U.S. Department of Justice
National Institute of Corrections

A Guide to Preparing for and Responding to

Jail Emergencies

Self-Audit Checklists

Resource Materials

Case Studies

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A Guide to Preparing for and Responding to

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Contents

Contents (continued)

Exhibits

Foreword

The National Institute of Corrections (NIC) has maintained a substantial focus on emergency preparedness for prisons. In 1981, NIC first offered seminars on dealing with major crises to prison administrators throughout the country. Even before that, NIC had provided technical assistance on emergency preparedness to various state prison systems. In the wake of some of the worst riots, hostage situations, and natural disasters, NIC has often been asked to provide specialized expertise in conducting independent, critical incident reviews (also referred to as "after-action reports"), usually in the form of technical assistance projects.

In 1996, NIC published *Critical Analysis of Emergency Preparedness: Self-Audit Materials.* An updated and expanded version of that guide was published in 2005 as *A Guide to Preparing for and Responding to Prison Emergencies: Self-Audit Checklists, National Survey Results, Resource Materials, Case Studies.* Both of those publications were intended to provide prison managers and administrators with comprehensive, detailed checklists with which they could evaluate the readiness of a prison or entire state department of corrections for a major emergency or large-scale crisis. NIC also sponsored a series of interrelated seminars providing hands-on training to prison administrators in the use of these new audit instruments.

Jails have always shared many of the same concerns and needs as prisons with regard to emergency preparedness. However, until recently, jails have placed less emphasis on emergency preparedness than has been true of prisons. Clearly, large-scale crises and major emergencies represent the same kind of catastrophic risks to jails that they do to prisons. In fact, what I wrote on the subject more than 10 years ago in the Foreword to NIC's *Critical Analysis of Emergency Preparedness: Self-Audit Materials*[1] applies to today's jails equally well:

> *Emergency preparedness is a crucially important topic…for every correctional institution. Large-scale inmate violence or a natural disaster can threaten the lives of both the institution staff and inmates. In hours, a major emergency can cost…tens of millions of dollars and result in many years of litigation. The negative publicity surrounding a major institutional crisis can also be overwhelming and almost interminable.*
>
> *Emergency preparedness is often not afforded the priority that it needs and deserves. In some cases, this may be due to complacency. In other cases, it happens because establishing a comprehensive system of emergency preparation and emergency response is not easy. It requires budget, time, equipment, interagency coordination, and long-term management attention.*

[1] Jeffrey A. Schwartz and Cynthia Barry, *Critical Analysis of Emergency Preparedness: Self-Audit Materials* (Washington, DC: U.S. Department of Justice, National Institute of Corrections, 1996).

Over the past several years, a number of factors both internal and external to U.S. jails have resulted in a burgeoning appreciation for emergency readiness. The events of September 11, 2001, have made terrorism a local as well as an international issue. High profile escapes, large-group disturbances, staff murders, and hostage incidents have served to put jails interminably at the top of the news and remind those of us in this field of the risks inherent in operating any correctional institution. Moreover, an executive order signed by the President has made it mandatory to familiarize staff in all correctional agencies with the National Incident Management System (NIMS). The most graphic evidence of the importance of emergency preparedness to jails lies in the stark video footage of events surrounding Hurricane Katrina, particularly with regard to the problems encountered in attempting mass evacuation of the jails in southeast Louisiana. For all the reasons outlined above, and perhaps more, there is a newfound wave of interest in emergency preparedness among this country's jails. That is, in itself, a very positive development because few issues relate as directly to community safety, staff safety, and inmate well-being as does emergency preparedness.

It is NIC's hope that this publication will be broadly useful to U.S. jails in planning for crises, emergencies, and natural disasters and in developing the appropriate response capacities to cope with these events where they cannot be prevented.

Morris L. Thigpen
Director
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Preface

After working with jails and prisons across the United States and Canada for more than 35 years, with a substantial amount of that work centered on emergency preparedness, we find that several conclusions have become apparent. The most positive is the developing appreciation for the emergency preparedness on the part of jails that Morris L. Thigpen describes in the Foreword. There are a number of other conclusions that are more challenging or more troubling. Jails are well behind prisons in this area. Today, most state departments of corrections and most individual prisons have thorough, extensive, and detailed emergency plans and there is staff training on those plans. There are emergency specialists ranging from negotiators to public information officers to tactical teams, and there are drills, exercises, and specialized emergency equipment.

Certainly, some jails carefully and thoughtfully prepare for emergencies. However, in too many jails, preparation is seriously substandard or lacking altogether. Some jails have emergency plans or manuals that are badly out of date or so poorly developed in the first place that they would be of little or no use to staff in a real crisis. Further, staff often have no training or familiarity with those plans; in a fast-developing major emergency, staff would have no chance to read the plans. Instead, they would simply rely on experience and instinct and hope for the best. The evidence that most jails are inadequately prepared for major emergencies is beyond dispute, and it extends to a very broad range of areas. For example, most administrators in corrections and law enforcement now acknowledge that staff and their families will predictably have extraordinary needs during and after major emergencies. The aftermath of Hurricane Katrina underscored this conclusion. Yet many jails have no realistic plans for dealing with hostages after release, assisting their families during an incident, or addressing the gamut of other staff and staff family issues that go far beyond counseling for posttraumatic stress.

There are several reasons why many U.S. jails are poorly prepared for major emergencies. One is that some jails simply believe "it can't happen here." Of course, when it does happen, it is too late. A second reason is that most U.S. jails are sheriff's jails. The sheriff's department may have a well-trained, professional correctional emergency response team (CERT) or special weapons and tactics (SWAT) team and well-developed contingency plans for various kinds of large-scale problems in the community, but the jail may be an afterthought, or there may be an assumption that if a serious problem occurs within the jail, the patrol side of the organization will handle it. Also, if the patrol and investigative divisions of the sheriff's department are the prestigious assignments and the jail is the "red-headed stepchild," then an issue as technically complex and demanding as emergency preparedness is unlikely to be near the top of anyone's list.

A third reason emergency preparedness in jails is not what might be hoped for nationally

involves the task itself. Good emergency preparedness is neither quick, nor cheap, nor easy. In an era of ever-tightening resources, it is difficult to divert any of those scarce resources from day-to-day needs, even though everyone recognizes that a badly handled major emergency can negatively define an entire organization for many years.

Not all the news about emergency preparedness is bad. There are more positive aspects than may be apparent, some of which are subtle. First, although some kinds of jail emergencies cannot be prevented (e.g., tornadoes or floods), other kinds can be (e.g., disturbances and escapes). Good preparation is inevitably good prevention. Second, even when emergencies cannot be prevented because they are outside the jail's control, good preparation can mitigate the impact of the crisis. Thus, even in a natural disaster, the difference between a massive tragedy and an emergency managed without deaths or serious injuries may depend on the jail's level of preparedness.

A less obvious advantage has to do with day-to-day security. Most correctional institutions that have engaged in a major initiative to strengthen their emergency preparedness have found along the way that their security practices and security procedures improved significantly, even though the emergency effort did not target those areas specifically.

It stands to reason that if a jail is to achieve a reasonable level of emergency preparedness, there must be some way to evaluate the jail's current degree of readiness for emergencies and then measure its progress toward achieving optimum preparedness. That is the primary purpose of the self-audit materials at the heart of this guide. They are intended to enable a jail to evaluate its own emergency preparedness in a thorough, objective, and detailed manner.

One final issue must be emphasized: size. A 5,000-bed jail is not the same as a 50-bed jail. In fact, there are many, many more 50-bed jails in this country than 5,000-bed jails. Yet materials developed for jails too often address only the issues of the 1,000- or 5,000-bed institution and ignore the concerns of smaller jails. In this guide, NIC, the project advisory board, and LETRA, Inc., have worked to overcome that problem and make *A Guide to Preparing for and Responding to Jail Emergencies* a resource that addresses the needs of small jails as well as the larger jails. Thus, this guide provides two self-audit instruments: a basic emergency preparedness checklist for smaller jails and an expanded checklist for larger jails. It is our hope that the supervisor or administrator in a smaller jail or a police "holding facility," will not be frustrated or intimidated by the audit instrument intended for larger jails but will instead find the audit instrument designed for smaller jails to be easily and immediately applicable.

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Acknowledgments

This guide is the result of a cooperative agreement funded by the National Institute of Corrections (NIC). However, it could not have been developed without the efforts of many individuals.

Five consultants served as an advisory board for this project, each of whom has a long history and deep experience with jails. Joe Lynch is the jail administrator for a 100-bed facility in Auglaize County, Ohio. Tony McClung is a consultant in charge of the homeland security program of the Georgia Association of Chiefs of Police. Prior to that, he worked with county and municipal jails throughout Georgia before retiring after 34 years of service. Bill Page is a senior risk consultant with the Michigan Municipal Risk Management Authority. He is also a retired jail administrator whose former responsibilities included oversight of jails training for the Michigan Department of Corrections. Larry Powers is the jail administrator for the Spartanburg County Jail in South Carolina. Dennis Williams was the jail administrator for the Escambia County Sheriff's Office and is now the director of research and planning for that agency in Pensacola, Florida.

Each of the five members of the advisory board made major, original contributions to this guide and also provided ongoing review and critique as the guide developed. We are indebted to each of them for their professionalism, expertise, and commitment to this project.

NIC did not just fund this project. The staff of the NIC Jails Division played an active and continuing role in the development of this guide. Richard Geaither, now with NIC's National Academy; Alan Richardson, formerly a Jails Division staff member; and Virginia Hutchinson, Jails Division Chief, all made substantive contributions to this guide, particularly in the planning stages of the project. Jim Barbee, also a long-time Jails Division staff member, served as NIC's program manager for this project from its inception. Jim provided suggestions on content, offered alternative strategies and methods of organization, and generally helped the project staff in more ways than can be enumerated. Without Jim's generous and ongoing support, this project would not have been completed in its current form. Rita Rippetoe served as NIC's publications coordinator throughout this project. In addition to substantive contributions, Ms. Rippetoe kept communications flowing among the authors, other NIC staff, and the editors. We are particularly grateful for her unfailingly positive approach to problems and questions.

For authors, it is a luxury to be able to work with professional editors. This manuscript was edited in its entirety by Donna M. Ledbetter, a senior editor and writer; Janet M. McNaughton, the editorial team lead; and other staff of the Lockheed Martin Corporation, Rockville, MD. Good editors do a great deal more than correct typos and misspellings. Ms. Ledbetter and Ms. McNaughton were as helpful in reorganizing

whole sections of this manuscript as in making the grammar and syntax consistent. They were patient with the authors' many idiosyncrasies of style and supportive throughout a quite lengthy editing process. The authors remain solely responsible for any errors in this guide, but Ms. Ledbetter, Ms. McNaughton, and the staff at Lockheed Martin have our thanks for making this work more professional and readable.

NIC developed this guide through a cooperative agreement with LETRA, Inc., of Campbell, CA. LETRA is a nonprofit training and research organization with many years of experience in working with law enforcement and correctional agencies across the United States and Canada. LETRA has specialized in developing comprehensive emergency systems for prisons and jails and in training prison and jail staff in emergency preparedness for the past 30 years. Several people associated with LETRA supported this project and made contributions to this guide, and we gratefully acknowledge that assistance. Sylvia Heins was LETRA's office manager throughout most of this project and had primary responsibility for preparing draft materials, providing logistical support to project staff and consultants, and formatting draft materials. She also carried out a wide range of other duties that kept the project moving forward.

The last section of this guide consists of case studies featuring a variety of high-profile emergency situations in jails. In most instances, the case study was developed either by the jail staff after the emergency or by LETRA, Inc., with the active cooperation and assistance of the jails involved. It is not easy or comfortable after a major emergency or large-scale crisis to publish an analysis of what went right and what went wrong, but that is one of the most important ways that those of us in the field learn, and it is one of the hallmarks of professionalism. We extend our thanks to those jails that provided materials or otherwise assisted in the preparation of the case studies in this guide.

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Section 1

Introduction

In This Section

Which Jails Will Benefit From These Self-Audit Materials?

This guide is intended for all jails, whether small, megasized, or somewhere in between; whether private or public; whether high security or minimum security; whether presentenced or sentenced. Whether a jail is a short- or long-term facility; a city, county, or regional facility; a holding facility or a full-service jail; emergency readiness is a crucial consideration, and the self-audit materials provided in this guide will be relevant.

Jails and Major Emergencies

Emergency preparedness is a central, even critical, issue throughout American corrections. Today, most public agencies must have emergency plans, and even private businesses have turned to disaster preparedness and business recovery planning. Jails, however, are not like other public agencies. They are responsible for the safety of large numbers of individuals who are usually locked up and cannot protect themselves in many emergency situations. Further, and perhaps ironically, the very people who are locked up and whose safety must be assured are the source of the most frequent and most serious jail emergency situations. Finally, the first priority for every jail is community protection, which means that even in the chaos of a major emergency, jails must ensure against escape.

No jail is immune from large-scale emergencies. A small, minimum-custody jail facility housing short-term inmates may be at very low risk for riot and disturbance situations, but a minimum-security designation and small size are no shield against fire, earthquake, chemical spill, or staff walkout. A hostage situation—perhaps the jail crisis demanding the most sophisticated response—can happen at any correctional facility. Contrary to the belief of some, "no smoking" policies did not signal the end of fire risk for jails. For example, the lack of self-contained breathing apparatus (SCBA) units means staff may not be able to evacuate inmates (or themselves) in the event of a serious fire. There may be an unwritten rule that jails must be built near railroad tracks or a curve in a major highway, but that has not lead to widespread planning for Hazardous Materials: Awareness and Operations situations.

A complicating factor is that the twin risks that an emergency will happen and that it will then go badly are heightened by population overcrowding and decreases in staffing levels and other resources, and also by the elimination of some programs that help stabilize jails (e.g., educational programs, earned good time, etc.). Along with overcrowding, (which is typically more severe in jails than in prisons), today's jail populations are substantially more violent, more influenced by gang issues and increasingly comprised of more individuals with serious mental health disorders. Add to this equation that jails have limited control over who comes and goes, so that a new police initiative or an event in the community can result in a sudden and unpredicted influx of new prisoners. Unlike prisons, which collect a great deal of information on almost

(continued on p. 5)

Could This Be You?

An electrical fire starts in an area of the jail without sprinklers and that staff cannot reach quickly. Some of the materials burning are plastic, and the heating/ventilation/air conditioning (HVAC) system spreads a thick, heavy, toxic black smoke throughout the jail. The on-duty weekend staff do not know how to shut off the HVAC system.

A crowded visiting hall is one of the first areas filling with smoke, but deputies cannot open the doors without allowing inmates out of the jail along with the visitors. The crowd has panicked and people are reported down. The fire has disabled some of the electric system (unfortunately, not the roof-mounted HVAC system), and the emergency generator does not operate the door panels. The jail has never conducted an actual evacuation of housing areas since fire drills have always been staff walkthroughs or simulated evacuations. There are not enough sets of emergency keys because they were distributed too late, and the manual unlocking of the single- and double-cell areas cannot keep up with the rate at which those areas are filling with smoke.

Staff have already retreated from some housing areas to avoid being overcome by the smoke, leaving inmates trapped in those areas. Fire equipment and firefighters are arriving quickly, but they have not toured the jail and are unfamiliar with its layout. With the chaos at the main entrance to the jail, there are not enough deputies to escort the firefighters through the jail. There are preliminary reports of multiple fatalities, including some staff.

* * * * *

Two inmates with a smuggled handgun have taken a correctional officer, a nurse, and a doctor hostage in the jail's clinic. A second correctional officer was shot and wounded in the initial melee and is also inside the clinic in unknown condition. The two inmates are awaiting trial in a first-degree murder capital case stemming from a particularly brutal robbery-homicide they (allegedly) committed together. They are yelling that they want a car and safe passage out of the jail or they will kill a hostage in 10 minutes.

The jail has no hostage plan and no negotiators. The shift supervisor is trying unsuccessfully to reach the jail director (it is a county department of corrections) because policy prohibits taking firearms into the jail's secure perimeter. With two locked steel doors at either end of a long corridor, and the second door barricaded, an assault into the clinic area will be slow and extremely difficult. The jail's correctional emergency response team (CERT) does cell extractions but is not trained or equipped for hostage rescue.

One of the inmates in the clinic is on an outside telephone line to a local radio station. The inmates also have two staff radios and can monitor all transmissions because there is no tactical channel.

Could This Be You? (continued)

The local police chief is offering his negotiating team, but they work for his tactical commander and will only work in the situation with the police department's special weapons and tactics (SWAT) team and if the police are given sole authority over the hostage incident, which the shift supervisor cannot grant. The response to the increased number of media inquiries is "No comment." The shift supervisor has just been told the nurse's family is being interviewed live on TV.

* * * * *

A category four hurricane ("Maude") has changed course dramatically and is now expected to make direct landfall in the area of the jail in 24 hours. The jail's informal (unwritten) evacuation plan calls for relocating inmates to 3 surrounding county jails and, if necessary, to a small federal prison that is within 30 miles. That prison was evacuated 2 days ago, and 2 of the 3 surrounding jails are already empty. A request 12 hours ago for county buses was rejected because they were committed to schools, hospitals, and senior residences. Movement is no longer possible because the roads are in gridlock.

The roof and windows of the old half of the jail will have trouble if winds exceed 70 to 80 miles per hour. The emergency generator has not been tested recently but should have fuel for 24 hours. Water should not be a problem as long as the municipal water system is not compromised. Flooding in the jail area will not be an issue unless the storm surge exceeds 6 feet.

Panic has been growing in the community since the storm track changed. Jail staff are tense and many are requesting time off to get their families out of the area. Jail administration is denying those requests and notifying staff calling in sick that they must show up or be terminated. Keeping on-duty staff informed is difficult, but they are getting information from inmates who are watching dayroom TVs. Pretrial and sentenced misdemeanants are requesting to be released in return for a promise to present themselves at the jail after Hurricane Maude has passed. They are being informed there is no such process and that their current predicament is one more consequence of their crimes.

all inmates, jails house pretrial populations that include many individuals who are "unknown quantities." The most dangerous situations involve prisoners who know both that serious felony warrants are outstanding against them and that the jail does not yet know their status. These conditions are ubiquitous in U.S. jails. As a result, most jails are in a more precarious position with regard to major emergencies than they were 15 or 20 years ago.

