is confidential, but medical staff can breach this confidentiality when justified. It is important for you to know this because medical staff sometimes believe that there are no circumstances under which they can disclose information.

- The courts say somewhat the same thing, but not as rigidly. You can find court decisions that say inmates have a constitutional right to privacy in medical information. The right is not absolute, and it can be breached for legitimate penological interests. Where there is such a justification, the privacy right can be breached.

  One circuit court has said that there is absolutely no right to privacy. That is, once in an institution, the inmate has no rights. Another court says that it is not clear what rights an inmate may have. That is, the court's response is a mixed bag. In general, the courts will give you deference when you say that there is a legitimate reason to share information.

  With respect to AIDS, you could make the case that officers are safer if they know an inmate has AIDS. However, medical staff say that officers are safe in any case if they practice universal precautions. The courts have not generally said this is highly confidential information, but a shouted disclosure by an officer does not count as a legitimate penological interest.

Questions from Meeting Participants

Below are some issues or questions raised by meeting participants, followed by Bill Collins' responses.

- *Is cost a legitimate issue in terms of care?*

  The fact that medical care is expensive does not excuse you from providing care if it is otherwise necessary. Of course, the Constitution does not require you to buy the most expensive medications if a current medication works. For example, if your psychiatrist can be pinned down to say that old medications are still effective, you could defend continuing to use the old ones—unless the inmate is suffering side effects.

- *What if the standard of care in your community is the use of new drugs?*

  Cases do not always require the standard of care in the community. Whether you can use less expensive psychotropics will depend on the particular patient. Another scenario: An inmate was badly beaten by other inmates. Jail staff took him to the hospital, where he was bandaged. He was sent back to jail by hospital staff, who said that if certain symptoms later appeared, "We need to know as soon as possible because it may indicate a serious head injury." The jail commander responded by releasing the inmate, dropping him at a freeway interchange. Local police talked a local motel into taking him that night, but he suffered a relapse. He sued, citing deliberate indifference, but lost on a technicality. In this instance, of course, the jail did release the inmate solely to avoid medical bills. This is a common practice, but here, the circumstances put the inmate in the community at substantial risk. The jail was being far from benevolent in releasing him, and was deliberately

indifferent to a serious medical need. So, be careful about delaying care in order to save money.

- *Can medical personnel say that an inmate is HIV+ so that he can be sent back to state prison?*

  In that case, the inmate will still get treatment. The courts have said that budget considerations are relevant in placement issues, including release, if treatment will be available.

- *Rebecca Craig (California Medical Association) indicated that if you are giving medications to a prisoner, you should assume that you are obligated to provide 2-3 days of meds upon release.*

  It is certainly not a bad idea to give bridge medications; it depends on the person's condition, on the medicine being prescribed, and a variety of other circumstances.

- *The real issue is not 2-3 days of medications. Having connections to health and mental health providers in the community is more important.*

  Yes.

- *Why do I need to keep officers in the hospital with an inmate? We are willing to pay for his care even if he is released on his own recognizance, but we don't want to keep staff in the hospital. We will assume the burden of care, or there may be other ways for his care to be paid for.*

  This sounds reasonable, as long as he continues to get care and you are comfortable with discharging him. You may, of course, have to pay for the care if no other resources are available.

Other Comments on HIPAA Regulations

Does HIPAA apply to your jail? There is a significant question here. You provide health care, of course, but for HIPAA to apply, you also have to be involved in the electronic transmission of records. In addition, there is a HIPAA loophole that can apply. "Personal health information" may be disclosed when the institution "represents" that disclosure is "necessary" for:

- Health, safety of inmate(s), staff
- Health, safety of transport officers
- Administration and maintenance of safety, security, good order of institution.

An outside provider can share otherwise confidential personal health information with the jail if the jail indicates one of these situations. However, if you are dealing routinely with a provider such as a hospital, you should develop a specific consent form tailored to your circumstance. It should say that the provider "may disclose information to the jail when the jail represents" one of the situations listed above. This is really an issue the provider needs to worry about, not the jail administrator, but the provider may need to understand that you have the right to ask for and receive confidential health information.

CONTRACT PROVIDER LITIGATION

Scenario: "Your jail's private contract medical provider is being sued for a variety of alleged poor medical practices. For some reason, the suit does not name the county or any county employees.

The contract between the county and the medical provider provides that the company will defend and hold the county harmless for any inmate litigation. This aspect of the county was emphasized in contract negotiations as "reducing the county's burden of litigation." The contract also provides that the company will advise the County Department of General Administration about any litigation."

The Question: What actions, if any, should you as jail administrator take with regard to the litigation?

Don't Ignore the Litigation

You could be liable under a variety of circumstances. The jail and county must provide medical care. If inadequate medical care is a chromic problem, there is clearly a county liability exposure issue. In the same way a county may not be liable for one instance of misuse of force by an officer but would be liable if there were a pattern or practice of misuse of force, then you would be liable if it is jail or county practice to ignore poor medical care.

As the jail administrator, you want to know the issues in the suit against your medical provider. Is it a single alleged incident, or is it a pattern? Or is it the case that care was appropriate and there is no cause? The jail administrator and county attorney should be involved in ongoing monitoring of the litigation and, of course, in active monitoring of the contract. Remember that you have ultimate responsibility to provide medical care, so you cannot ignore the suit if the contractor is not providing what it is committed to deliver.

Questions

- *I can understand the need to respond to complaints and grievances, but it seems like active monitoring might put more of the responsibility back on us.*

  Let's set aside the question of litigation and liability and talk about contract law. If you are contracting out much of what you are doing, it is prudent to actively monitor the contracts. You must be actively involved in monitoring what is going on, in part, to ensure that the public is getting its money's worth. A court may point to your obligation to keep track of things; in existing cases, usually the problem is that the county has taken too lax an approach to the contract. Your contract negotiation needs to address how you will monitor the contract, including records you will have access to. If the monitoring function is given to someone not involved in the jail, I would be concerned.

  One of the ways that medical staff get into litigation is through an insensitive attitude toward inmates' conditions. When there is an attitude of deliberate indifference, you will be liable. The job of the medical staff is to provide medical care comparable to that available in the community, not to be super custody staff. Where you become aware of litigation, you should get involved early to understand the nature of the issues and your liability exposure. It is helpful if you can do that with the assistance of counsel.

INVOLUNTARY MENTAL HEALTH TREATMENT

Serious mental illnesses are covered by the requirement to provide medical care, of course. A deliberate indifference to mental illness is covered by a jail's constitutional duty to

address medical concerns. The courts have made it clear that there is no inmate right to rehabilitation, but jails do have a duty involving mentally ill inmates.

Inmates can refuse meds, except if:

- The inmate has a serious mental illness;
- Is a danger to himself or others; or
- Treatment is in his best medical interest

Under these three conditions, an inmate can be involuntarily medicated; this applies to pretrial as well as sentenced inmates. A qualified mental health professional must decide about these conditions in a specific instance. Check your state law on civil commitment, as it may require certain procedures that are more stringent than the Constitution requires.

If there is an emergency, no hearing of any sort is required. If it is not an emergency, the Supreme Court said that you do not have to go to court. You can establish an internal process to address the issue of involuntary medications. This will involve a hearing that looks somewhat like a disciplinary hearing and includes on the hearing panel a psychiatrist who was not involved in making the initial decisions about medication. If an inmate is refusing to take meds and doesn't fall into any of the three categories, you cannot invoke the power to involuntarily medicate him. You need to remember that psychotropics are not crowd control tools.

Medicating Involuntarily for Medical Purposes

- *Is there any authority to force a pretrial detainee to take meds to keep him competent to stand trial?*

  The answer is probably "yes," but don't make the decision unilaterally. Involve the court and district attorney to get a court order saying that you can medicate to keep the detainee competent. The courts are struggling with what is appropriate in this context. If you are acting pursuant to a court order and don't act fraudulently, you are protected. In an instance in which you have a pretrial detainee and competency is not involved, but he is a danger to himself and others, the offender's criminal attorney may have no right to object. However, you may want to notify the attorney of your plan to medicate the inmate involuntarily.