Another factor affecting how jails deal with major emergencies is the change in composition of the jail workforce. Recent years have seen the wholesale retirement of staff who began their careers in the late 1960s and 1970s—staff with 25 or 30 years of experience, many of whom had been through riots and hostage incidents and had demonstrated leadership under fire. Today, most jail staff receive far better pay and enjoy earlier

retirement than was the case "in the day." A jail staff member is also far more likely to switch agencies or even switch careers than was true 20 or 30 years ago. Thus, staff turnover is relatively high. In most sheriff's jails, new deputies must have from 2 to several years' tenure in the jail before they have enough seniority to be transferred to patrol. That process is then repeated at every promotional level.

Two consequences are that the jail's staff remains young and relatively inexperienced and that morale suffers because most deputies wanted to be law enforcement professionals rather than corrections professionals. Jails also promote staff much more quickly than was once customary. A jail captain may have 8 years of service now, whereas 20 years ago a "young" captain in the same department would have had 16 to 20 years of experience. In the absence of a deep experience base, agencies are far more dependent on policies, plans, and particularly on training. The mix of youth, inexperience, and low morale among staff with overcrowding and higher percentages of violent and mentally ill inmates can be incendiary.

Every sheriff and every jail administrator recognizes that a riot, a fire, or a hostage incident may be over in a matter of hours or less but may profoundly change the facility and the agency forever. One of the case studies in this guide recounts the story of a small jail in which a fire resulted in 42 inmate and visitor fatalities in less than 5 minutes. The fatal shooting at the courthouse in Atlanta, GA, and subsequent escape continue to reverberate through that community, and it appears that the name of Attica prison will remain legendary among correctional facilities. If the likelihood and dangers of large-scale crises in jails are widely acknowledged as real, does it not follow that almost all jails would commit serious time, resources, and thought to emergency preparedness? In fact, that is not the case. The reasons are complex.

First, most jails have not given high priority to emergency preparedness because planning for emergencies does not seem as pressing as day-to-day problems—until there is an actual emergency. Second, most people judge emergency situations by their outcome—whether they ended well—rather than by looking at how the situations were handled: whether staff performed properly, the right training and equipment were in place, policies were proved valid, etc. In too many systems, no serious scrutiny or review takes place until a situation ends in tragedy. Third, as this guide illustrates, effective, comprehensive emergency preparedness is demanding and difficult to achieve. Fourth, most jails are part of a larger sheriff's office, and emergency preparedness tends to be defined as a community and patrol division issue. Patrol, and perhaps other divisions or bureaus, may be given priority over jails for resources. Fifth, some traditions in jails actually work against effective emergency preparedness through:

- Management by personality rather than by procedure and policy.
- Separate plans for various types of emergencies, with no requirement that the plans be integrated, consistent, or current.
- The deep-rooted belief that riots and hostage situations are the only jail emergencies that really matter.
- The equally deep-rooted belief that planning is not really important because every emergency situation will be different.

Assessing Emergency Readiness

Effective planning plays a crucial role in preventing major emergencies and, as importantly, in containing crisis situations once they arise. With good planning, some situations—planned disturbances, some kinds of fires, some types of hostage incidents—may not occur in the first place. Good planning can also result in early

Characteristics of a Good Correctional Emergency Preparedness System

The hypothetical case studies in this section point to major flaws and absences in emergency preparedness systems. Regrettably, these omissions are all too common. Some facilities operate with little or no emergency system in place. Other facilities do have systems, but know their emergency preparation and response capabilities are outdated, inadequate, or otherwise unhelpful. In both of these situations, the facility needs a comprehensive emergency preparedness system, and identifying the key parameters of such a system may help. The following 13 characteristics represent the minimum criteria for an effective system of emergency preparation and response in a correctional facility.

1. Practical: The system must be useful to line staff, supervisors, and managers both before and during an emergency. It should not be theoretical. It should provide specific direction and procedures, tell staff what to do and what not to do, identify choices, etc.

2. Simple: The KISS, "Keep It Simple, Stupid," principle applies here. Emergency provisions that are too technical or too sophisticated may be beyond some staff. If the emergency system is overly complex, staff may forget key elements when an unanticipated crisis occurs. Compare the following instructions for maintaining facility fire doors:

> *Keep all fire doors closed in any major emergency unless ordered to open specific doors to assist with inmate evacuation.*

Versus

> *Type I and Type II doors are maintained closed in fire situations but are opened in other natural disasters and may be opened in emergencies involving inmate violence reaching Level Three or above. Type III doors shall be controlled by the highest ranking supervisor on scene in unaffected areas of the institution and by the Incident Commander in areas directly affected by the emergency.*

The first set of instructions is reasonably straightforward. The second set is neither straightforward nor simple.

intervention that resolves small, localized crises before they escalate into major emergencies that threaten the entire institution. The lack of effective emergency preparedness may increase the likelihood both that a major emergency will occur and that if a large-scale crisis does occur, it will be worse than necessary.

If a jail does not have the level of emergency preparedness it wants or needs, assessment is the logical first step. Traditionally, jail administrators have either asked their own staff to conduct an assessment or have contracted with outside consultants to do the job. Each

Characteristics of a Good Correctional Emergency Preparedness System (continued)

3. Corrections-Specific: An emergency system that was not developed specifically for correctional facilities is unlikely to be effective in a jail. For example, although an emergency system developed for nuclear facilities may be sophisticated and comprehensive, it will not tell staff in high-security housing what to do differently when evacuating administrative segregation inmates as compared with protective custody inmates. It will not help staff operate under lockdown conditions, and it is not likely to be useful in preventing staff retaliation after a major disturbance. No amount of discussion about who reports to whom and who controls which resources will substitute for the sound, detailed correctional practices that must be at the heart of an emergency system if it is to be effective for jails or prisons.

4. Generic: A single plan that addresses all major emergencies (an "all risk" plan) is more effective than the traditional approach of having a different plan for each different kind of emergency. Keeping staff trained and current with 8 or 10 different emergency plans is impossible, and there is little chance that staff will remember and differentiate among the various plans. Because 70–90 percent of what is done in any major emergency in a correctional facility is common to all emergencies—particularly in the crucial first 30 to 40 minutes—it makes sense to have a single plan that covers those common elements. Appendixes or addenda specifying additional steps particular to each type of emergency should then be added at the end of the generic emergency plan.

5. Policy-Based: Developing an emergency plan to no policy is impossible. Who is in charge at the outset of a major crisis is a policy decision, not a training or planning issue. Similarly, more specific questions such as what is nonnegotiable in a hostage situation and who, if anyone, is authorized to deviate from policy during an emergency, must be determined by policy decisions. Furthermore, with regard to some issues, emergency policies should differ markedly from day-to-day policies. Thus, an effective emergency system and its plans must be developed with regard to specific decisions about emergency policies.

approach has its own drawbacks. Involving the management staff of a jail in evaluating the strengths and weaknesses of its emergency preparedness (policies, procedures, plans, equipment, etc.) may be all the motivation they need to begin to improve their emergency systems. On the other hand, staff may lack the objectivity to point out areas in which they are at fault. Even if they are objective, in-house staff may not notice obvious problems because they have worked under the conditions for so long that they think of them not as problems but as the natural state of affairs. Further, internal staff are unlikely to be aware of the breadth of alternative solutions available across U.S. jails. Finally, politics and personalities can compromise the integrity of an internal assessment.

A different set of problems arises if jail administrators engage consultants. First, consultants

Characteristics of a Good Correctional Emergency Preparedness System (continued)

6. True System: The word "system" is badly overused, but with regard to emergency planning and response, it is appropriate and essential. To be a true system, all parts of a jail emergency system—each element of planning and response—must be compatible and operate seamlessly. Each element must be developed with full awareness of all other parts of the system. For example, the policy, procedures, and training for hostage negotiators must take into account and fit with tactical team operations. Both of these areas must be entirely consistent with the emergency policy on command and with training for staff at the level of shift commander and above. If one or more of these system elements is not consistent with the training and procedures for first responders, the outcome of an emergency could be tragic. This principle, "true system," is one of the biggest challenges in developing an effective jail emergency system.

7. User Friendly: The jail emergency system must be quick and easy to work with, and designed primarily for on-duty staff. When a major emergency strikes, there is no time to read through lengthy instructions or research questions. If the staff on duty cannot begin to contain an emergency, it may be irrelevant that the jail has highly trained and sophisticated specialists, because they will arrive too late.

8. Checklist-Driven: The primary method of making an emergency system user friendly, simple, and practical is to build as many of the procedures as possible into checklists. A checklist keeps staff from relying solely on memory. Checklists embody the key procedures for responding to an emergency and condense the experience and judgment of senior staff into an outline form that any staff member can follow. Checklists remind staff of the specifics in an emergency plan and of information covered in training. Later, they serve as accurate and detailed logs of what was done when and by whom.

9. Agencywide: In a department with more than one jail facility, it is essential that emergency plans follow the same format and principles in all facilities. Furthermore, the emergency plans at any one

cost money, and a serious evaluation may be expensive. Second, most consultants have specialized areas of expertise. Some are very good with fire prevention and fire-fighting systems, others with correctional emergency response teams (CERTs) and special weapons and tactics (SWAT), and still others with training hostage negotiators—but very few consultants have indepth experience and expertise with the entire gamut of comprehensive emergency preparedness issues. Third, management staff may see outside consultants as "walkthrough experts" and not take them seriously. Finally, political rather than purely constructive motives may govern how a jail chooses to use a consultant's report.

The self-audit materials in this guide offer an alternative to those traditional methods of

Characteristics of a Good Correctional Emergency Preparedness System (continued)

facility must plan for the use of resources from the other facilities. Thus, while each facility will have its own emergency plan, the emergency system will be agencywide.

10. Tailored to Each Facility: Tailoring systems to each facility applies to agencies that operate more than one jail. For example, the emergency plans at a new highrise facility with elevators will in some respects be dramatically different from the emergency plans for an older, "Auburn Style" (telephone-pole design) jail facility. Similarly, the emergency plans for a work-release center will be very different from those for a high-security facility. If emergency plans are so general that the same plan fits all jail facilities, then the plan may be close to useless. A good emergency plan, on the other hand, may specify that the vehicle sallyport be double posted early in any emergency and that inmate phones on living units be disconnected. However, not all jail facilities have a vehicle sallyport or inmate-access phones on living units. Without that kind of facility-specific detail, emergency plans are unlikely to be helpful.

11. Detailed: An emergency system must be detailed, whether in describing armory checkout procedures, outlining relief of staff during an extended emergency, or in addressing hundreds of other issues. A generalized emergency system fails to prepare staff adequately and to provide direction during an actual emergency.

12. Auditable: A good emergency system must be subject to audit. If it is not, the agency cannot know how much of the system is in place or how well staff maintain it. A good emergency system will include audit measures and procedures.

13. Field Tested: Field testing is not an essential criterion, but it is highly desirable. Staff do not want an emergency system that looks and sounds good but has never been tested under real life conditions. If a jail needs to develop or adopt an emergency system, it should insist on one that has been used successfully in other jails and that has been tested through a variety of real crises and emergencies.

evaluating emergency readiness in jails. A self-audit has the obvious advantage that the price is right; there are no external costs, and a jail can conduct the audit at a time that is most convenient. Although the audit is conducted by the jail's own staff, the detailed and objective nature of the checklists works to overcome many of the concerns with political and personality issues. Jail staff conducting the audit are no longer limited to answering questions derived from their own experience or preconceived notions of what constitutes adequate emergency preparedness. For the many jails that have never attempted a rigorous analysis of their planning or preparation for large-scale crises, these materials offer a convenient, inexpensive, and practical solution.

Are You Prepared?

For each type of crisis or emergency listed in the table below, rate how likely your jail is to face that situation in the next 10 years: impossible (I), highly unlikely (U), possible (P), or likely (L). For each situation you ranked possible or likely, fill in the remaining columns about your degree of preparation for that type of emergency. (For situations you rated impossible or highly unlikely, go no further.)

Event	Likelihood (I, U, P, L)	Level of Preparation: Current Detailed, Realistic Plan	Level of Preparation: All Staff Trained to Policy/Plan	Level of Preparation: Specific Drills/ Exercises
1. Disturbance/riot				
2. Major fire				
3. Hostage incident				
4. Mass escape				
5. Tornado				
6. Flood				
7. Hurricane				
8. Earthquake				
9. Staff job action				
10. Epidemic				
11. Bomb/explosion				
12. HAZMAT				
13. Terrorist incident				
14. Mass casualties				
15. Mass evacuation				

Key: I = impossible, U = highly unlikely, P = possible, L = likely, HAZMAT = hazardous materials

Small Jails and Large Jails

Emergency preparedness is often seen as an issue for medium-sized and large jails but not for smaller jails. Nonetheless, a compelling case can be made that emergency preparedness is more challenging—and equally important—for small jails. Larger jails have resources that do not exist in many smaller jails. These resources may include equipment, budgets, staffing patterns, training time, and many other things. Yet an emergency demands the same types of response and functions from a smaller facility as from a larger one. Someone must deal with the media. Negotiators may be required. Someone must attend to the special needs of staff and their families. With sharply limited resources, the smaller jail is challenged to be reasonably prepared and—in the event of an emergency—challenged to respond. Even external resources are different. The larger jail is likely in a larger community with a city police department and major fire department close by. The smaller jail may have no surrounding or adjacent police department,

and the local fire department may be a volunteer organization that is not as well trained or as well equipped as its urban counterparts. Moreover, many of the staff of a smaller jail may also serve in the volunteer fire department and cannot function in both capacities at the same time.

This guide is designed to be truly practical and useful for smaller jails as well as larger jails. The administrator of a smaller jail or the sheriff in a county with a smaller jail should not allow the size of this guide or the number of questions and degree of detail in the checklists to be intimidating. Although the larger jail self-audit checklist is extremely thorough and detailed by design, the self-audit checklist for smaller jails is basic and straightforward. Administrators of jails with 25 beds to 125 beds are strongly encouraged to review the smaller jail self-audit checklist before deciding whether the materials in this guide may be helpful.

The goal of the larger jail self-audit checklist is to be all-inclusive. For managers and administrators of larger jails, including mega jails, the larger jail checklist will likely prove challenging and demanding; some jails, particularly jails that have given little attention to emergency preparedness, may find the audit instrument somewhat overwhelming.

The key question is, "What is a smaller jail and what is a larger jail?" The answer is a decision for the reader to make. This guide does not provide a definitive numerical answer. Clearly, a 100-bed jail is a smaller jail and a 2,000-bed jail is a larger jail, but what of a jail that has 225 beds? Should that jail use the self-audit checklist for smaller jails or the one for larger jails? The jail may choose to use either or both. That is, the 225-bed jail may find that the checklist for smaller jails raises so many serious issues that it has no need or desire to delve into more detail. On the other hand, the jail may find it looks quite good in terms of the basic issues raised for smaller jails, and then it may wish to pick and choose additional material from the larger jail checklist and include that in its self-audit.

Finally, it must be recognized that two different 500-bed jail facilities may arrive at very different decisions about these materials, and each decision may be well justified. One facility may have extensive emergency plans and may have conducted ongoing emergency training and be generally sophisticated and current with regard to emergency preparedness. The other 500-bed jail may have nothing in place with regard to emergency preparedness. The former facility may rightfully decide to use the larger jail self-audit while the latter facility quite reasonably decides to begin with the version for smaller jails. Facilities of similar size will differ markedly in history, culture, and preparation with regard to major emergencies, and one self-audit instrument will not be appropriate for all jails. The National Institute of Corrections and those who participated in the development of this guide hope and intend that almost every jail across the country will find something in these materials that will be of use to it in evaluating its emergency preparedness.

Development of This Guide

An interesting parallel exists between emergency preparedness audits and security audits. Like emergency preparedness audits, security audits were once rare in jails. Today they are far from universal, but they are quite common. That change may be attributed largely to the advent of detailed self-audit checklists designed to evaluate security practices in correctional institutions. As the National Institute of Corrections (NIC) supported the development of generic security self-audit checklists and made them available to the field without cost, jail and prison administrators needed little encouragement to apply those instruments to their own facilities. The annual security audit, conducted internally using a standardized self-audit checklist, is a mainstay of many correctional institutions. That history and reasoning may be extended to emergency preparedness self-audits quite directly.

Several factors led to the development of this guide. In 1996, NIC published a set of self-audit materials on emergency preparedness for prisons in *Critical Analysis of Emergency Preparedness: Self-Audit Materials,* the first extensive emergency preparedness audit materials available in the United States. The reaction to that publication was extremely positive, and its success led directly to the substantially expanded and updated set of prison emergency preparedness self-audit checklists and related information published by NIC in 2005 as *A Guide to Preparing for and Responding to Prison Emergencies: Self-Audit Checklists, National Survey Results, Resource Materials, Case Studies.* Some jail administrators encountered those NIC publications and used them to evaluate emergency preparedness in their own jails, but it was clear that if NIC wanted to reach a wider jails audience, self-audit materials would have to be designed specifically for jails. Also, as alluded to in the Preface, events ranging from the attacks of September 11, 2001, to Hurricane Katrina raised awareness of the crucial nature of emergency preparedness efforts in jails across the country.

The Relationship of This Guide to the Earlier NIC Prison Publications

Although this guide is based in part on the two prison emergencies publications cited above, it has been rewritten and restructured to address the particular concerns of jails. The guide includes several other changes that are the result of criticisms, suggestions for improvement, and ideas for reorganization that came in response to the earlier NIC publications. Finally, this guide also reflects changes in the environment in which jails operate that have occurred over time. For example, in 1996, no one could foresee today's pervasive concern with terrorism, and the original publication on emergency preparedness did not consider counterterrorism strategies. Similarly, in 1996, there were few connections between the Federal Emergency Management Agency and local jails. That is no longer the case.