STRIP SEARCHES

Strip searches have been addressed in a couple of cases dealing with "clothing exchanges." As I have made clear previously, no matter what you call it, if you have a policy that requires arrestees to take off all their clothes for direct observation by a member of custody staff, the "reasonable suspicion" rule will apply. The jail has no justification for a strip search, by whatever name, unless there is reasonable suspicion that an arrestee is concealing weapons or other contraband. The court is likely to find any other strip search requirement a massive intrusion into an arrestee's privacy.

You can require an inmate to change into your clothing or to shower. The problem comes if an officer is watching. Having an officer observe the shower process is acceptable, but privacy protection, such as translucent screens or shoulder-high screens, is required.

In the Stanley case (7th Circuit) the jail process required an arrestee to go into a private area and remove clothing down to underwear with an officer watching. The court ruled that was not an unreasonable intrusion, but an acceptable search. An interesting sidelight to the Stanley case was a woman arrestee who was not wearing a bra. However, the court said that was her problem, not the jail's, as she was not required by jail policy to take off all her clothes.

When Does an Arrestee Become an Inmate?

An arrestee becomes an inmate upon leaving and then returning to the jail, e.g., for a first outside jail court appearance or a medical visit. When an arrestee has been placed in a general population housing unit, he/she is subject to search on the same grounds as others in the unit. Whatever criteria your policy defines for strip searches must apply to all inmates. However, you are not permitted to strip search someone simply on the basis of his or her placement in general population.

Questions

- *What about cross-gender pat-downs?*

  Cross-gender pat down searches of male inmates by female officers are permitted, but not cases of female inmates being pat-searched by male officers. In general, women coming into jail have different expectations of privacy than men do. I would be worried about a policy of having males doing pat-searches of female inmates. In an emergency, that's different, but don't allow it on a routine basis.

- *What about openly gay staff searching someone of the same gender?*

  There has been no court ruling on this.

- *What about male officers searching female inmates' cells?*

  That is not a problem. What might come up is a male officer while doing a search viewing female inmates in states of undress.

- *Can charges be used to define reasonable suspicion?*

  Yes, charges, including violence, possession of drugs, etc., can be used to justify reasonable suspicion.

- *Can you do a strip search when an inmate returns to custody from a furlough?*

  No; reasonable suspicion does not apply.

TRANSSEXUAL INMATES

A district court case has recently addressed the transsexual issue in terms of treatment. In the case, the court says that transsexuality can be a serious medical need. The administration had been saying that it would continue treatment for a transsexual who was receiving it on the outside but would not initiate it. The court ruled, however, that this is a medical decision rather than an administrative one. We are going to see difficult issues around transsexuals in jail.

What seems to be consistent in lower court decisions is that a properly diagnosed gender disorder will be seen as a medical/mental health need, which triggers some duty of treatment. One case says that you must give the inmate more than therapy to allow him to get along in a male prison. You must give the case to a competent medical provider, probably a specialist, and start with the idea that you will do what the expert advises.

THE SELF-FOULING INMATE

Everyone has inmates who spread fecal materials on the walls and doors of their cells as acting out behavior. What are your thoughts about the following two approaches to dealing with this behavior?

1. Remove the inmate from the cell, place him in 4-point restraints for self-harm issues, and have staff decontaminate the cell. Put the inmate back in the cell after a specified period of time. This behavior repeatedly occurs, and the inmate has no mental health issues. It is acting out behavior. Does this amount to using restraints as punishment for the behavior?

2. Offer the inmate the opportunity and materials to clean his cell and shower at the beginning of every shift. All of this is recorded on videotape. The goal is to have the inmate take responsibility for his actions. This process would not be used with mentally ill inmates, however. The inmate is evaluated for medical and/or mental health issues that might contribute to his behavior.

- *The second approach actually works.*

  Yes, and the courts have approved such a process. There is a point at which the jail must intervene. However, I would suggest that you not leave the inmate in a dirty cell more than a day or two.

  The first approach outlined above mentions "self-harm issues," but there is no basis for believing that the behavior constitutes a threat to the inmate himself. Therefore, the restraints are really a punishment.

Other approaches to the problem used by meeting participants:

- *Keep the inmates in restraints for a specified time. If he won't agree to behave, he will not be released. An inmate has been in restraints for as long as 8 hours under these circumstances.*

  You must be able to show that you are monitoring the inmate's health and well-being while he is in restraints. Eight hours sounds like a long time; I am not sure what the court would say about 2-4 hours, but that would probably not constitute cruel and unusual punishment.

- *In our jurisdiction, a multidisciplinary team that includes an officer, a mental health provider, and a nurse must make a decision together. Often, the mental health representative says that it is in the best interest of the inmate to be restrained (in soft restraints). He is taken out of the dirty cell, which is cleaned, and he is allowed to shower and return.*

  If he is in restraints for the time it takes to clean his cell, that is fine, but I would question this if it were for a longer period. Any time you use restraints in such a circumstances, keep the inmate restrained for no longer than necessary.

THE UPSTAIRS BUNK

Scenario

A 350-pound inmate, in jail for only a few days for a very minor offense, was assigned a second bunk. The assignment was probably made simply on a "space available" basis. An officer ordered the inmate to clean the ceiling vent above his bunk. Inmates commonly plugged the vents with a sort of papier maché mixture to cut down on drafts. While poking at the vent with a screwdriver or similar tool, the inmate somehow fell off the bunk, seriously injuring his wrist. The ensuring lawsuit includes a variety of claims, the specifics of which are not important.

Are there are other potential bunk accidents waiting to happen and, with them, lawsuits waiting to be brought?

- Who gets assigned to top bunks? Is any thought given to an inmate's physical dexterity or lack thereof in making top bunk assignments? How many old, arthritic, seriously obese inmates are climbing into top bunks in your jail tonight?
- How do inmates get to the top bunk? Via a ladder? Or stepping onto the lower bunk, putting a foot on the table (built to hold a 350 pound man, right?) and then sort of leaping for the bunk?
- Are there other problems associated with top-bunking?

Incidentally, the lawsuit I describe includes a negligence claim: the jail failed to use ordinary care. This is a much easier burden to meet than "deliberate indifference." There are no answers on this issue; it is just something to ponder.

For additional information, contact Bill Collins, Attorney at Law, 4923 Lemon Road NE; Olympia, WA 98506; 360-754-9205; billcol@attbi.com

TOPICS FOR THE NEXT LARGE JAIL NETWORK MEETING

RICHARD GEAITHER, NIC JAILS DIVISION

The following topics were proposed for the next meeting:

1. A legal issues update all day on Monday
2. Gangs--how to handle them, i.e., segregate or mix them in with regular population. Suggest that the presentation cover a cross-section of regions. What has been effective? (Could be dealt with as point-counterpoint presentation.)
3. Growing mental health populations--programs, grants/funding, approaches such as mental health courts, and diversion.
4. Best practices to handle inmates' legal access besides a law library. Could canvass electronically to see how agencies are handling and then describe at the meeting.
5. Best practices in handling mail (operational approaches, not legal issues)

1. Budget issues—how to market to elected officials.
2. Jail evacuation planning-- who has done it and how has it gone?
3. Pharmaceuticals and how they are marketed—what is the best way to hire a pharmaceutical company
4. Corrections Corps concept.
5. Prisoner reentry at the county level, with a focus on mental health and continuity of care.

Topics Selected

The group selected the following topics for the July 11-13, 2004 meeting:

- Gangs
- Mental health populations

APPENDIX 1: MEETING AGENDA

U.S. Department of Justice
National Institute of Corrections 04J2401

LARGE JAIL NETWORK MEETING

February 8-10, 2004 Raintree Plaza Conference Center
Longmont, CO

Agenda

Sunday, February 8, 2004

6:00 pm	Introduction and Overview . . . . . Richard Geaither Correctional Program Specialist . . . . . Larry Solomon, Deputy Director National Institute of Corrections . . . . . Virginia Hutchinson, Chief Jails Division National Institute of Corrections
6:30 pm	INFORMAL DINNER
7:30 pm	***Domestic Emergency Preparedness and Response and the Impact on Large Jails*** . . . . . Sue Mencer, Director Office of Domestic Preparedness Department of Homeland Security
8:30 pm	ADJOURN