This guide, like its NIC predecessors, draws primarily on expertise from the field. That is, ideas about what is important and what is not important in terms of jail readiness for crises and emergencies, what are best practices, and what are promising new ideas come in large part from staff working in jails and prisons across the country. The two checklists at the heart of this guide are not derived from some theoretical perspective nor are they intended for academic use. Importantly, most of the material in the two emergency preparedness checklists has been field-tested by line staff, supervisors, and managers in working jails and found to be essential, important, or helpful.

What Is in This Guide?

The first section of this guide has discussed the rationale for self-audit materials on emergency preparedness, their history and development, and their goals. Section 2, "Conducting an Audit," discusses the purpose and philosophy of auditing and then presents specific information and recommendations about who should conduct an audit, when to conduct it, and how that should be done. Sections 3 and 4 present the smaller jail and larger jail checklists, respectively. In addition, readers may download these checklists from the NIC website at *www.nicic.gov.* These electronic versions make it possible to share the checklists via e-mail or a local area network in addition to being able to print them.

Section 5, "Resource Materials," presents three important papers: "Leadership Issues During Crises," "Prevention of Jail Emergencies," and "Emergency Teams." The first paper focuses specifically on leadership during jail emergencies, but much of the discussion could apply to crisis management in other settings. Some of the issues discussed in this paper are quite relevant to day-to-day operations as well as to crises and emergencies. The paper on preventing jail emergencies covers a broad range of measures that have the potential to decrease risks and reduce the probability that a jail will actually face a major crisis. The paper on jail emergency teams discusses some of the specialized teams—including tactical, hostage negotiation, and crisis intervention teams—required to respond to emergency situations in jails. The emphasis in this paper is not on the required training, equipment, or policies and procedures for such teams. Instead, it examines the salient issues surrounding the management of emergency teams.

Section 6, which concludes the guide, presents case studies illustrating how jails have responded to a variety of emergency and crisis situations. The majority of these case studies were written specifically for this guide.

Section 2

Conducting an Audit

In This Section

Purpose and Philosophy

Purpose of an Emergency Preparedness Audit

Conducting emergency preparedness audits is important for a number of reasons. Some reasons are obvious, others more subtle.

An audit **validates a comprehensive emergency preparedness system.** For a jail, comprehensive readiness for crises, natural disasters, and major emergencies is no easy matter; it is a far-reaching effort that can take years to develop fully and can require large amounts of money, staff time, management attention, and other scarce resources. **An audit specific to emergency preparedness makes a strong statement** that all of the work undertaken to develop and maintain the emergency system has been intended, planned, and coordinated.

Perhaps the most obvious reason for an audit is that it provides management with an **objective assessment of the progress and status of the emergency system.** Because a jail's emergency system is necessarily large and multifaceted, nothing short of a systematic audit procedure will effectively evaluate the system. A jail's emergency preparedness coordinator may be familiar with several substantial problems and may also have several initiatives awaiting funding or management commitment. However, the person in charge of emergency preparedness is inevitably too close—too involved in the system and too familiar with what is in place—to serve as an independent evaluator. To varying degrees, the same will be true of the facility's managers and emergency specialists, who may be quite familiar with its emergency preparedness and response capabilities. An objective and detailed audit process can surmount these limitations. For management, then, the emergency preparedness audit offers the opportunity to identify weaknesses, deficiencies, developing problems, areas of vulnerability, inconsistencies, and simple mistakes in the facility's emergency preparedness efforts.

The audit also provides an **opportunity to evaluate or reevaluate resource allocation.** For example, a jail's correctional emergency response team (CERT) program may have become more and more expensive because of costs associated with increased training time and range practice, while its hostage negotiators may have stopped training regularly and may not have worked together for more than a year. It may be time for the jail's administrators to revisit the priorities reflected in the allocation of their training resources. Such questions of resource allocation and relative priorities run throughout a comprehensive emergency system.

Relatively frequent audits can help a leader **identify tendencies toward complacency and cutting corners in critical practices.** Audits can also offset the dangerous consequences of fast turnover in management and supervisory positions. Rapid turnover means a loss of knowledge and experience in important areas. Without regular audits, a facility's policies and post orders may come to bear little resemblance to actual practice.

Another central purpose of an emergency preparedness audit is to **verify compliance with standards and policies.** Regardless of whether the standards or policies involved are at the departmental or facility level, or whether the standards are external (e.g., from the American Correctional Association) or internal, the point is that the organization has adopted them and expects them to be followed. Compliance with stated standards and policies goes hand in hand with accountability, which is essential to any management endeavor. However, even if a policy is well written, disseminated, discussed, and reinforced by training, compliance is not guaranteed. Although first-line supervisors generally carry the primary responsibility for day-to-day compliance with policies, a comprehensive review is the best way to ensure compliance with policies, standards, and written procedures in an area as broad as emergency preparedness.

An audit may also be an excellent **staff development tool** and may increase staff awareness of crucial issues related to emergency preparedness. This function of the audit applies not only to the audit team members, but also to the facility's staff at large. As the audit team reviews records, asks about emergency procedures, observes emergency responses, and focuses on the less visible aspects of emergency preparedness, jail staff infer this message: management believes emergency preparedness is important and is checking to see if things are as they should be. Inevitably, staff other than audit team members spot deficiencies as the audit progresses. In addition, when management takes corrective actions after reviewing audit findings, those actions will likely have greater impact because of the staff's heightened awareness of emergency issues. Employees who have not understood why some procedures were necessary for emergency preparedness may come to appreciate the rationale for those procedures. Finally, the audit offers the facility staff a chance to learn best practices with regard to emergency preparedness.

All of these reasons point to the same conclusion: an audit of a jail's emergency preparedness system provides an opportunity to improve that system. That is the ultimate goal. If management does not subscribe to that goal, then there is little point to engaging in a vigorous, demanding, and detailed evaluation of the emergency system. (The same can be said of any kind of large-scale institutional audit, and this guide's focus on emergency preparedness in no way suggests that an audit in this area is more important than, or conceptually different from, a security audit or other kinds of major audits.)

Philosophy

Protecting the community is the primary mission of all jails. An audit of emergency preparedness is consistent with that mission. In fact, with the exception of some highly specific aspects of jail operations such as perimeter security, one would be hard pressed to find an activity **more closely related to protecting the public** than evaluating the jail's readiness to handle large-scale crises and major emergencies.

Emergency preparedness audits also involve philosophic considerations beyond the jail's mission. If the jail is a policy-driven organization, then audit procedures necessarily will be philosophically consistent with that orientation. In a personality-driven organization or in an organization that has no consistent orientation with regard to decisionmaking, audit processes may be less helpful or even counterproductive.

More specifically, an audit should be a win-win approach to improving emergency preparedness. It should define current conditions and offer opportunities for improvement. However, if an audit becomes a kind of witch hunt ("who screwed up, and where and when?"), then it will not be a positive exercise and it will be unlikely to help the jail improve. Worse, if administrators regard the audit as an opportunity to assign

blame for shortcomings, then staff will be defensive and the audit results will almost certainly be inaccurate and incomplete. This point is critical: **Sending the wrong message to staff about the purpose and philosophy of an emergency preparedness audit will invariably compromise the audit findings themselves.**

Similar considerations apply to the concept of "audit scores." Some audits and audit procedures, such as audits of American Correctional Association standards, produce an overall numeric score for the facility. Jail administrators often speak proudly of such scores ("We got a 99.2 percent and that is the highest score any jail in our state has ever received"). For the emergency preparedness audits presented in this guide, however, such a view would be meaningless or worse. Every staff member involved in these audits should understand from the outset that **there is no acceptable overall score.** The individual items in the self-audit checklists are not presented in any particular relationship to each other and are not of equal weight or value. In fact, different jails probably will place different weights and values on different items, and that is as it should be. Thus, an overall score or average rating is meaningless, and may be misleading or even dangerous. As Richard Franklin pointed out in a National Institute of Corrections (NIC) monograph on security auditing, "It is quite possible to drown in a river that has an average depth of 6 inches."[1]

Before an emergency preparedness audit begins, its underlying philosophy should be discussed and disseminated. That philosophy should include the following goals:

- To support the mission of the jail in general and the jail's emergency preparedness system specifically.
- To increase staff awareness of emergency preparedness and provide opportunities for staff development.
- To provide management with rigorous, objective, detailed, professional assessments of the current status of the emergency preparedness system, with particular attention to unusual strengths and weaknesses.
- To provide opportunities for recognition of innovation and excellence.

[1] Richard Franklin, *Conducting Security Audits: A Special Issues Seminar Hosted by the NIC Prisons Division and the NIC Academy, Program No. 93 P3201* (Washington, DC: U.S. Department of Justice, National Institute of Corrections, 1993).

Preliminary Considerations

Deciding To Audit

Using the self-audit materials in this guide to assess the emergency preparedness of a jail will be demanding, and the results may be daunting—especially if the jail has not previously placed a high priority on emergency preparedness. Before deciding to conduct an emergency preparedness self-audit, jail management should first consider all of the implications and be ready to support the process fully.

Management should also closely examine some very specific considerations before initiating an emergency preparedness audit:

- ***Be careful what you wish for.*** This is an example of "Don't ask questions if you aren't prepared for the answers." Consider the following:
  - o Does jail management really want to know the results of a detailed and demanding review of emergency preparedness?
  - o Do jail managers and/or department-level administrators have a realistic view of the jail's current degree of emergency preparedness?
  - o Do jail managers believe emergency preparedness in the jail is reasonably good because there has been no recent major crisis?
  - o If the jail audit results document a pattern of dire needs and unmitigated risks, will leaders react constructively or will they be defensive and in denial?

Audit Decisions in Multiple Facility Departments

If a sheriff's office or local department of corrections simply mandates emergency preparedness audits at all jails in the jurisdiction without first discussing the subject with facility managers and giving them time to consider it, the audits will take place but the timing may not be good and the process may not be supported at the facility level. An audit initiated by administrative decree from above is likely to produce resentment from facility-level management, and that resentment will informally but effectively be transmitted to facility staff. As a result, the audit effort is unlikely to be a positive learning experience, and the results may be inaccurate and incomplete. Thus, it is prudent for administrators to involve facility-level management in the decision to conduct emergency preparedness audits jurisdictionwide.

Optimally, jail leaders and department leaders will consider these questions candidly and realistically before embarking on an audit.

More than occasionally, a facility undertakes an audit because line staff or mid-managers recognize serious problems in the jail and

suggest an audit as a way to bring the problems to management's attention. That is, when leadership is not responsive to subordinates' suggestions or concerns, those subordinates may push for an audit, hoping it will alert management to serious jail deficiencies. That strategy may be successful, but it also has substantial risks. When management is not committed to an audit initially, they may ignore the results of the audit. Worse, unfavorable results may provoke anger toward the audit team (the "blame the messenger" syndrome) or the subordinates who advocated for the audit.

- **What else is going on?** If another activity is demanding large amounts of staff time and pushing staff hard, expecting an audit to proceed smoothly at the same time is unreasonable. The audits in this guide, though not extremely lengthy, should begin only when they are likely to be "the only game in town" for several days.
- **Can audit team members focus exclusively on the process until it is completed?** Management must make the commitment that, barring some absolute emergency, the small number of staff assigned to the audit team will be free to complete the audit without interruption. This means avoiding the all-too-common practice of assigning staff to a project and then reassigning them before they complete the project. If management fails to honor its commitment of staff time, an otherwise serious audit effort will be undermined or rendered useless.
- **Is management committed to reviewing the audit findings?** Sometimes management tends to regard an audit as completed once the team has finished filling out the forms. Actually, the most important work in the audit process does not begin until the checklists have been finished. **The single most important product of the audit process is management decisionmaking**—at review meetings, in which audit findings are discussed and analyzed—that develops a plan of corrective action and followup. Managers must commit to participating in the review process. Top managers should recognize that the review will be time consuming. Before the audit begins, managers should agree to an initial review meeting and should understand that, barring emergencies, they will need to attend all review meetings.

Selecting a Self-Audit Checklist

A jurisdiction with a single jail facility may choose to use either the Emergency Preparedness Self-Audit Checklist for Larger Jails or the Emergency Preparedness Self-Audit Checklist for Smaller Jails. That is, for some jurisdictions, it may be difficult to decide which of these two checklists will be more helpful for their jail. For other jurisdictions, the answer will not be difficult because the jail in that jurisdiction is quite small, and it will be obvious that the checklist for smaller jails is most appropriate. Jurisdictions with a single, large jail facility may draw the opposite conclusion.

Deciding which checklist to use also may be difficult for jurisdictions with multiple jail facilities. In particular, there are many counties that have two jails: a sentenced facility and a presentenced facility. In these situations, the presentenced facility is almost always multilevel with regard to security, with minimum-security or minimum/medium security areas at the low end but including maximum-security areas as well. On the other hand, county sentenced facilities seldom include maximum security or high security areas (except for segregation units), and the facility is usually designated as minimum/medium or medium security.

If a jurisdiction has both pre-sentenced and sentenced facilities, should both facilities use the same checklist, or should the pre-sentenced facility use the checklist for larger jails while the sentenced facility uses the checklist for smaller jails? The answer is a local decision. As a guideline, however, it is typically easier to work with the results of the audits if both facilities use the same checklist. Also, the decision about which checklist to use should have more to do with facility size than with security level.

A different situation occurs when a jurisdiction has one or more large jail facilities but also one or more small, freestanding, minimum-security facilities. Most typically, the latter facilities might be residential work-release centers, but there are a variety of other types as well. In these cases, it will almost always be the correct decision to use the checklist for smaller jails. Even then, administrators should recognize that local police or fire departments, rather than the jail system itself, may be responsible for some checklist items.

Who Should Conduct the Audit?

The audits in this guide are better performed by a team than by an individual. Once a team completes the audit, it may be acceptable for an individual, perhaps the jail's emergency preparedness coordinator, to manage the audit followup.

Using a team for an audit has distinct advantages. Most obviously, more staff develop interest in and ownership of the jail's emergency preparedness; secondarily, the jail benefits from two or three independent assessments, which may reveal problems that would not have come to light had a single person conducted the audit.

The audit team should have two to four members. Management should appoint one member as team leader. If the jail has an emergency preparedness coordinator or someone in charge of the emergency area but perhaps with a different title, that individual should be part of the team but should not serve as team leader. (Issues of ownership, defensiveness, ego, lack of perspective, etc., might interfere with a coordinator's ability to lead the team objectively.) The team leader must have sufficient rank or other status to have access to all relevant data and all areas of the jail.

Ideally, at least one member of the audit team will be from another jail within the department, from some other area of the department (if it is a sheriff's jail), or even from a jail in another jurisdiction. This may not be practical and it is not essential, but it does contribute to the independence and objectivity of the audit. At least one member of the team should be from management or midmanagement level. In general, team members should be chosen on the basis of experience, credibility, knowledge of custody and security operations, and, to a lesser extent, familiarity with emergency operations. To avoid compromising the audit's objectivity, management should not create an audit team composed predominantly or entirely of emergency specialists (e.g., a four-person team consisting of the jail's CERT leader, armory officer, emergency preparedness coordinator, and chief negotiator).

The audit team should meet with the jail's top managers before beginning the audit. Members should clearly understand their recourse if they encounter serious resistance or other trouble as they conduct the audit. (Typically, a team will have negotiated the right to call an impromptu meeting with top administrators to review such situations and will wait until management intervention clears the way before proceeding with the audit.) The team members should meet at the end of each day while the audit is in process. This requirement may seem overly structured but, in practice, it has proven to be essential. Individual team members working in different

areas can get distracted, lose perspective, etc., and the end-of-day meeting serves to bring the team together to sort out trivial problems from serious problems and keep efforts coordinated. They should meet face-to-face with top management as soon as they complete the self-audit checklists, before the management review meetings take place. During this prereview meeting, the team gives top management an informal read on how the audit progressed, the most important conclusions, and any particularly surprising findings. It should be the verbal equivalent of a written executive summary, and it should prevent major surprises at the management review meeting.

Standards for Auditors

The self-audit checklists do not attempt to impose standards for emergency preparedness but rather provide criteria by which jails can measure their own preparedness. However, certain basic standards of conduct should guide the efforts of the audit team.

1. **Maintain confidentiality.** Audit findings and information are confidential, to be shared initially with the jail's top management only. The administration should determine how the findings are disseminated from that point on.

2. **Be considerate.** To the extent possible, auditors should not interfere with ongoing operations. They should respect other staff responsibilities.

3. **Report dangerous situations.** If auditors encounter a life-threatening condition or situation, they should report it immediately to the jail administrator.

4. **Be discreet.** When auditors find a problem or potential deficiency in an area, they should not explain it or point it out to staff in the area unless asked. However, if asked, audit team members should provide accurate, straightforward answers about what they are looking for and what they are finding. They should limit the information shared to the question asked and should not encourage discussion. If the issue is confidential (e.g., a plan for responding to an employee work stoppage or job action), the auditors should say that they are looking at a confidential matter and should provide no information.

5. **Be professional.** Auditors must not use their role, information, or findings to impress other staff or create dissension.

6. **Try not to single out individuals.** To the extent possible, auditors should not report in a way that singles out individual staff members. However, if the reported problem results from complacency, cutting corners, ignorance of policy, or other violations of sound practice or policy, auditors may have to cite specific persons or posts in need of training or supervisory attention. There may also be situations where it is impossible to report audit findings forthrightly without implicating a staff member. For example, if the jail armory is in terrible condition, and there is only one armory officer, the audit finding will inevitably identify the armory officer as responsible for the problem. An auditor must not allow the desire to protect a staff member affect the purpose of the audit.

7. **Be ethical.** Auditors should not create artificial situations to detect deficiencies in practices (e.g., hide keys left lying around or tamper with documents to see how long the change goes unnoticed by staff). Instead, they should seek legitimate opportunities to evaluate practices (e.g., fire drills, emergency counts). There is an important difference

between openly testing a policy or procedure (asking, for example, "Would you show me the insulin syringes so we can verify the count against the inventory balance in the log?") and setting staff up (e.g., planting contraband to see if it is discovered). The former is good auditing; the latter is not.

8. **Audit rigorously.** Auditors should be rigorous and demanding. They do a disservice to the jail if they assume something is acceptable without verification, gloss over problems, or give the jail a pass on an item they know to be deficient to some extent.

9. **Choose appropriate methods.** Direct observation of practices is the best way to audit individual items and generally is a more reliable method than reviewing records and policies or interviewing staff and inmates. It often is necessary to use both observation and documents to ensure that practice and policy are consistent.

10. **Maintain objectivity.** Auditors should maintain objectivity, professionalism, and perspective. No one is perfectly objective, but auditors should neither hope to find problems with almost everything nor hope for extremely positive findings. The easiest way to ensure objectivity is to focus on the evaluation criteria and not on personal preferences.

11. **Be a reporter, not an advocate.** The auditor's job is fact finding, not decisionmaking. Top management decides what will be done concerning the audit findings. Although auditors can and should recommend and advise when they believe they have insight about a deficiency, their primary role is to present the facts as they find them. The audit team and its work product may lose credibility if top management perceives that auditors are advocating strongly for certain decisions and are heavily invested in what is done with the audit findings.

Disclaimers

Before moving on to the specifics of how to use the self-audit materials in this guide, readers should be aware of some fundamental points about the nature of these materials and about jail audits in general:

- This audit system does not represent advice from NIC about what a jail's emergency system should or should not include. That decision has to be made by the jail's management.
- The self-audit checklists in this guide are not the only method for evaluating emergency preparedness in a jail. One alternative is to retain consultants to perform such an analysis. Another is to conduct comprehensive critical incident reviews when serious situations occur.
- An emergency preparedness audit is **not** a security audit. The two types of audits should complement each other, but one cannot be substituted for the other. Both are extremely important undertakings in a jail. NIC has developed a comprehensive, sophisticated security audit manual, which interested readers are encouraged to consider as the foundation for an indepth evaluation of institutional security policies, procedures, and practices.
- Some departments engage in policy audits, and many conduct their audits against some national or state set of correctional standards—most commonly, the American Correctional Association standards. Because such audits cover so many areas, they are not detailed or comprehensive with regard to emergency preparedness (or institutional

security). A jail may "pass" all of the emergency preparedness items on a national standards audit and yet be woefully unprepared for a large-scale crisis.

- Jail administrators must be absolutely clear about what type of emergency preparedness audit they are conducting and must be equally clear in communicating this information to staff. Is it a policy audit, an operational audit of practices, or both? If a jail passes a policy audit, the staff may assume all is well when in fact there are major problems with practices, procedures, and operations, which were not within the purview of the policy audit. Clarity about the purpose and scope of an audit is essential. (The audit materials in this guide cover both policies and practices.)

How To Use the Self-Audit Checklists

All managers who will be involved with the self-audit of emergency preparedness should read these instructions thoroughly before proceeding. (Some issues discussed in this section were raised in previous sections of the guide but bear repeating here.)

***Note: The checklists are also available from NIC on the Web at* www.nicic.gov.**

Overview

The purpose of the self-audit checklists in this guide is to help a jail administrator evaluate its readiness to contend with a major emergency. The two checklists—one for smaller jails and one for larger jails—are extensive but they are **not** all-inclusive. They cannot cover every emergency preparedness-related issue and detail, and some of the issues and details that are not covered may be crucial for a particular jail. The ultimate decision about what is important in emergency preparedness must be the province of each individual department or facility.

Similarly, **the fact that a jail does not meet some of the criteria in the checklist does not necessarily mean that the facility is wrong or in jeopardy.** For example, if the jail's management has thoughtfully decided not to purchase certain equipment or not to include certain policies or procedures in the jail's emergency preparedness plan, there may be an excellent reason for that decision. Conversely, if management has decided that certain criteria *are* important but has not complied with them or if it simply has never considered some of the criteria, then the checklist may serve a useful purpose in stimulating corrective action or consideration of new possibilities.

The checklists in this guide can provide a framework for a thorough review of emergency preparedness. Before getting started, however, the jail contemplating such a review should carefully consider the following points:

- If the self-audit is not going to be taken seriously and conducted rigorously, it probably should not be done at all. An audit that glosses over problems or fails to report deficiencies can create an illusion of emergency preparedness and may be more dangerous than no assessment at all.
- The manner in which a facility approaches the audit is most important. If top management expects a grade or scorecard from the audit, then that perspective will be transmitted to subordinate staff, and the audit process is unlikely to be productive. Management should emphasize that these are **self**-audits designed to **help** the jail review highly important areas. The audits should be a source of ideas and constructive change, not criticism.
- If the audits are not done carefully and accurately, the results will be misleading. If auditors are unsure about an item, they should investigate it further or leave it blank.

A Note About Minimum-Security Facilities

A small or minimum-security facility typically does not have the same set of risks for emergency situations as a large, high-security jail. (This fact illustrates the importance of good risk assessment as a starting point for emergency preparedness.) A minimum-security facility may have a relatively low risk of large-scale disturbances or planned hostage incidents and so may understandably choose not to maintain its own tactical teams. However, such situations certainly are possible in a minimum-security facility, and if a facility does not have its own tactical team, it needs to know who would provide one if needed. Furthermore, compared to many large, high-security facilities, a small or minimum-security facility may be at greater risk for loss of life from some other kinds of emergencies (e.g., fires, tornadoes). Most items in the self-audit checklists for emergency preparedness are relevant for small or minimum-security facilities, even though these facilities have unique considerations (e.g., staff may be responsible for multiple functions in an emergency, and the facility may depend heavily on external resources). In this sense, **emergency preparedness is often a greater challenge for the small or minimum-security jail** than for the large, high-security facility that has far greater resources.

Guessing and assuming will defeat the purpose of the audit.

- Top management should schedule a meeting to review audit findings as soon as the audit team has completed the checklists. All appropriate administrators and managers should attend. During the extensive field testing of the self-audit materials, review meetings were strongly correlated with the usefulness of the self-audit process to the department or facility involved. Without such meetings, a department or facility may never address the problems a careful self-audit can reveal.

These audits are not intended to take a long time to complete. In field testing, the time required for audit teams (typically two to four staff) to complete the earlier version of the larger checklist ranged from 1 to 2 days.

What resources will be needed to conduct a self-audit? The checklist for larger jails will require two to four assigned staff (see "Who Should Conduct the Audit?" p. 23, for staff qualifications). Auditors will require approximately 2 days of uninterrupted time to complete the checklist. They will need full access to all areas of the facility, to staff who manage specialized functions in an emergency (e.g., the CERT leader and hostage negotiators), and to all relevant policies, procedures, and other written documents. (Access to all areas during all shifts is especially critical because, as stated earlier, **it is more important to audit practices than to audit documents.**) The checklist for smaller jails will perhaps require one day of uninterrupted time from two staff. Neither of the self-audits will require special equipment or unusual resources.

Directions

This section provides specific directions for beginning an audit, completing the audit checklists, and completing a Summary of Noncompliance Items for each checklist. (Underlined words are the actual terms the checklist and summary forms use to label spaces

A Note About Sections 5 and 6 in This Guide

Reading the sections that follow the checklists—"Resource Materials" and "Case Studies"—is not a prerequisite for completing the self-audit checklists. These materials are intended to provide additional background information, a thought-provoking source of new ideas and approaches, and some lessons learned in responding to jail emergencies.

for entries.) Examples of completed checklist and summary pages follow the directions.

Getting Started

1. The guide contains two assessment documents (self-audit checklists). The first is for smaller jails and the second is for larger jails. Each checklist is separate and freestanding. Be sure you have the right document.

2. Make as many photocopies of each checklist as needed. For example, if you will be auditing 3 facilities and you want 2 copies for each jail, plus some extras, you may want to start by making 10 copies of the original. Retain the original, unmarked, for future reference and use.

3. Also make copies of the noncompliance summary sheet at the end of each checklist. Auditors complete this summary for use by management in reviewing the audit results. In field testing, auditors typically needed between 5 and 15 of the summary sheets for each checklist. A particular facility may need fewer or more, depending on how many items are partially met, not met, or not applicable (see direction 9). Note that the format of the summary sheet is the same for both checklists.

4. One person should be in charge of the audit. That person need not conduct the entire audit alone but should direct and supervise every aspect of it. The person selected to lead the audit should be high ranking enough to be aware of all necessary information. The selection should send the appropriate message to staff regarding the importance of the audit to the jail.

5. Plan to conduct the audit without interruption, in a relatively short period of time. It should not take months to complete, and it should not stop while individual items are fixed or brought into compliance. (However, as noted earlier, if the team discovers a life-threatening problem, it should report the situation to management immediately.)

6. Before attempting to complete the checklist, read the "Glossary of Terms" that follows these directions. Every jail has some unique terminology, and the same term may mean different things in different facilities. Some ambiguity about terminology may be inevitable in these generic checklists, but the glossary should help to minimize this problem.

Completing the Checklists

7. On the first page of the checklist, enter the facility name, the audit team leader's name, and the names of everyone on the team. Print the names legibly.

8. Each item on the checklists has two blanks to be filled in: status and method. The items do not have to be taken in the order presented, **but all items must be completed.**

9. **Status.** For every item, enter a code in the status box: MC ("meets criterion"), PM ("partially meets criterion"), NM ("criterion not met"), or NA ("not applicable"). **Choose just one status code for each item.** Make no other entry in the status box.

   Determining status. For some items, the distinction between MC and PM, for example, will be a difficult judgment call. In assigning status to items, try to be rigorous and consistent. Remember that an item checked MC probably will not be reviewed further. Items checked with any of the other three status codes, however, should be subject to further discussion and review.

   Substitutes. If the facility or department does not have the specific item mentioned in the checklist but has something else that serves the same purpose, enter NM for that item rather than MC. The management review will determine whether what is in place is comparable to or better than what is specified in the checklist.

   Written policies. Several checklist items ask for specific written policies. Do not check MC just because almost all staff understand something to be informal policy (even though it is not written) or because a group of related items are scattered throughout procedural manuals (where they would be of little use during an emergency). The facility may follow a particular procedure regularly, but if the checklist asks whether that procedure is "required by policy" and it is not part of written policy, then the status box should show NM.

10. **Method.** For every item, enter in the method box the code(s) for the method(s) used to determine status: OB ("observed"), DR ("document review"), SI ("staff interview"), II ("inmate interview"), and/or OT ("other"). **You may enter more than one method.** This is not like the status box, where only one entry is permissible. Enter all of the methods actually used. If you enter OT, specify the other method used.

11. **Comments.** Use this field to record notes about an item's status or the audit process. Keep in mind that the noncompliance summary (see below) requires explanations for any items not coded MC. The comments field also provides extra space for describing "other" audit methods (OT entries in the method box).

12. When every item on a page has been completed, the audit leader should print his or her name at the bottom of the page and date it (unless another audit team member has completed all items on the page, in which case that team member should sign and date the page at the bottom).

13. **NC#.** When the entire checklist is complete, the audit team leader should fill in the NC# (noncompliance number) boxes at the far right of the form. The objective here is to create a numbered list of items subject to management review. Starting on the first page of the checklist, use the NC# boxes to number **consecutively** all items **except those with the code MC.**

Summary of Noncompliance Items

14. At the end of each checklist is a page titled "Summary of Noncompliance Items." The purpose of this summary is to list all items that did not fully meet criteria (i.e., all items coded PM, NM, or NA) and to explain the reasons for noncompliance. As noted above, management will use this summary in its review of the audit results. The audit team leader completes the first three columns of the summary (entries may be typed or

handwritten). The other columns are completed during the management review.

15. **Audit team leader.** Using as many copies of the summary page as necessary, list every item numbered in the NC# boxes in the checklist (i.e., every item not coded MC). First, enter the NC# (entries should be in **NC#** order). Below the NC#, enter the **status** code and the **method** code. (Thus, for each noncompliance item, you will make three entries in the first column: NC#, status code, and method code.) Under **Item Description,** briefly summarize the item (as a convenience, so reviewers will not have to refer back to the checklist). Under **Reason for Noncompliance,** explain why the item was marked PM, NM, or NA. (Be brief, clear, and forthright. If there is no clear reason, leave the space blank. Do not invent an explanation.) At the top of each page, enter your name, the date the page was completed, and the page number.

16. **Management review.** Use the noncompliance summary to document management response for each noncompliance item. Under **Assigned To,** enter the name of the person assigned responsibility for bringing the item into compliance (leave blank until the item is reviewed and an assignment is made). Under **Due Date,** enter the date compliance is to be completed (enter a date only if the item has been assigned). The administrator responsible for reviewing the audit results should sign his or her name under **Approved By** and date the signature under **Approval Date** after he or she has reviewed and approved the corrective action. (Typically, the reviewer should not be a member of the audit team. Different administrators may review different items, or one administrator may review all items.)

The Management Review Meeting: Translating Audit Results Into Action

The management review meeting may be the most crucial element in the entire emergency audit process. If the meeting is not attended by the "right" people (the facility's top managers) or if management's consideration of the audit results is superficial or defensive, the entire audit effort may be rendered useless.

For most jails, the management review process will be lengthy—two or more meetings may be required to complete the work. Management must be willing to consider policy and practices in detail. For any particular item, it may be tempting to conclude that "What we are doing is more than adequate." However, managers should never reach that decision without understanding why the audit instrument includes the criterion in question—i.e., specifically how the criterion relates to best practices in emergency preparedness and how the jail's practices differ from the criterion.

As with so many other areas of corrections, there is no substitute for strong leadership in management reviews of emergency audit results. If the jail administrator or other top manager is in and out of the review meeting and appears uninterested or dismissive in responding to the audit team's findings, other staff will follow that lead and the results will be less than constructive. On the other hand, if the leader clearly is determined to translate audit results into action, other staff will be inspired to share that commitment.

Examples of Completed Forms

Completed Page of Self-Audit Checklist

A Guide to Preparing for and Responding to Jail Emergencies

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

CHECKLIST FOR LARGER JAILS

Criterion	Status	Method	Comments	NC#
2. Does policy or regulation specify all approved types of weaponry, chemical agents, ammunition, and other defensive equipment?	MC	DR	Policy 04.5.12 (Dec. 4, 2005) Actual list contained in Reg. 237 (May 21, 2007)	46
3. Does policy or regulation specify minimum quantities of such weaponry, chemical agents, ammunition, and other defensive equipment?	NM	DR	no such Policy.	47
4. Is the armory currently in compliance with these policies and procedures?	PM	DR OB SI	most equipment in compliance. Olt Winchester shot guns not on approved list. New OC grenades not on approved list.	
5. Is the armory secure from rioting inmates?	MC	OB SI		48
6. Are armory keys restricted from inmate areas?	NM	SI OB DR	no policy or procedure. Armory officer + tactical captain both on living units, both carry armory key on their key rings.	
7. Do on-duty staff have immediate 24-hour access to the armory?	MC	SI OB	Armory key under glass seal in main control.	49
8. Is the armory inventoried at least monthly?	PM	SI DR	Firearms inventory monthly. complete armory inventory quarterly.	50
9. Do management-level staff inspect the armory at least quarterly?	NM	DR SI	no management review of armory in last 2 days.	

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable.
Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See section 2: How to Use the Checklists, direction 13.

AUDITOR: Melissa Whalley, Lt. DATE: June 15, 2009

Completed Page of Summary of Noncompliance Items

SUMMARY OF NONCOMPLIANCE ITEMS
Emergency Preparedness Self-Audit Checklists

AUDITOR: Melissa Whalley, Lt., Team Leader PAGE 10 OF 18

DATE: July 7, 2009

NC #	Item Description	Reason for Noncompliance	Assigned To	Due Date	Approvd By	Approval Date
46 Status: NM Method: DR	Does policy specify minimum quantities of firearms, chemical agents, etc.?	No such policy. Decision: Keep as is. Needs will change in 2011 when new facility opens.	NA	NA	D. Cole, Capt.	7/7/09
47 Status: PM Method: OB, DR	Is armory in compliance w approval list and policy?	Some items not on approved list. Get rid of old shotguns, modify approval list to include OC grenades.	Dep. James Olsen	Aug. 14, 2009		
48 Status: NM Method: SI, OB, DR	Armory keys restricted from inmate areas?	Armory key is on keyring of Tactical Capt. and Armory Officer. Both go into living units with keyrings.	New policy: Capt. D. Pierce	Aug. 28, 2009		
			Directive From D. Cole, Capt.	7/7/09	B. Otto, w/shadow	7/7/09
49 Status: PM Method: SI, DR	Is armory inventory completed monthly?	Firearms: Monthly Full Quarterly inventory of armory. Decision: Adequate as is.	NA	NA	Capt. D. Cole	7/7/09
50 Status: NM Method: DR, SI	Management inspection of armory on quarterly basis?	No management review of armory in last two years. Decision: Begin mngmt. reviews/inspections quarterly.	Capt. D. Cole	Nov. 1, 2009		

Review of all items on this page completed: Yes ✓ No

NAME: David Cole, Capt. - Jail Commander

SIGNATURE: [signature] DATE: 7/7/09

Glossary of Terms

After action report: See **critical incident review.**

Chain of command: A prioritized list, by job title, of the individuals who would assume command of the facility in an emergency.

Chain of custody: Procedures and documentation that verify who is in possession of evidence, the location of the evidence, and the integrity of the evidence at every point in time.

Command post: The location from which the emergency operation is directed and controlled. It is almost always in or at the facility experiencing the emergency and is the place from which the commander works.

Commander:

> **Initial commander:** The person in charge of the facility and the emergency at the beginning of a large-scale crisis.
>
> **Ultimate commander:** The individual, by job title, who assumes and maintains authority over the facility and the emergency once he or she arrives and is briefed. The person who remains in charge until the emergency has been resolved.