Monday, February 9, 2004

8:00 am	Defining Network Issues: Presentation and Discussions of Issues Important to You
8:45 am	BREAK

9:00 am	Systemic Approaches to Contagious Disease Prevention . . . . . Dennis Williams Escambia County, FL . . . . . Don Leach Lexington/Fayette, KY Urban County Government
9:45 am	Roundtable and Open Discussion . . . . .
10:15 am	BREAK
10:30 am	Response by Jail and Public Health Officials to Contagious Disease Emergencies . . . . .
	Small Group Discussion . . . . .
11:15 am	Individual Group Reports . . . . .
12:00 pm	LUNCH
	Special Presentation
1:00 pm	National Sheriff's Association: Weapons of Mass Destruction Initiative: Jail Evacuation Planning and Implementation . . . . Sheriff Joseph Oxley Monmouth County, NJ . . . . . Mike Jackson, Project Dir. National Sheriff's Association
2:00 pm	BREAK
2:45 pm	Part II National Sheriff's Association: Weapons of Mass Destruction Initiative: Jail Evacuation Planning and Implementation
3:15 pm	BREAK
3:30 pm	Part III National Sheriff's Association: Weapons of Mass Destruction Initiative: Jail Evacuation Planning and Implementation
	Round Table and Open Forum Discussions . . . . .
5:00 pm	ADJOURN

Tuesday, February 10, 2004

8:00 am	Legal Issues Update for Large Jails	Bill Collins Attorney at Law Olympia, WA
9:30 am	BREAK	
9:45 am	Legal Issues Update/Round Table Open Forum Discussion	
11:00 am	Presentation of Future Meeting Issues and Meeting Evaluations	
11:30 am	Recap and Closeout	Richard Geaither
12:00 pm	ADJOURN	

A box lunch is available

APPENDIX 2: LIST OF MEETING PARTICIPANTS

U.S. Department of Justice
National Institute of Corrections 04-J2401

LARGE JAIL NETWORK MEETING

February 8-10, 2004 Longmont, CO

FINAL PARTICIPANT LIST

Steve Roderick, Captain
Alameda County Sheriff's Office
5325 Broder Boulevard
Dublin, CA 94568
(925) 551-6550

Michael Addington, Director of Institutions
Alaska Dept. of Corrections
4500 Diplomacy Drive
Anchorage, AK 99508
(907) 269-7409

J. Grayson Robinson, Sheriff
Arapahoe County Sheriff's Office
13101 E. Broncos Parkway
Centennial, CO 80112
(720) 874-4165

Bob Lauderdale, Bureau Chief
Arapahoe County Sheriff's Office
13101 E. Broncos Parkway
Centennial, CO 80112
(720) 874-4165

Mike Pinson, Director of Corrections
Arlington County Sheriff's Office
1425 North Courthouse Rd., Suite 9100
Arlington, VA 22201
(703) 228-4460

Gary Merline, Director
Atlantic County Dept. Of Public Safety
5060 Atlantic Avenue
Mays Landing, NJ 08330
(609) 645-5877

John Duffy, Warden
Bergen County Jail
160 South River Street
Hackensack, NJ 07601
210-527-3042

Amadeo Ortiz, Deputy Chief
Bexar County Sheriff's Office
200 North Comal
San Antonio, TX 78207
(210) 335-6219

Rick Frey, Lieutenant Colonel
Broward County Sheriff's Department
555 SE 1 Avenue
Fort Lauderdale, FL 33301
(954) 831-8875

John Sells, Commander
Caddo Parish Sheriff's Office
1101 Forum Drive
Shreveport, LA 71107
(318) 677-5296

Thomas J. Pocock, Commissioner
City of Atlanta Department of Corrections
254 Peachtree Street SW
Atlanta, GA 30303
(404) 865-8062

Michael Plumer, Jail Administrator
Dane County Sheriff's Office
115 West Doty St.
Madison, WI 53703
(608) 284-6165

John L. Ford, Chief Deputy
Davidson County Sheriff's Department
506 Second Avenue, North
Nashville, TN 37201
(615) 862-8170