Contingent contracting: A formal agreement for crucial services that may only be required during or after an emergency. Typically, the agreement includes either an annual retainer or a rate of compensation that is substantially above market, to guarantee that the jail will receive highest priority for the services or equipment in an emergency.

Correctional emergency response team (CERT): See **tactical team.**

Cover group: A group of staff sent to the location of a reported emergency, with responsibility for isolating and containing the emergency.

Critical incident review: A comprehensive and factual review of a major emergency, with emphasis on lessons learned. Also referred to by some agencies as an "after action report."

Critical indicator system: A mathematical or other analytic procedure that produces a summary of the frequency of certain events and the trend of those frequencies over time. Such events may include grievances per month, inmate-on-inmate assaults per month, inmate disciplinary actions per month, percentage of inmates in protective custody by month, etc.

Deactivation checklist: A list of actions and procedures to be followed immediately after the resolution of a major emergency. See also **step-down plan.**

Defend in place: Also called "safe harbor." An alternate strategy to mass evacuation of a facility to another location, used when time and/or circumstances make mass evacuation impractical. This strategy differs with type of emergency but usually involves concentrating inmates and staff in the easiest locations to defend and then further mitigating risks with equipment, supplies, or specialized procedures.

Desert island operations: A plan to operate a jail for an extended period of time without contact or assistance from outside the facility—for example, if a hurricane and flood cut off all road access and communications, and air access is impossible because of severe weather.

Disturbance control team: A sublethal force team or riot squad that is trained to clear a yard or retake a cell block when there is an inmate disturbance. A disturbance control team usually trains with shields, batons, and chemical agents. It is distinguished from a **tactical team** that trains with firearms.

Emergency operations center (EOC): A physical location—a situation room or "war room" set up and staffed to provide high-level administrative support in an emergency, usually at a headquarters or a sheriff's administrative office. The EOC is distinguished from a command post, which is usually set up onsite to direct the emergency operation.

Emergency post orders: A job description for a specialized function that exists only in an emergency or for a function that is different during an emergency than it is day to day.

Emergency preparedness coordinator: The staff member assigned the responsibility for emergency preparedness. This may be a part-time or full-time assignment, and the staff member's title will vary in different jails.

Emergency staff services (ESS): A planned operation providing comprehensive support and assistance to traumatized staff members and families of staff, during and after an emergency.

Federal Emergency Management Agency (FEMA): The federal agency charged with building and supporting the nation's emergency management system. By law, each state must maintain a state emergency management agency that coordinates with FEMA.

Fireloading: The amount of potentially combustible material available to contribute to the growth of a fire. In jails, this term is often used to refer to the amount of inmate personal property (magazines, clothing, etc.) in cells but, more properly, it also includes material in corridors, store rooms, or anywhere else a fire might reach.

Hazardous materials (HAZMAT) team: A team that is trained to deal with toxic gas releases, chemical spills, etc. HAZMAT teams may be public or private and vary widely in training and capabilities.

Initial response checklist: Also known as command post checklist. A prioritized list of actions to be taken by the initial commander at the onset of an emergency. The checklist should include columns for initials and time next to each item. It is generic rather than specific to a particular type of emergency.

Intelligence function: In day-to-day operations, a person or persons in charge of coordinating information about certain types of security threats and problems for the entire facility. In an emergency, the intelligence function is an operation designed to help resolve the situation by developing information about motives, plans, identities, etc., of the inmates or victims involved.

Job action: A strike, "blue flu," or other crisis caused by staff acting in concert and intentionally interfering with the operation of the facility.

Planned use of force: The use of force in a situation where time and circumstances allow some degree of planning, marshaling of resources, and supervisory or management review and direction. The opposite of "reactive use of force."

Plot map: Also called a "plat map" or a "platte map." For a jail, a map or diagram of the grounds or compound showing buildings, fences, and other developments to scale. "As built" plans and diagrams often differ from "initial design" plans and diagrams; current, as-built plans and diagrams are preferable for almost all emergency purposes.

Risk assessment: An examination of a jail's relative exposure to various types of emergencies. Determines which emergencies are most probable and which areas of the facility are most vulnerable. See also **vulnerability analysis.**

Safe harbor. See **defend in place.**

Special weapons and tactics (SWAT) team: See **tactical team.**

Stepdown plan: A plan for how a facility will return to normal operations after an emergency. A stepdown plan may involve days, weeks, or even months. See also **deactivation checklist.**

Sublethal force: Force that is not reasonably expected to produce death or permanent bodily injury. Sublethal force includes use of chemical agents, pain-compliance holds, batons, electronic immobilizing devices, water hoses, etc. Also referred to as "less than lethal" or "less lethal" force.

Tabletop exercise: A planned activity in which a small group of facility staff is presented with a simulated emergency situation. The exercise is conducted either verbally or with paper and pencil in an office setting; it does not involve role-playing, use of actual jail facilities, or resources from external agencies.

Tactical team: A weapons team trained for situations such as hostage rescue and firearms assault. Distinguished from a disturbance control team or sublethal force team. Many tactical teams are called SWAT (special weapons and tactics) team, CERT (correctional emergency response team), or some similar acronym.

Tone: The "climate" or interpersonal atmosphere of a jail, sensed by experienced staff when walking through the facility.

Turnout gear: Outer clothing worn for firefighting. Typically a jacket and pants, worn with a hat and high boots. Key characteristics are a waterproof/water-resistant outer fabric and the ability to protect the skin from burns and blistering due to radiant heat.

Vulnerability analysis: A detailed review of a jail's areas, functions, people, equipment, procedures, etc., to determine relative risks and the attractiveness of various targets. This term is commonly used with regard to counterterrorism activities, whereas **risk assessment**—a similar concept—is more frequently used with regard to general emergency preparedness and natural disasters.

Section 3

Emergency Preparedness Self-Audit Checklist for Smaller Jails

In This Section

Emergency Preparedness Self-Audit Checklist for Smaller Jails

Emergency Preparedness Self-Audit Checklist for Smaller Jails: Outline

Emergency Preparedness Self-Audit Checklist for Smaller Jails

FACILITY: _____ DEPARTMENT: _____

TEAM LEADER: _____

AUDIT TEAM: _____

Criterion	Status	Method	Comments
I. General Considerations			
A. Does the jail have an identified system of emergency preparation and/or emergency response? ➡ I.B.2			NC#
B. Does the jail have a statement of its objectives or goals in major emergencies? ➡ I.B.1			NC#
C. Emergency policies ➡ I.C 1. Command a. Does policy specify who is in initial command of the jail in an emergency?			NC#
b. Does policy specify who is in ultimate (final) command of the jail in an emergency?			NC#
c. Does policy specify the institutional chain of command in an emergency?			NC#
d. Does policy state any limitations on the authority of the person in command during an emergency?			NC#

➡ See marked section of Emergency Preparedness Self-Audit Checklist for Larger Jails.

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Smaller Jails (continued)

Criterion	Status	Method	Comments
e. Does policy specify how to change command in an emergency?			NC#
2. Notifications a. Does policy specify that the jail make notifications in a major emergency? b. Does policy include a priority level or order in which those notifications will be made?			NC#
3. Use of force a. Does policy differentiate between planned use of force and reactive use of force?			NC#
b. If planned use of lethal force is necessary, does policy state who will use such force?			NC#
4. Public information a. Does policy identify who at the jail will deal with the media during an emergency?			NC#
b. Does policy specify who at the jail has the authority to release information during a major emergency?			NC#

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Smaller Jails (continued)

Criterion	Status	Method	Comments
5. Training a. Does policy provide additional minimum requirements for emergency preparedness training for staff at shift command level and above?			NC#
b. Does policy specify emergency preparedness training standards for inmates (fire evacuation, tornado, etc.)?			NC#
6. Deviation from policy a. Does policy identify which individuals have the authority to deviate from policy in an emergency?			NC#
b. Does policy outline responsibilities of a staff member if he/she is ordered to deviate from policy in an emergency?			NC#
7. Evacuation a. Does policy require detailed plans for an offsite (out-of-compound) evacuation? b. Does policy require detailed plans for an onsite (out-of-buildings) evacuation?			NC#

➡ See marked section of Emergency Preparedness Self-Audit Checklist for Larger Jails.

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Smaller Jails (continued)

Criterion	Status	Method	Comments
8. Hostage incidents a. Does policy specify that persons taken hostage have no rank or authority and that staff will not comply with orders from a person held hostage?			NC#
b. Does policy provide a statement listing nonnegotiable items?			NC#
9. Emergency coordinator: Does policy require that one individual at the jail have overall responsibility for emergency preparedness?			NC#
10. National Incident Management System (NIMS): Does policy require the jail to maintain compliance with NIMS?			NC#
D. Emergency tests/drills ➡ IV.B 1. Does policy state how often the jail must conduct emergency tests/drills?			NC#
2. If yes, has the standard been met during the past 12 months?			NC#
3. Does policy require that the jail conduct some tests/drills on evenings, weekends, and on all shifts?			NC#

➡ See marked section of Emergency Preparedness Self-Audit Checklist for Larger Jails.

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Smaller Jails (continued)

Criterion	Status	Method	Comments
4. Does the jail conduct unannounced fire drills in which inmates are actually evacuated?			NC#
II. Prevention of Major Emergencies			
A. Management philosophy ➡ V.A			
1. Is prevention of major emergencies stressed at management meetings?			NC#
2. Do managers consistently review prevention issues with subordinates?			NC#
3. Does management stress early intervention in problem situations?			NC#
4. Does management stress the need for frequent, open communication between staff and inmates?			NC#
5. Does management monitor staff/ inmate communication issues?			NC#
6. Are staff trained to recognize traditional signs of impending trouble (stockpiling commissary items, more racial grouping than usual, etc.)?			NC#
7. Does management inspect the jail regularly for fire risk?			NC#

➡ See marked section of Emergency Preparedness Self-Audit Checklist for Larger Jails.

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Smaller Jails (continued)

Criterion	Status	Method	Comments
B. Classification ➡ V.E 1. Is there an objective inmate classification system?			NC#
2. Is the classification system followed rigorously?			NC#
C. Security ➡ V.F 1. Does the jail perform random cell searches for contraband?			NC#
2. Is there a standard for the minimum number of random cell searches to be performed in a given time period?			NC#
3. Has the cell search standard been met during the past 12 months?			NC#
4. Does the jail perform random security inspections of cells (bars, locks, vents, etc.)?			NC#
5. Is security equipment organized and maintained in good working order?			NC#
6. Is there a standard specifying the frequency of inspections of perimeter security, vehicle and pedestrian entrances, gates, sallyports, visiting areas, control centers, and administration areas?			NC#

➡ See marked section of Emergency Preparedness Self-Audit Checklist for Larger Jails.

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Smaller Jails (continued)

Criterion	Status	Method	Comments
7. Does the jail conduct random urinalysis testing of inmates?			NC#
D. Inmate grievance system ➡ V.G 1. Is there an inmate grievance system?			NC#
2. Does management review a monthly or quarterly summary of all grievances, including subject, area of jail, and number of grievances upheld and denied?			NC#
III. Jail Emergency Plans			
A. Does the jail have a single, comprehensive emergency plan (versus individual plans for various emergencies)? ➡ VI.C			NC#
B. Did the jail's emergency plan go through a formal approval procedure, and is the plan signed and dated? ➡ VI.D			NC#
C. Are the jail's emergency plans checklist-driven? ➡ VI.G			NC#
1. Do the jail's emergency plans include an initial response (command post) checklist?			NC#

➡ See marked section of Emergency Preparedness Self-Audit Checklist for Larger Jails.

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Smaller Jails (continued)

Criterion	Status	Method	Comments
2. Does the jail's emergency plan include procedures and checklists for specific types of emergencies, including disturbances, hostage, fire, natural disaster, etc.?			NC#
3. Does the plan include procedures and a checklist for the aftermath of a major emergency, such as command post deactivation?			NC#
D. Do the emergency plans specify interagency responsibilities? ➡ XI			NC#
E. Do the emergency plans specify staff recall procedures? ➡ VIII.A			NC#
F. Are copies of facility plot plans and/or blueprints kept in or available to the jail's designated command post? ➡ VIII.B			NC#
G. Do the emergency plans include provisions for dealing with injured staff, staff held hostage, and their families during and after an emergency? ➡ XIX			NC#
H. Do the emergency plans include provisions for operating medical and food service functions during an emergency? ➡ VIII.L & XX			NC#
I. Do the emergency plans specify the primary location for an emergency command post? ➡ XIII.A			NC#

➡ See marked section of Emergency Preparedness Self-Audit Checklist for Larger Jails.

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Smaller Jails (continued)

Criterion	Status	Method	Comments
J. Do the emergency plans include procedures for emergency lockdowns and emergency counts? ➡ XIV.F			NC#
IV. Staff Specialists			
A. Does the jail have its own correctional emergency response team (CERT), special operations response team (SORT), or other tactical team? If not, has the jail made specific arrangements to use another agency's team? ➡ IX.A			NC#
B. Does the jail have its own hostage negotiators and, if not, are there specific arrangements for the jail to use another agency's negotiators? ➡ IX.C			NC#
V. Training			
A. Do all uniformed jail staff receive at least 8 hours of training on the emergency plans and procedures? ➡ X			NC#
B. Do all jail staff participate in emergency drills and exercises? ➡ IV.B			NC#

➡ See marked section of Emergency Preparedness Self-Audit Checklist for Larger Jails.

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Smaller Jails (continued)

Criterion	Status	Method	Comments
VI. Emergency Equipment			
A. Does the jail conduct an inventory of emergency equipment, including the armory, at least annually? ➡ XII.A			NC#
B. Does policy or regulation specify all approved weaponry, chemical agents, ammunition, and defensive equipment? ➡ XII.C.2			NC#
C. Does the jail have sufficient chemical agents to control a major disturbance or riot at the facility? ➡ XII.C.12.a & b			NC#
D. Does the jail have an adequate supply and variety of firearms? ➡ XII.C.13.a & b			NC#
E. Does the jail have an emergency generator? ➡ XII.F			NC#
F. Are emergency sets of keys available for all areas of the jail? ➡ XII.E			NC#

➡ See marked section of Emergency Preparedness Self-Audit Checklist for Larger Jails.

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
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AUDITOR:_____ DATE: _____

SUMMARY OF NONCOMPLIANCE ITEMS
Emergency Preparedness Self-Audit Checklists

AUDITOR: _____ PAGE _____ OF _____

DATE: _____

NC #	Item Description	Reason for Noncompliance	Assigned To	Due Date	Approved By	Approval Date
Status:						
Method:						
Status:						
Method:						
Status:						
Method:						
Status:						
Method:						
Status:						
Method:						

Review of all items on this page completed? Yes_____ No_____

NAME: _____ DATE: _____

SIGNATURE: _____

Section 4

Emergency Preparedness Self-Audit Checklist for Larger Jails

In This Section

Emergency Preparedness Self-Audit Checklist for Larger Jails

Emergency Preparedness Self-Audit Checklist for Larger Jails: Outline

Emergency Preparedness Self-Audit Checklist for Larger Jails

FACILITY: _____ DEPARTMENT: _____

TEAM LEADER: _____

AUDIT TEAM: _____

Criterion	Status	Method	Comments
I. Emergency System			
A. Is there a philosophy statement or mission statement governing major emergencies?			NC#
B. Goals, objectives, and overall emergency system 1. Is there a written statement of the jail's goals or objectives in major emergencies?			NC#
2. Does the jail have an identifiable, comprehensive, written overall system of emergency preparation and emergency response?			NC#
C. Emergency policies 1. Command a. Does policy specify who is in initial command of the jail in an emergency?			NC#
b. Does policy specify who is in ultimate (final) command of the jail in an emergency?			NC#
c. Does policy specify the jail's chain of command in an emergency?			NC#

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AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
d. Does policy state any limitations on the authority of the person in command during an emergency?			NC#
e. Does policy specify how to change command in an emergency?			NC#
2. Notifications and communication a. Does policy require the jail to make specific notifications during a major emergency?			NC#
b. Does policy specify the role of the sheriff's command staff in the central office during an emergency and the relationship of the jail to the command staff or central office during an emergency?			NC#
c. Does policy require a communications plan for emergency operations?			NC#
3. Use of force a. Does policy differentiate between planned use of force and reactive use of force?			NC#
b. Does policy state the conditions under which the jail may engage in the planned use of lethal force during an emergency?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
c. Does policy state the conditions under which the jail may engage in the planned use of sublethal force during an emergency?			NC#
d. Does policy specify minimum standards (training, equipment, etc.) for individuals who may engage in planned use of lethal force?			NC#
4. Public information a. Does policy require a media plan for emergencies?			NC#
b. Does policy specify who at the jail has the authority to release information during a major emergency?			NC#
c. Does policy explain how media operations will be coordinated between the jail and the sheriff's command staff or the department's central office during an emergency?			NC#
d. Does policy identify who will be responsible for communicating with the local community in an emergency?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
5. Training a. Does policy provide minimum requirements for training all staff in emergency preparedness?			NC#
b. Does policy provide additional minimum requirements for training staff at shift command level and above?			NC#
c. Does policy include specific requirements for training various staff specialists (negotiators, public information officers, etc.)?			NC#
d. Does policy provide standards for both initial and annual/refresher training for emergencies?			NC#
e. Does policy specify training standards for inmates (fire evacuation, tornado, etc.)?			NC#
6. Deviation from policy a. Does policy identify which individuals have the authority to deviate from policy in an emergency?			NC#
b. Does policy outline responsibilities of a staff member if he/she is ordered to deviate from policy in an emergency?			NC#

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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
7. Does policy require that one individual at the jail have overall responsibility for emergency preparedness?			NC#
8. Evacuation a. Does policy require detailed plans for an offsite (out-of-compound) evacuation?			NC#
b. Does policy require detailed plans for an onsite (out-of-buildings) evacuation?			NC#
9. Hostage incidents a. Is there a policy statement specifying that persons taken hostage have no rank or authority and that staff will not comply with orders from a person held hostage?			NC#
b. Is there a policy statement listing nonnegotiable items?			NC#
10. Employee job action a. Does policy require the jail to maintain a plan (or an appendix to a generic emergency plan) for responding to a strike or other employee job action (e.g., "blue flu")?			NC#