Fred J. Oliva, Director
Denver Sheriff's Department
1437 Bannock Street, Room 508
Denver, CO 80202
(720) 865-9567

Dolores Messick, Major
El Paso County Detention Facility
P.O. Box 125
El Paso , TX 79941-0125
(915) 546-2228

Dennis Williams, Director
Escambia County Sheriff's Office
P.O. Box 17800
Pensacola , FL 32522
(850) 436-9822

Michael Herrell, Major
Franklin County Sheriff's Office
2460 Jackson Pike
Columbus, OH 43223
(614) 462-7132

Thomas Rovelli, Chief of Operations
Hampden County Sheriff's Department
627 Randall Road
Ludlow, MA 01056-1079
(413) 547-8000

Moses Pollard, Assistant Superintendent
Hampton Roads Regional Jail
2690 Elmhurst Lane
Portsmouth, VA 23701-2745
(757) 488-7500

Kim Stelter, Major
Harris County Sheriff's Department
1200 Baker Street
Houston, TX 77002
(713) 755-7260

Thomas Merkel, Inspector
Hennepin County Sheriff's Office
350 South 5th Street, Rm 6, Courthouse
Minneapolis, MN 55415
(612) 348-9982

Michael Wade, Sheriff
Henrico County Sheriff's Office
PO Box 27032
Richmond, VA 23273
804-501-4571

David Parrish, Colonel
Hillsborough County Sheriff's Office
P.O. Box 3371
Tampa, FL 33601
(813) 247-8318

John Rutherford, Sheriff
Jacksonville Sheriff's Office
501 East Bay Street
Jacksonville, FL 32202
(904) 630-2120

Gordon Bass, Director
Jacksonville Sheriff's Office
501 East Bay Street
Jacksonville, FL 32202
(904) 630-5847

Donald Leach, Administrative Officer
Lexington/ Fayette Urban County Government
600 Old Frankfort Circle
Lexington, KY 40510-9689
859-425-2612

Otto Payne, Acting Chief
Metro Louisville Corrections Department
400 S. Sixth Street
Louisville, KY 40202
(502) 574-2167

Jon Hess, Undersheriff
Kent County Sheriff's Office
701 Ball Avenue NE
Grand Rapids, MI 49503
(616) 632-6101

Steve Van't Hof, Captain
Kent County Sheriff's Office
701 Ball Avenue NE
Grand Rapids, MI 49503
(616) 632-6401

Larry Mayes, Interim Director
King County Dept. of Adult Detention
500 5th Avenue
Seattle, WA 98104
(206) 296-1268

Craig R. Nelson, Commander
King County Department of Detention
500 Fifth Avenue
Seattle, WA 98104-2332
(206) 296-1208

Paul Martin, Chief of Detention
Las Vegas Metro Police Department
400 Stewart Avenue
Las Vegas, NV 89101-6199
(702) 671-3951

David Pankoke, Deputy Chief
Marion County Sheriff's Department
40 South Alabama Street
Indianapolis, IN 46204
(317) 231-8244

Wayne H. Shirley, Chief Deputy
Mecklenburg County Sheriff's Office
801 East Fourth Street
Charlotte, NC 28202
(704) 336-8171

Harry Tipton, Director
Metropolitan Detention Center
5800 Shelly Road, SW
Albuquerque, NM 87151
(505) 839-8706

Ronald K. Malone, Superintendent
Milwaukee County House of Correction
8885 S. 68th Street
Franklin, WI 53132
(414) 427-4785

John Husz, Warden
Milwaukee Secure Detention Facility
P.O. Box 05740
Milwaukee, WI 53205-0740
(414) 212-6820

Ronald Bonforte, Warden
Monmouth County Department of Corrections
1 Waterworks Road
Freehold, NJ 07728
(732) 431-7850

Robert Maldonado, Superintendent
Monroe County Sheriff's Office
130 Plymouth Ave. South
Rochester, NY 14614
(585) 428-3143

Pat Hunton, Commander
Monterey County Sheriff's Office
1414 Natividad Road
Salinas, CA 93906
(831) 755-3878