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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
b. Does policy require the jail to plan for employee job actions confidentially and to distribute the restricted plan only to a designated group of top managers?			NC#
11. Mutual aid a. Does policy require the jail to maintain written mutual aid agreements with other corrections and/or law enforcement agencies?			NC#
12. Allied agencies a. Does policy require the jail to maintain written interagency emergency agreements with civilian agencies (fire department, utility companies, hospitals, etc.)?			NC#
13. Natural disaster and fire planning a. Does the jail have policies in place specific to natural disaster and fire planning, response, and recovery operations?			NC#
b. Is there a requirement to update risk assessments and modify emergency plans and procedures when a major modification has been made to the jail facilities or to its operations?			NC#

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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
14. Risk assessment a. Does policy require the jail to conduct annual risk assessments for emergencies, including natural disasters, fires, and terrorist incidents?			NC#
15. Counterterrorism a. Does policy specify command and coordination with local law enforcement, the local health department, state police, the state emergency management agency, the FBI, and the U.S. Department of Homeland Security?			NC#
b. Does policy specify which agencies to notify during a terrorism event?			NC#
D. Does the jail emergency system include a high degree of redundancy (checks and balances, backup systems, multiple levels of protection)?			NC#
II. National Incident Management System (NIMS) Compliance			
A. Does policy require the jail to maintain compliance with NIMS, pursuant to Executive Order HSPD-5?			NC#

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NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
B. Has the jail generally achieved NIMS compliance?			NC#
1. Have all jail staff completed NIMS training?			NC#
2. Does the jail have a continuity of operations plan (COOP)?			NC#
3. Does the jail's emergency plan include incident action plans (IAPs) for specific types of emergency situations?			NC#
C. If the jail has adopted an emergency plan primarily defined by NIMS, has it been modified to make it corrections specific?			NC#
D. If the department has adopted an emergency system primarily defined by NIMS, has it been tailored in detail to the specifics of the jail?			NC#
III. Role of Sheriff's Command Staff or Central Office in Emergencies			
A. Does the sheriff's administration or the department's central office have its own emergency plan for a jail emergency?			NC#
B. Are interagency responsibilities detailed in the plan?			NC#

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NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
C. Does the emergency plan include a public information plan?			NC#
D. Does the emergency plan include a resource allocation plan?			NC#
E. Does the plan specify how the sheriff's command staff or central office will communicate with unaffected jails during the emergency (if the department has multiple jail facilities)?			NC#
F. Does the plan outline responsibilities for communicating with the county executive/mayor's office and the board of commissioners/supervisors?			NC#
G. Does the plan include a duty officer system or other 24-hour notification method?			NC#
H. Emergency operations center (EOC) 1. Does the sheriff's command staff or the central office plan call for establishing an EOC during an emergency?			NC#
2. Is the location of the EOC specified?			NC#

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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
3. Are an adequate number of telephones (or telephone jacks), adequate radio communications, and the ability for an open phone line with the jail available in EOC?			NC#
4. Are current emergency plans for each jail, and diagrams of each jail, available in the EOC?			NC#
5. Does the EOC have broadcast and cable television, an AM/FM radio, and a video recorder?			NC#
6. Does the plan outline EOC security procedures?			NC#
7. Is the EOC large enough for the number of individuals necessary to staff it?			NC#
IV. Emergency System Review			
A. Audit procedure			
1. Is there a departmentally specified procedure for auditing each jail's emergency system?			NC#
2. Does the jail conduct an annual review or audit of its emergency preparedness system?			NC#

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
B. Emergency tests/drills 1. Is there a standard for how often the jail must run emergency tests/drills?			NC#
2. If yes, has the standard been met during the past 12 months?			NC#
3. Are monitors always assigned to evaluate emergency tests/drills?			NC#
4. Are monitors and/or evaluators trained and authorized to temporarily or permanently stop an emergency exercise, drill, or simulation in the event of a serious safety or security problem?			NC#
5. Do policies or procedures require monitors and/or evaluators to debrief staff involved in drills and exercises, pointing out strengths and weaknesses observed?			NC#
6. Are monitors required to provide written evaluations of every test/drill?			NC#
7. Does someone in authority routinely review and approve monitors' evaluations and recommendations of emergency tests/drills?			NC#

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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
8. Does policy require that some emergency tests/drills be conducted on evenings and weekends and on all shifts?			NC#
9. Does policy require that some tests/drills include a variety of emergency scenarios?			NC#
V. Prevention of Major Emergencies			
A. Management philosophy 1. Is prevention of major emergencies stressed at management meetings?			NC#
2. Do managers consistently review prevention issues with subordinates?			NC#
3. Does management stress early intervention in problem situations?			NC#
4. Does management stress the need for frequent, open communication between staff and inmates?			NC#
5. Does management monitor staff/inmate communication issues?			NC#
6. Does management aggressively monitor the "tone" (climate) of the jail?			NC#

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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
7. Does each jail's top manager visit and review all areas of the facility at least twice per month?			NC#
B. Are all staff trained to recognize traditional signs of impending trouble (stockpiling commissary items, more racial grouping than usual, etc.)?			NC#
C. Does the jail use a "critical indicator system" (mathematical/statistical charting of trends in inmate grievances, assaults, etc.)?			NC#
D. Is there a formalized facilitywide intelligence function, as distinguished from security threat group operations or facility investigations?			NC#
E. Classification 1. Is there an objective inmate classification system?			NC#
2. Is the classification system followed rigorously?			NC#
3. Is there a system that identifies and manages high-risk inmates (escape risks, racists, violent psychotics, assault risks, security threat groups, etc.)?			NC#

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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
F. Security 1. Does the jail perform random urinalysis testing of inmates for illegal drugs?			NC#
2. Is there a standard for the minimum number of random cell searches to be performed in a given time period?			NC#
3 Has the cell search standard been met during the past 12 months?			NC#
4. Is there a "shakedown log" for the facility or for each area that documents all random searches of cells or areas of the jail?			NC#
5. Does the facility perform random security inspections of cells (bars, locks, vents, etc.)?			NC#
6. Do managers and supervisors monitor day-to-day security issues closely and regularly?			NC#
7. Are supervisors and managers required to regularly file written reports evaluating security practices?			NC#
8. Are there logged or otherwise documented inspections of the internal and external areas of each housing unit on a daily basis?			NC#

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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
9. Is there a standard specifying the frequency of inspections of perimeter security, vehicle and pedestrian entrances, gates, sallyports, visiting areas, control centers, and administration areas?			NC#
10. Are these inspections logged or otherwise documented?			NC#
11. Are staff assignments monitored to ensure adequate staff experience in the most volatile areas of the jail?			NC#
12. Is there a security inspection/review of tool control and key control at least monthly?			NC#
13. Are such inspections/reviews documented?			NC#
G. Inmate grievance system 1. Is there an inmate grievance system?			NC#
2. Has an outside agency, such as the U.S. Department of Justice, or a court, certified or reviewed the inmate grievance system?			NC#

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Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
3. Is there a monthly summary of all grievances, including subject, area of facility, numbers upheld and denied, and percent answered within time standards?			NC#
4. Does management regularly review the substance of inmate grievances?			NC#
VI. Jail Emergency Plans			
A. Are jail emergency plans required to be written in a standardized format?			NC#
B. Is there a formal approval process for jail emergency plans?			NC#
C. Does the jail have a single, comprehensive emergency plan (versus individual plans for various types of emergencies)?			NC#
D. Has the jail's emergency plan been formally reviewed during the preceding 12 months, and is it signed and dated?			NC#
E. Is each copy of the plan identified by a unique number or letter, and is there an inventory system for the copies?			NC#

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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
F. Does the emergency plan include a procedure for documenting changes and updates to the plan?			NC#
G. Checklists 1. Does the plan include an initial response (command post) checklist?			NC#
2. Does the plan include job-specific checklists to be used during emergencies (emergency post orders)?			NC#
3. Does the plan include a deactivation checklist?			NC#
H. Is the jail emergency plan tailored to the specific facility?			NC#
VII. Risk Assessment			
A. Does the jail's emergency plan require an annual risk assessment?			NC#
B. Is the section on risk assessment specific to the facility?			NC#
C. Does the risk assessment include identification of those emergencies judged most likely to occur at the facility?			NC#

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Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
D. Does the risk assessment identify facility "hot spots"?			NC#
E. Does the risk assessment include provisions for mitigating those risks that could be reasonably reduced?			NC#
VIII. Preparation			
A. Emergency notifications 1. Are home phone, cell phone, and pager numbers of key staff immediately available in the initial command post?			NC#
2. Are home phone, cell phone, and pager numbers available for staff specialists (public information officers, negotiators, etc.) as well as for top managers?			NC#
3. Are the phone numbers for key emergency staff and top management staff maintained separately from general staff recall phone lists?			NC#
4. Are the general staff recall phone procedures organized by geographic proximity to the jail?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
5. Are staff emergency notification lists (next of kin) updated annually?			NC#
6. Are special ID cards used to expedite entry of outside emergency personnel?			NC#
7. Is there a system in place to minimize the number of calls the control center must make in an emergency (e.g., phone trees)?			NC#
8. Are there phone lines that can be restricted to outgoing calls in the event of an emergency?			NC#
B. Plot plans 1. Are plot plans/blueprints for every area of the facility available in the command post?			NC#
2. Do plot plans show the location and type of all emergency utility cutoffs (electric, water, gas, oil, etc.)?			NC#
3. Do plot plans show all fire extinguishers, standpipes, fire hose locations, and secondary fire access doors?			NC#
4. Does the facility have current video of all areas showing entry, egress, windows, door operation, and floor layout?			NC#

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NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
5. Is there a mechanism to update emergency plot plans if the facility is modified or renovated?			NC#
C. Can all inmate pay phones and/or outside phones be disabled quickly in an emergency?			NC#
D. In an emergency, can staff quickly disable inmate access to television?			NC#
E. Are all roofs painted with numbers or letters for helicopter identification?			NC#
F. Are all buildings labeled with large letters or numbers on at least two sides for immediate identification by outside agency staff?			NC#
G. Is an inventory of serious staff medical conditions available to the commander during an emergency?			NC#
H. Is a list of staff blood types available to the commander in an emergency?			NC#
I. Is there a written plan for dealing with inmate family members who may come to the jail during an emergency?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
J. Is there a plan for providing information on the status of individual inmates to family members via phone during an extended emergency or evacuation?			NC#
K. Are there written procedures for command post security during an emergency?			NC#
L. Is there a plan for operating food service during an emergency?			NC#
M. Is there a written plan for facilities maintenance engineering during an emergency?			NC#
O. Is there a written plan for medical operations during an emergency?			NC#
P. Is the jail's main control room secure in the event of inmate violence?			NC#
IX. Staff Specialists			
A. Tactical teams			
1. Does the jail have its own tactical team trained to respond to emergency situations?			NC#

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
2. If the jail does not have its own tactical team, have clear, detailed, written arrangements been made with an external tactical team?			NC#
3. Are the tactical team's structure and minimum size specified in writing?			NC#
4. Is the tactical team currently at or above minimum strength?			NC#
5. Is the tactical team currently in compliance with its written minimum training standards?			NC#
6. Does the tactical team include an individual with medical training (nurse, medical technician, etc.) and a video operator?			NC#
7. Does the tactical team's equipment currently meet specified standards?			NC#
8. Does the tactical team train with the jail's command-level staff and negotiators?			NC#

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
9. Does the tactical team practice with a wide variety of scenarios?			NC#
10. Are tactical team members available by pager?			NC#
11. Does the tactical team include snipers?			NC#
12. Are the team members' leave and vacation schedules coordinated to ensure maximum team availability?			NC#
B. Disturbance control 1. Does the jail have a disturbance control team?			NC#
2. If the jail does not have its own disturbance control team, have clear, detailed, written arrangements been made with an external disturbance control team?			NC#
3. Are the disturbance control team's structure and minimum size specified in writing, and is the team currently at minimum strength?			NC#
4. Are the minimum training standards for the disturbance control team specified in writing and is the team currently in compliance?			NC#

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
5. Does the disturbance control team include an individual with medical training (nurse, medical technician, etc.) and a video operator?			NC#
6. Does the disturbance control team's equipment currently meet minimum written standards?			NC#
7. Are all team members current with chemical agent training?			NC#
C. Hostage negotiators 1. Does the jail have its own trained negotiators?			NC#
2. If not, does the jail have detailed written arrangements with external negotiators who would be used in an emergency?			NC#
3. If the jail relies on external negotiators, do the arrangements guarantee the availability of the negotiators to the facility on a 24-hour basis and with an acceptable response time?			NC#
4. Does the number of negotiators currently available meet the written standard?			NC#
5. Is there an identified chief negotiator and assistant chief negotiator?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
6. Are there minimum standards for initial and refresher training for negotiators, and are all negotiators currently in compliance?			NC#
7. Is the working structure of the negotiating team specified in writing?			NC#
8. Do the negotiators have a portable audiotape recorder, throw phone, and preprinted negotiation log forms?			NC#
9. Do the negotiators train with the jail's command-level staff and with the tactical team?			NC#
D. Public information officer (PIO) 1. Does the facility have an identified PIO?			NC#
2. Is there at least one alternate or assistant PIO?			NC#
3. Are minimum training standards specified for the PIO, and are they met?			NC#
4. Is a written overview or description of the facility available for distribution to the media in an emergency?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
5. Is there a procedure for logging and returning media phone calls in an emergency?			NC#
6. Are there procedures to establish a toll-free information line during an extended emergency?			NC#
7. Is the required equipment available for the identified media center during an emergency (podium, easel, microphone and sound system, departmental seal, phone jacks, etc.)?			NC#
X. Training			
A. Do new security staff receive at least 8 hours of training on the facility's emergency plan and emergency procedures?			NC#
B. Do new civilian (nonsecurity) staff receive at least 4 hours of training on the facility's emergency plan and on emergency preparedness?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
C. Have all facility staff at the level of shift commander and above received at least 20 hours of formal training on emergency preparedness?			NC#
D. Have all facility staff at the level of shift commander and above participated in emergency preparedness exercises/drills?			NC#
E. Have all facility staff received at least 4 hours of training on emergency situations during the past 2 years?			NC#
F. Has the facility conducted emergency exercises or simulations during the past year that involved external (mutual aid) agencies?			NC#
XI. External Agency Agreements			
A. Does the jail have written agreements for assistance during an emergency with the following external agencies: 1. State police?			NC#
2. Local police?			NC#
3. Local sheriff?			NC#

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NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
4. Nearby state and local correctional facilities (including institutions, federal prisons, immigration services)?			NC#
5. National Guard?			NC#
6. Local fire department?			NC#
7. Nearest hazardous materials (HAZMAT) team?			NC#
8. Local hospitals and ambulance service?			NC#
9. Local and state emergency management agencies?			NC#
B. Does each written external agency agreement include the following: 1. Emergency contact names and 24-hour phone numbers?			NC#
2. Services and equipment the agency can provide?			NC#
3. Reporting (staging) locations?			NC#
4. Command and jurisdictional relationships?			NC#

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NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
5. Provision for annual review of the agreement?			NC#
XII. Emergency Equipment			
A. Is there a comprehensive inventory of emergency equipment?			
1. Is the inventory available to the command post?			NC#
2. Is the inventory current within the past 12 months?			NC#
3. Does the inventory include the location of each item?			NC#
4. Is emergency equipment secured to prevent inmate access?			NC#
B. Is there a comprehensive motor vehicle inventory for the jail?			
1. Is the vehicle inventory available to the command post?			NC#
2. Is the vehicle inventory updated for accuracy at least quarterly?			NC#
C. Armory			
1. Are there written policies and procedures for the armory?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
2. Does policy or regulation specify all approved types of weaponry, chemical agents, ammunition, and other defensive equipment?			NC#
3. Does policy or regulation specify minimum quantities of such weaponry, chemical agents, ammunition, and other defensive equipment?			NC#
4. Is the armory currently in compliance with these policies and procedures?			NC#
5. Is the armory secure from rioting inmates?			NC#
6. Are armory keys restricted from inmate areas?			NC#
7. Do on-duty staff have immediate 24-hour access to the armory?			NC#
8. Is the armory inventoried at least monthly?			NC#
9. Do management-level staff inspect the armory at least quarterly?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
10. Is there a written procedure for checking out weapons and other armory equipment?			NC#
11. Is there a procedure to ensure that an individual staff member is currently qualified in firearm and/or chemical agent use prior to issuing a firearm and/or chemical agent to that individual (except for training or qualification purposes)?			NC#
12. Chemical agents a. Are there sufficient chemical agents to control a large riot at the facility?			NC#
b. Are several different types of chemical agents (pyrotechnic, blast, barrier, smoke, etc.) available both as projectile and throwing grenades?			NC#
c. Are all chemical agents clearly dated?			NC#
d. Are all chemical agents (except those for training use) within the manufacturer's recommended shelf life?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
e. Does policy specify a minimum number or percentage of security staff who must currently be qualified in the use of chemical agents and is the facility in compliance with that requirement?			NC#
f. Does policy require immediate medical screening/treatment for offenders and staff who have been exposed to chemical agents?			NC#
13. Firearms a. Considering the size and nature of the jail, is there an adequate supply of firearms?			NC#
b. Are the types of firearms and ammunition appropriate for the nature of the facility and for the location and function of armed posts?			NC#
c. Are all firearms cleaned, inspected, tested, and sighted on a regular schedule?			NC#
d. Does policy specify a minimum number or percentage of security staff who must currently be qualified in the use of firearms and is the facility in compliance with that requirement?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
14. Armory inventory a. Do written procedures specify how the armory shall be inventoried, and how frequently?			NC#
b. Has the armory been inventoried in detail, including ammunition, at least quarterly during the last year?			NC#
D. Does the jail's emergency equipment include an adequate supply of the following: 1. Flexcuffs (four times the entire inmate population)?			NC#
2. Steel restraints?			NC#
3. Binoculars?			NC#
4. Flashlights and batteries?			NC#
5. Distraction devices (flash-bang grenades)?			NC#
6. Loud hailers?			NC#
7. High-visibility clothing (fluorescent vests, etc.)?			NC#

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NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
8. Portable smoke ejectors?			NC#
9. Portable emergency generator?			NC#
10. Portable lighting?			NC#
11. High-speed cutting torch?			NC#
12. Bolt cutters?			NC#
13. Radios with a tactical channel?			NC#
14. Riot shields?			NC#
15. Helmets with face shields?			NC#
16. Riot batons?			NC#
17. Potable water (48 to 72-hour supply)?			NC#
18. Fire axes?			NC#
19. Gas masks?			NC#
20. Large-scale delivery systems for chemical agents (37-mm or 40-mm launchers, projecto-jet, etc.)?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
21. Stun shields or stun guns?			NC#
22. Other intermediate force options (pepperball system, beanbag rounds, multiple baton rounds, etc.)?			NC#
E. Emergency keys 1. Are there emergency keys for all buildings and areas of the jail?			NC#
2. Is there a set of emergency keys outside the perimeter of the jail?			NC#
3. Are emergency keys and locks color coded for quick identification (red for fire, etc.)?			NC#
4. Are emergency keys and locks notched for night identification?			NC#
5. Are emergency keyrings soldered or welded closed to prevent unauthorized removal of keys?			NC#
6. Do emergency keyrings include a metal disk ("chit") stamped with the name of the area the ring accesses and the number of keys on that ring?			NC#
7. Have all emergency keys and locks been tested in the past 12 months?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
F. Emergency generator 1. Is there an emergency generator?			NC#
2. Is the emergency generator and available fuel adequate to run critical areas of the jail and critical equipment safely for 72 hours?			NC#
3. Are the critical areas and equipment powered by the emergency generator documented and tested annually to confirm that power is adequate?			NC#
4. Is the emergency generator secure from inmate sabotage?			NC#
5. Are staff trained to know which systems will be run on emergency power and which will be inoperable during a main power outage?			NC#
6. Is there battery-powered lighting in the emergency generator areas?			NC#
7. Is the emergency generator full-load-tested for 10 minutes or more at least quarterly to determine that it is in proper working order, and are such tests documented?			NC#

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NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
XIII. Locations			
Are the following locations specified in the facility emergency plans:			
A. Command post?			NC#
B. Alternate command post?			NC#
C. Command post location outside the compound?			NC#
D. Media room and/or staging area?			NC#
E. Staff/family support area?			NC#
F. Inmate family area?			NC#
G. Staff staging/reporting area?			NC#
H. Mutual aid staging area?			NC#
I. External traffic control points?			NC#
J. Mass casualty/triage area?			NC#

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NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
K. Disturbance control team dressing/ assembly area?			NC#
L. Tactical team dressing/assembly area?			NC#
XIV. Procedures			
A. Does the facility have a general procedure for responding to major emergencies?			NC#
B. Do procedures call for audio recording in the command post during an emergency?			NC#
C. Do written procedures specify who will keep a log during an emergency?			NC#
D. Do written procedures call for double-posting key locations and specify those locations in an emergency?			NC#
E. Does procedure call for relieving staff from noncritical posts in an emergency?			NC#
F. Are there written procedures for emergency lockdown and emergency count?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
G. Is there a procedure for controlling the initial staff response to a reported emergency to avoid setup or distraction (as opposed to a procedure in which all available staff respond as quickly as possible to the location of the reported emergency)?			NC#
H. Is there a standard procedure for sending staff to investigate a report of a developing emergency (a cover group)?			NC#
I. At the onset of a major emergency, could the jail quickly account for all staff, visitors, and volunteers within the jail and determine the identities of those not accounted for?			NC#
J. Are emergency traffic-control procedures specified?			NC#
K. Does procedure call for cutting off inmate telephones at the onset of a major emergency?			NC#
L. Is there a procedure for briefing on-duty and returning staff about the nature of an emergency?			NC#
M. Does procedure call for informing the inmate population of emergency conditions on a discretionary basis?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
N. Does the facility use a system of first responders?			NC#
O. Does the facility use a system of second responders?			NC#
P. Does the jail have plans, procedures, and the capacity to intervene quickly with force to stop or contain a spreading disturbance?			NC#
XV. Evacuation and Fire Safety			
A. Is there an evacuation plan for all areas of the facility?			NC#
B. Does every area of the facility have a secondary evacuation route?			NC#
C. Are evacuation routes posted in all areas?			NC#
D. Are there battery-powered or emergency-generator-powered emergency exit lights in all living and program areas?			NC#
E. Self-contained breathing apparatus (SCBA) units 1. Are SCBAs available in or adjacent to all living areas of the jail?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
2. Are SCBAs stored or hung on walls in pairs and are staff trained to use them in pairs?			NC#
3. Are SCBAs examined annually for functionality?			NC#
4. Are all SCBAs inspected, charge checked, and tagged at least quarterly?			NC#
5. Have all staff been trained in the use of SCBAs?			NC#
6. Does the SCBA training for all staff include donning the SCBA, achieving a seal, and then breathing for some period of time?			NC#
7. Have all staff had refresher training on SCBA use within the past 24 months?			NC#
F. Fire drills and other fire safety measures 1. Are staff trained in fire evacuation procedures for areas currently assigned?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
2. Are inmates given orientation on fire evacuation procedures?			NC#
3. Are fire drills unannounced?			NC#
4. Are all fire drills: a. Monitored and evaluated in writing?			NC#
b. Timed for clearing the area in which the drill was held?			NC#
c. Timed for clearing a count of inmates evacuated?			NC#
5. Does the jail conduct actual evacuation fire drills on all shifts?			NC#
6. Are there minimum standards for how often actual evacuation fire drills must be conducted in each area of the facility, and have those standards been met in the past 12 months?			NC#
7. Are written fire drill reports, evaluations, and plans for improvement reviewed and approved by management?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
8. Has the local or state fire marshal inspected the facility within the past year for compliance with state/local fire codes and regulations?			NC#
9. Are all fire extinguishers charged, tagged, and inspected at least quarterly?			NC#
10. Are all fire hoses and standpipes charged, inspected, tested, and tagged at least annually?			NC#
11. Have firefighting trucks and equipment been brought into facility areas to make sure the equipment can be connected and used effectively in each area?			NC#
12. Fire prevention and response a. Does the jail have written standards for the amount of inmate property permissible in cells or dormitories and are these written standards consistent with minimizing fireloading in living areas?			NC#
b. Are all areas of the jail inspected at least monthly to determine if there is excess fireloading?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
c. Does the jail have a staff member in charge of fire safety?			NC#
d. Are all areas of the facility inspected at least monthly to determine if fire doors are operable, if fire exits and evacuation routes are kept clear, and if there is a written report of each inspection?			NC#
e. Are inmates given orientation on fire evacuation procedures?			NC#
G. Are manual unlocking devices and/or backup keys available onsite for unlocking every living area of the facility 24 hours a day?			NC#
H. Are manual unlocking devices tested at least quarterly?			NC#
I. HAZMAT 1. Does the jail have a staff member responsible to identify and inventory hazardous materials?			NC#
2. Are all hazardous materials and flammable liquids stored in locked metal cabinets?			NC#

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NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
J. Is there a written, realistic, offsite evacuation plan?			NC#
K. If yes, does the offsite evacuation plan include the following: 1. Potential destinations?			NC#
2. Specific transportation alternatives?			NC#
3. Security procedures during evacuation?			NC#
4. Which inmate records must be moved with inmates?			NC#
5. Procedures for providing medical services during and after the evacuation?			NC#
6. Provisions for coordinating with local and state police during the evacuation?			NC#

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
7. Arrangements for meal service at the new location?			NC#
8. Arrangements for inmate identification and count at the new location?			NC#
9. Arrangements for housing and security at the new location?			NC#
10. Predetermined evacuation routes?			NC#
11. Procedures for protection or destruction of confidential records that cannot be evacuated?			NC#
12. Procedures for maintaining security of the facility after evacuation?			NC#
13. Procedures for reoccupying the facility after the emergency has concluded?			NC#
L. Are there defend-in-place ("safe harbor") procedures, equipment, and supplies to protect the inmate population in emergencies when evacuation is not necessary or feasible?			NC#

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
M. Have areas been designated for defend-in-place within the facility, based on the types of potential hazards identified?			NC#
N. Are facility staff trained on the defend-in-place areas and procedures?			NC#
O. Does the jail have a procedure for establishing a toll-free phone number to communicate with staff if the facility is inoperable?			NC#
XVI. Organizational Structure			
A. Is an emergency organizational structure defined in detail?			NC#
B. Are responsibilities for managing the unaffected portions of the jail during an emergency specified?			NC#
C. Are supervision and direction of the cover group (staff initial response group) specified?			NC#
D. Is supervision of perimeter staff during an emergency specified?			NC#
E. Is the responsibility for coordinating on-duty and returning staff identified?			NC#

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
F. Is the responsibility for liaison with external agencies assigned?			NC#
G. Is the intelligence function during an emergency described and responsibility for it assigned?			NC#
H. Is the responsibility for coordinating emergency staff services (ESS) assigned?			NC#
I. Are there written guidelines (emergency post orders) available for each specialized emergency assignment?			NC#
J. Is there an emergency checklist available for each specialized emergency assignment?			NC#
XVII. Extended Emergencies			
A. Is there a written plan for staffing in an extended emergency (beyond 12 hours)?			NC#
B. Is responsibility assigned for scheduling and assignments in an extended emergency?			NC#
C. In an extended emergency, do specialized assignments dictate the length of the shift?			NC#

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
D. Does the plan for extended emergencies include provision for staggered relief of key positions?			NC#
E. Does the plan for extended emergencies include arrangements for onsite bivouac of key staff?			NC#
XVIII. Aftermath			
A. Incident review and damage assessment 1. Are incident review and damage assessment procedures outlined and responsibilities assigned in the emergency plan?			NC#
2. Is there a procedure for assessing and reporting deaths, injuries, and/or escapes?			NC#
3. Is there a procedure for accounting for all on-duty and off-duty staff?			NC#
B. Are report writing and debriefing procedures detailed in the emergency plan?			NC#
C. In the aftermath of an emergency, is there a review and approval procedure for all reports?			NC#

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
D. Is there a chain-of-custody procedure for all reports, logs, photos, video, and audiotapes, etc.?			NC#
E. Is there a procedure for gathering external agency reports?			NC#
F. Do procedures specify the identification, segregation, and interviewing of inmate suspects and witnesses?			NC#
G. Are crime scene preservation procedures specified?			NC#
H. Are criminal evidence collection and preservation procedures specified?			NC#
I. Is immediate liaison with criminal prosecution authorities required?			NC#
J. Does the plan include procedures for managing released hostages?			NC#
K. Are medical and psychological screening required for key and/or traumatized staff?			NC#
L. Does the emergency plan specify developing a media relations strategy as part of the aftermath activities?			NC#

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
M. Do procedures specify releasing information updates to all on-duty staff?			NC#
N. Do procedures specify releasing information about emergency status to inmate populations?			NC#
O. Do procedures require developing a plan for communicating with the local community?			NC#
P. Do procedures require developing a plan for regularly briefing the mayor or county executive and other branches of local government?			NC#
Q. Is there a procedure for establishing emergency purchasing and payroll authority in the wake of a major crisis or natural disaster?			NC#
R. Does the emergency plan include procedures to prevent staff retaliation?			NC#
S. Do the emergency plans specify how key positions will be staffed and relieved in the aftermath?			NC#
T. Does the emergency plan include procedures to deactivate the command post?			NC#

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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
U. Do the emergency plans mandate the development of both a short-term stepdown plan and a long-term stepdown plan after any major emergency?			NC#
V. Is a short-term stepdown procedure required before key staff are relieved of duty, and does that procedure include measures to prevent reescalation or new violence?			NC#
W. Is a critical incident review mandated and are critical incident review procedures specified?			NC#
X. Is civil liability review mandated?			NC#
Y. Is a review of insurance issues mandated?			NC#
Z. Do the emergency plans specify other procedures to cope with an extended emergency?			NC#
XIX. Emergency Staff Services (ESS)			
A. Is there a general plan for ESS?			NC#
B. Are responsibilities for ESS during emergencies assigned?			NC#

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
C. Are ESS resources for specialized help (e.g., trauma counseling) identified?			NC#
D. Does the family support plan include provisions for child care, transportation, and emergency financial assistance?			NC#
E. Does the plan include a staff liaison assigned to each family of a hostage/injured staff during and after the emergency?			NC#
F. Is a staff family briefing area identified in the ESS plan and is it separate from the inmate family area and the media briefing area?			NC#
G. Does the plan include provisions for individual and group trauma counseling within 48 hours of the incident?			NC#
H. Does the plan include procedures for rehabilitating traumatized staff?			NC#
I. Is administrative leave mandatory for hostage/ traumatized staff?			NC#
J. Does the plan include death notification procedures?			NC#
K. Does the plan include housing assistance for homeless staff after a natural disaster?			NC#

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
XX. Medical Services			
A. Is there a comprehensive medical plan for a facility emergency?			NC#
B. Does the plan include mass casualties/triage?			NC#
C. Does the plan include evacuation procedures for nonambulatory or critically ill inmates?			NC#
D. Is a location other than the infirmary identified for mass casualties/triage?			NC#
E. Does the jail have an emergency-equipped medical crash cart?			NC#
F. Are an adequate number of gurneys available for a major crisis?			NC#
G. Are backup medical resources in the community identified for use in a large-scale emergency?			NC#
XXI. Natural Disaster Planning			
A. Does the jail conduct routine training in natural disaster response, including drills and exercises?			NC#

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NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
B. Does the jail have emergency response plans and checklists specific to natural disaster response?			NC#
C. Does the jail have a plan to operate the facility with reduced staffing levels should a natural disaster make that necessary?			NC#
D. Has the jail planned for "desert island operations" (operating for an extended period without contact or assistance from outside) in the event of a natural disaster?			NC#
E. Does the facility have current copies of the county emergency management agency's emergency operating plan and are those copies kept with or as part of the facility's emergency plan?			NC#
F. Are staff encouraged to maintain a family emergency preparedness kit at home?			NC#
G. Are staff encouraged to identify family relocation areas?			NC#
H. Have staff been encouraged to maintain a 3-day supply of their medications and an extra pair of eyeglasses onsite?			NC#
I. Are staff encouraged to identify an out-of-area relative or friend for family phone contacts and to relay messages?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
J. Are there specific tornado procedures in the jail's emergency plans?			NC#
1. Have tornado shelter areas been identified within the facility?			NC#
2. Are there procedures for evacuating towers or other vulnerable staff posts in the event of a tornado watch or warning?			NC#
3. Are there procedures for bringing in outside inmate work crews and/or moving at-risk inmate groups to safety in response to a tornado watch or warning?			NC#
4. Does the facility have written procedures mandating that the yard and other outside areas of the facility be inspected each spring for objects or supplies that might become airborne and hazardous in a tornado?			NC#
5. Do inmates receive orientation on tornado response and participate in tornado drills at least once per year?			NC#
6. Does the facility have a National Oceanic and Atmospheric Administration (NOAA) radio with battery backup and warning alarm?			NC#

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
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NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
K. Does the facility have a specific response plan for earthquakes?			NC#
1. Are the facility's maintenance plans, diagrams, and architectural records available onsite?			NC#
2. Has the facility completed a structural engineering review of earthquake-vulnerable buildings to design potential retrofitting with foundation ties, sheer wall, foundation beams, etc.?			NC#
3. Have staff and inmates received specific training on response to earthquakes?			NC#
L. Has the jail conducted a thorough risk assessment of vulnerable areas and equipment in the event of rising water?			NC#
1. Does the facility have a plan for moving expensive or crucial equipment in the event of rising water?			NC#
2. Is the facility's offsite evacuation flood plan developed in stages, so it can be enacted in response to predetermined flood stages or severity of warning?			NC#

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
NC# Boxes: See section 2: How To Use the Self-Audit Checklists, direction 13.

AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
3. Does the facility's flood plan include an analysis of which access and egress routes would be rendered unusable at various flood stages, along with alternate access and egress plans for use during those flood stages?			NC#
M. Has the facility analyzed the surrounding area for potential situations involving hazardous materials, including the proximity of chemical and fertilizer manufacturing and storage facilities, and transportation routes?			NC#
1. Does the facility have interagency agreements or arrangements with a nearby HAZMAT team that is fully trained and equipped?			NC#
2. Has the external HAZMAT team participated in an emergency drill, exercise, or simulation at the facility within the past 3 years?			NC#
N. Do the jail's emergency plans include specific response procedures for a hurricane?			NC#
1. Has the facility conducted an analysis of all buildings to determine their ability to withstand hurricane-force winds?			NC#

Status: MC – Meets Criterion; **PM** – Partially Met; **NM** – Not Met; **NA** – Not Applicable
Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
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AUDITOR:_____ DATE: _____

Emergency Preparedness Self-Audit Checklist for Larger Jails (continued)

Criterion	Status	Method	Comments
2. Have staff and inmates received any specific training on preparing for and responding to a hurricane within the past 24 months?			NC#
O. Do the jail's emergency response plans include severe winter storms?			NC#
1. If the jail were to lose heat during extended below-freezing weather, does the facility have a backup system or backup plan?			NC#
2. Is the institution dependent on perimeter electronics that would be likely to fail in an extreme winter storm?			NC#
3. Is there a specific and detailed plan for managing the inmate population during an extended period of extreme winter weather?			NC#
4. Is there a plan for transporting staff to and from the facility in small groups or in pairs, for their own safety, during extreme winter weather?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify)
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AUDITOR:_____ DATE: _____

SUMMARY OF NONCOMPLIANCE ITEMS
Emergency Preparedness Self-Audit Checklists

AUDITOR: _____ PAGE _____ OF _____

DATE: _____

NC #	Item Description	Reason for Noncompliance	Assigned To	Due Date	Approved By	Approval Date
Status:						
Method:						
Status:						
Method:						
Status:						
Method:						
Status:						
Method:						
Status:						
Method:						

Review of all items on this page completed? Yes_____ No_____

NAME: _____ DATE: _____

SIGNATURE: _____

Section 5

Resource Materials

In This Section

Leadership Issues During Crises*

This section is intended as a think piece about leadership during crises and major emergencies. Although it focuses on crises in jails and prisons, most of the discussion is also relevant to leadership in other emergency services such as law enforcement and fire fighting.