Arthur M. Wallenstein, Director
Montgomery County Department of Corrections
51 Monroe Street, Suite 1100
Rockville, MD 20850-2320
(240) 777-9976

Timothy A. Moore, Chief Deputy
Multnomah County Sheriff's Office
501 SE Hawthorne, Suite 350
Portland, OR 97214
(503) 988-4409

Robert Davoren, Chief of Department
New York City Department of Corrections
60 Hudson Street, 6th Floor
New York City, NY 10013
(212) 266-1590

Cliff Uranga, Detention Center Administrator
Oklahoma County Sheriff's Office
201 N. Shartel
Oklahoma City, OK 73102
(405) 713-1935

Scott Bradstreet, Deputy Chief
Orange County Corrections Department
P.O. Box 4970
Orlando, FL 32802
(407) 836-3565

Matthew Hanley, Special Sheriff
Plymouth County Sheriff's Department
24 Long Pond Road
Plymouth, MA 02360
(508) 830-6200

Valerie Hill, Chief Deputy
Riverside County Sheriff's Dept.
P.O. Box 512
Riverside, CA 92502-0512
(909) 955-2492

Paul Cunningham, Chief Deputy
Salt Lake County Sheriff's Office
3365 S. 900 W.
Salt Lake City, UT 84119
(801) 743-5822

Lori Bird, Commander
San Diego County Sheriff's Department
9621 Ridgehaven Court
San Diego, CA 92123
(858) 974-2278

Steve Thompson, Director
Snohomish County Corrections
3000 Rockefeller Aveune, M/S 509
Everett, WA 98201
(425) 388-3474

Michael Costa, Assistant Sheriff
Sonoma County Sheriff's Office
2777 Ventura Avenue
Santa Rosa, CA 95403
(707) 565-1422

Roy Mueller, Director
St. Louis County Department of Justice Services
100 South Central Avenue
Clayton, MO 63105
(314) 615-4763

F. Patrick Tighe, Major
St. Lucie County Sheriff's Office
4700 West Midway Road
Ft. Pierce, FL 34981
772-462-3283

Myron Larson, Assistant Sheriff
Stanislaus County Sheriff's Office
250 East Hackett Road
Modesto, CA 95358
(209) 525-7156

David Balagia, Major
Travis County Sheriff's Office
P.O. Box 1748
Austin, TX 78767
(512) 854-9788

Mark Mustin, Chief Deputy
Virginia Beach Municipal Correctional Center
2501 James Madison Boulevard
Virginia Beach, VA 23456
(757) 427-4955

Marilyn Chandler Ford, Assistant Director
Volusia County Dept. of Corrections
1300 Red John Drive
Daytona Beach, FL 32120
(386) 323-3524

Odie Washington, Director
Washington D.C. Department of Correction
1923 Vermont Avenue, NW - Suite 203
Washington, DC 20001
(202) 671-2128

Gerald Cook, Chief Deputy
Weber County Sheriff's Office
721 W. 12th St.
Ogden, UT 84404
801-778-6722

Michael Williams, Chief
Yakima County Department of Correction
111 N. Front Street
Yakima, WA 98901
(509) 574-1706

LARGE JAIL NETWORK MEETING

February 8-10, 2004 Longmont, CO

Presenters and Guests

Ms. Sue Mencer, Director
Office for Domestic Preparedness
Department of Homeland Security
Washington, DC
sue.mencer@homelandsecurity.gov

Mr. Joseph Oxley, Sheriff
Monmouth County Sheriff's Office
50 East Main Street
Freehold, NJ 07728
732-431-7139

Mr. Mike Jackson, Project Director
National Sheriffs' Association
1450 Duke Street
Alexandria, VA 22314
571-238-2605
mjackson@sheriff.org

Mr. James Gondles, Executive Director
American Correctional Association
4380 Forbes Boulevard
Lanham, MD 20706-4322
301-918-1800

Mr. Stehpen Ingley, Executive Director
American Jail Association
2053 Day Road, Suite 100
Hagerstown, MD 21740-9795
313-790-3930

Mr. William Collins, Attorney at Law
4923 Lemon Road, NE
Olympia, WA 98506
360-754-9205
billcol@attbi.com