The literature on leadership is extensive. Much of it is concerned with leadership in industry, and many books are devoted entirely to qualities of leadership. This discussion, then, is not exhaustive; rather, it is intended to raise some of the most crucial issues concerning leadership during a crisis. The authors have not attempted to explore each issue in detail and also recognize that many aspects of leadership are not explored herein at all.

Importance of Leadership During Crises

The importance of leadership in an emergency or a major crisis cannot be overstated. The actions, decisions, style, presence, and direction of the person in charge will often determine the outcome of a situation. At a personal level, a leader's performance during a time of crisis may define his or her future, not only with regard to career, but also with regard to broader matters having to do with health, family, and life goals. In the world of corrections, a major crisis (e.g., the inmate uprisings at Attica and Santa Fe) can define for decades not only an institution and its leaders but also the entire larger organization.

Status of Leadership Development

Fortunately, in the wake of large-scale inmate insurrections (e.g., Attica, Santa Fe, Lucasville, and Camp Hill), most state prison systems and some medium-sized and large jail organizations now engage in serious and comprehensive emergency preparedness efforts. Unfortunately, many of these same organizations do not believe that they have the time, budget, or other resources to engage in serious leadership development. Leadership during crisis has received precious little attention within management development efforts and often receives short shrift even within emergency preparedness and crisis management training.

Preparation for Crisis Situations

Preparation for emergencies is essential, but every crisis will be different. In fact, no two jail or prison emergencies will ever be close to identical. A crisis in a prison or jail is, by definition, complex, and each situation is unique in many important aspects. This is not an argument against planning or preparation. To the contrary, the challenge is to find common elements that make it possible to generalize across crisis situations so that policy, procedure, equipment, and training can be developed and meaningfully applied. That proposition also holds true for leadership. The leader who has planned for

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emergencies and is personally and organizationally prepared is far more likely to succeed than the leader who has not. The common wisdom is that "leaders are born, not made." Yet, the individual who is *not* a "natural" leader but is well trained and prepared for crisis situations may be more successful and may exhibit more leadership than the individual who is a natural leader but lacks training and preparation.

On the other hand, a leader in a crisis situation can do everything right and still have a negative outcome or do everything wrong and have a positive outcome. After a riot, natural disaster, or other major emergency, judgments by the public, media, and political elements—and, often, even most of the corrections organization itself—are based on the outcome. Usually, however, only a few people actually know the details of what happened and recognize whether leadership was strong and positive and whether decisions were justified given the information available to the leader at the time.

It would be foolhardy to ignore the importance of attributes such as common sense, judgment, maturity, and even luck in a crisis, but that does not negate the importance of planning, training, and other preparation. Simply put, crises are situations in which it can be better to be lucky than good. The enlightened leader hopes to be both lucky and good but recognizes that he or she can only control the latter.

For the leader, it is crucial to recognize the role of luck (or fate, if one prefers), the fact that he or she will be judged primarily on the outcome of the crisis, and the fact that no amount of planning and preparation can anticipate everything that will be encountered in a real emergency. Consideration of these factors should occur *before* the leader actually manages a crisis. Otherwise, if a crisis ends badly, the aftermath can be personally devastating. These are not lessons best learned by trial and error.

The Isolation of the Leader During a Crisis

In addition to making the key decisions during a crisis, the leader is also setting the tone for the rest of the staff (and sometimes the inmates as well). The leader is on view during the entire crisis, typically surrounded by staff from beginning to end. Staff members may not offer alternatives while a decision is being made but may then quickly criticize that decision if the situation deteriorates. The leader experiences not only constant pressure from the situation itself but also constant scrutiny by staff.

Despite being surrounded and scrutinized by staff during an emergency, the leader is in a sense alone. Staff may offer fewer suggestions and participate less actively than the leader anticipated. The reasons are simple. Staff see the awesome responsibility of making life-and-death decisions, many are intimidated, and some are reluctant to become involved. Recognizing the pressure on the leader, staff may also be hesitant, fearing their contributions may interfere with the leader's work.

Strong teamwork can help to reduce the leader's sense of isolation. In general, it will not be possible to establish a good working team of top managers during a crisis unless those individuals have a history of teamwork and trust. Similarly, if the culture of the organization has been predominantly negative, staff will find it difficult to support each other during an extended emergency. There are some exceptions. Regardless of past relationships, staff sometimes rise to the occasion in a crisis, particularly in a short-term emergency. Also, emergency conditions do tend to bring out the best in many people. Over time, however, particularly during an extended emergency, the history and the culture of the organization will exert a strong influence on behaviors during the crisis.

After an emergency has ended, some crisis managers walk away nonchalantly and say something

like "I'm fine. I did what I had to do and it didn't affect me." (Some will dismiss that reaction as denial, and readers are free to draw their own conclusion.) However, most leaders emerge from a crisis and acknowledge a dramatic, sometimes profound, personal impact. Yet, in this "enlightened" era in which corrections has finally acknowledged the importance of posttrauma care and other emergency services for staff, it is disturbing that the one individual frequently omitted from psychological screening, employee assistance programs, posttrauma debriefing, and other forms of support is the leader.

Crisis Leadership Attributes

In the "good old days," a booming voice and stern demeanor were the qualities associated with effective leadership in prisons and jails. An intimidating physical presence seemed to help as well. Although corrections has not completely abandoned the old stereotypes, most professionals recognize that strong leadership has nothing to do with size or gender.

The word "strong" is important. In times of crisis, strong but flawed leadership may be preferable to weak leadership or no leadership at all. Almost all organizations depend on and reflect their leadership, and in paramilitary organizations such as correctional institutions, the central importance of leadership is heightened because of the enormous risks inherent in operating these organizations and because staff expect decisive direction.

No single set of characteristics defines the ideal leader. The huge literature on management and leadership makes this point beyond any argument, as many influential authors and theorists each advance their own set of essential attributes or qualities, with little or no overlap or synthesis. Those who are natural leaders seem to come in a wide variety of personality types: stern or humorous, quiet or verbal, etc. Similarly, those who have worked, trained, and studied to become effective leaders are a varied group. Individuals can be themselves and still develop and enhance qualities associated with effective leadership.

What, then, are the crucial qualities of effective leadership during a crisis? Integrity is the core and foundation. Decisiveness is obvious, as are calmness and support for subordinate staff. Many crucial qualities are not so obvious. Patience is near the top of the list; however, staff may misinterpret patience as indecisiveness. Maturity is a necessity; ego involvement and testosterone-driven behavior have the potential, quite literally, to be fatal. Tenacity, physical endurance, mental flexibility, and the ability to tolerate ambiguity are also high on the list. Communication skills, often overlooked in discussions of crisis management, are important; listening well and expressing oneself clearly and succinctly are skills that any crisis situation will test repeatedly. Understanding and compassion must be on the list, and analytic thinking may be a crucial quality. On the other hand, lack of judgment or lack of common sense can render any of these qualities and attributes ineffectual.

Because second guessing and blunt criticism are inevitable in extended crisis situations, self-confidence and grace under pressure might be excellent qualities to add to the list. Effective leaders need to know themselves and be able to draw on inner resources because, at the end of the day, no one else may be there. Once the crisis is over, they need to live comfortably with their decisions and their performance and must be able to continue to lead, which is often the greatest challenge.

Dynamics of a Crisis Situation

Cycles, waves, phases, stages—all of these terms characterize the progression of a crisis situation through time. Certain dynamics are characteristic

Important Qualities of Leadership During a Crisis

- Integrity
- Decisiveness
- Calmness
- Tenacity
- Patience and maturity
- Physical endurance
- Mental flexibility and creativity
- Tolerance for ambiguity
- Support for staff
- Communication skills
- Compassion
- Analytical thinking

of crisis situations, and these dynamics change as the crisis unfolds. To some limited extent, the dynamics of a crisis are predictable.

The Early Phase

The initial phase of an extended crisis situation (or the entirety of a short crisis or emergency) typically is quite different from the rest of an extended situation. If planning, preparation, and training have been good, much of the initial response is almost reflexive. A host of steps commonly taken when a crisis first arises—lockdowns, emergency counts, dispatching staff to try to resolve or to isolate and contain the situation, notifying top staff, etc.—may be carried out relatively easily because they have been planned and practiced. At this point, the leader's challenge typically is to figure out what has happened and what is continuing to happen. Early information is always incomplete or inadequate, and often some of the crucial information available early on turns out later to be simply wrong. Also, the early stages of crises usually are characterized by some degree of chaos, which makes it difficult to interpret available information.

Interpreting Available Information

During a crisis, every staff member typically has some specific task or defined responsibility. The only person who by necessity must take the long view and the broad view is the leader. That is, only the leader may have access to all of the information from all areas of the institution. If the leader does not recognize an important pattern in the events (indicating, perhaps, that the crisis is a planned mass escape rather than a spontaneous disturbance), no one else is likely to do so, and the actual nature of the problem may go unrecognized for a long time, with disastrous consequences. It is up to the leader to identify the broad parameters of the situation as soon as possible. How much of the institution is involved? Was this planned? Is "another shoe" about to drop (and if so, what might that "other shoe" consist of)? The leader is in the unenviable position of directing an immediate and almost all-consuming response while simultaneously functioning as a data analyst and as the only strategist in the situation.

Avoiding the "Ambiguity Trap"

Early in many crises, the leader is likely to encounter a specific trap. (In the later stages of a crisis, staff may press the leader to resolve the situation with a decisive use of force, which can be an additional trap, even though conditions do not warrant such action.) In the early stage, the leader may face pressure to adopt a view of the emergency that is inconsistent with the available information. It is an ambiguity trap. The leader

and many staff may want the certainty of knowing what they are confronting. However, because early information is typically incomplete, contradictory, or wrong, it may not be possible to know the true nature or extent of the crisis in the early stages. The leader must be able to tolerate ambiguity and reject the allure of false clarity that may lead to unfortunate outcomes.

Helping Staff Remain Calm

During the early phase of a crisis, the leader must be careful not to allow panic to set in among staff, particularly if the crisis threatens to overwhelm the initial response. In guiding staff through this intense period, the leader must be decisive without becoming impulsive. He or she must listen well but be resolute, even in the face of pressure or emotion from subordinate staff.

As the Crisis Unfolds

In an extended crisis, staff reactions will change predictably as the early adrenaline rush gives way to anger, anxiety, and doubt, along with moments of enthusiasm and even elation. Different staff will, of course, react differently. The volatility of the crisis situation itself and of the staff reactions to the situation make it essential that the leader remain steady and portray confidence and professionalism.

Serving as a Role Model

Although a sense of humor, if used judiciously, can be invaluable, a crisis is not a time for jokes. Nor is it a time for cynical observations, profanity, or expressions of anger. When staff realize that the crisis, with its attendant dangers and personal risk, may continue for a long time, the leader must function not only as the chief decisionmaker but as a highly visible role model.

In an extended crisis, the leader may also serve directly or indirectly as a role model for inmates. For example, in a large-scale hostage-taking incident, the leader's steady, measured responses may calm highly agitated inmates and bring down their emotional tone, which in turn may lessen the danger to the hostages. Additionally, the leader's steady demeanor may begin to build the inmates' trust toward the institution or department leadership, and that trust may be an essential ingredient in later attempts at resolution.

Fiction Versus Real Life

Television and movies often portray extremely dramatic, high-risk initiatives as the only way to successfully resolve emergencies. The wise leader recognizes that television and movie scripts are written to be compelling and that real-life emergencies often require thoughtful, measured, low-risk initiatives that are quite the opposite from what Hollywood might choose.

Meeting Staff Needs

The effective leader also recognizes the need to build staff confidence during the actual crisis event. Keeping in mind that the occasional mistake or bad behavior is always easier to recognize than the many things done correctly or unusually well, the leader must consciously look for ways to be positive with subordinate staff and to reinforce their actions and decisions—even if doing so means swallowing some doubts.

At the same time, some individuals can come apart under the pressure of crisis conditions, and it is seldom possible to predict who will be unusually strong in a crisis and who may fall apart. Inappropriate anger or incapacitating anxiety is a sign that a staff member is losing emotional control, and the leader must be aware of these signs. If a staff member is losing control, the leader usually will not have time to help

and should be prepared to have the individual removed, quickly and firmly, from the crisis situation.

The Resolution

As a crisis continues, the pressure on the leader builds. If the situation involves inmate violence, the leader almost always is urged to assault—to use a sniper or in some other way commit to a tactical initiative that will end the crisis. If a response was dismissed early in the crisis as too dangerous, the mere passage of time will seldom transform that option into a much better response. Nevertheless, the leader may be under pressure from many sources to end the situation. A tactical team may lobby for action, saying that they can assault quickly and take control with minimal risk. Political decisionmakers may be asking when they can expect something decisive to happen. Rank-and-file staff may strongly feel that doing something is better than doing nothing. Seldom does it help for the leader to explain that waiting, talking, planning, and further analyzing available information is far different from "doing nothing."

The leader's greatest pressure at this point may come from within. Managers have commonly reported that after some period of time in a crisis, they began to feel that it did not matter whether the situation ended badly or well, as long as it ended. That reaction may be typical and instinctual, but some crisis situations may demand an opposite and counterinstinctual posture. For example, during the 2-week siege of the federal prisons at Atlanta and Oakdale, Michael Quinlen, then Director of the Federal Bureau of Prisons, said "My patience is endless." Larry Meachum, the former Director of Corrections for Oklahoma and Connecticut, later pointed out in print that "Endless patience is active management." This concept is an especially important one for a leader to understand, particularly in an extended crisis situation.

Elements of Strategy

In an extended crisis, strategy is essential. The frantic pace of the emergency can easily consume everyone's time and attention, and staff can easily mistake tactics for strategy. It is up to the leader to take specific steps to focus on strategy, because it will not happen by accident. The leader may choose to take full responsibility for strategy, to work with one or more top staff members on strategy (a crisis management team approach), or to develop a separate

Tactics Versus Strategy

Strategies and tactics are both plans or courses of action. In general, whereas tactics are narrower, shorter term, and more limited in their objective, strategies are often intended for the duration of the situation; they are broad in scope, and their objective is to resolve the matter. The expression "we won the battle but lost the war" suggests good tactics but bad strategy.

In a developing jail disturbance, one leader's strategy might be to contain the disturbance and then let it dissipate on its own; another's might be to regain control as soon as possible before the inmates get better organized. These two very different (almost opposite) strategies would lead to very different tactics, and either strategy will suggest a rather large number of specific tactics.

Finally, when a tactic is unsuccessful, it is usually possible to try a different tactic. However, if the overall strategy is wrong, the entire venture may be lost.

group to formulate and evaluate strategy alternatives (a strategic planning group). Any of these choices will demand some of the leader's time and attention.

A common problem in formulating strategies is failing to consider risks as well as benefits. The leader must identify and weigh the risks of various strategies contemplated e.g., asking the SWAT team leader "You said with this kind of dynamic entry, your team has an 80-percent chance of controlling the hostage takers before they can reach the hostages. If you aren't successful, what do you expect we will have in injuries and deaths if we are in that 20 percent? And then how long will it take to control the situation? Is there any risk that other people may come under threat?")

Another common problem is simply failing to identify and evaluate additional strategies, particularly those that may be unusual and creative. A leader can easily lose perspective and concentrate too soon on a single, obvious strategy.

The leader must remember that crisis conditions tend to constrict creative thinking. This tendency may be an argument for using a strategic planning group, particularly during extended emergencies.

Aftermath and Deactivation Issues

Once a crisis has been resolved, the leader's responsibilities as a role model for staff may take precedence over decisionmaking responsibilities. The leader knows, from training, experience, and preparation, that the aftermath of a major crisis is often longer and sometimes more dangerous than the crisis itself. A huge amount of work remains to be done (e.g., preserving evidence, protecting the crime scene, developing a short-term stepdown plan, isolating key witnesses), and much of it cannot be postponed simply because staff are physically tired and emotionally drained. The leader must make it clear by direction, but also by example, that this work requires immediate attention.

The Road Not Taken

It is always hardest to analyze alternate strategies that are furthest from what is currently underway.

For example, in the midst of a long, very difficult hostage siege, the commander, through a well-trained negotiator, is making no progress deflecting the leader of the hostage takers from a time ultimatum tied to a threat to harm the hostages. While the commander tries different approaches with the hostage-taker leader, someone else suggests using a different negotiator and asking to talk with all the hostage takers at once, as a group. Surprisingly, it works. The leader is the most aggressive and committed of the hostage takers; as a group, the other inmates are "easier" and less focused. Changing negotiators does not undermine the rapport between the original negotiator and the inmate leader, and the change provides a logical reason for asking to talk with the group. This successful strategy might never have occurred to the commander, who was locked in to the confrontation with the inmate leader and was no longer evaluating alternative approaches.

It is the leader's responsibility to see that the road not taken is, at least, fully considered.

Responding to Criticism

This is also the point when instant media analysis of the event often leads to internal and external criticism, recriminations, and even outright

expressions of guilt and anger. Here, the leader must walk a fine line. The leader must thank staff for their efforts and, where it is reasonably clear that work has been good, acknowledge that. On the other hand, in the case of controversial issues, media criticism, and inmate complaints, the leader cannot make snap judgments and simply exonerate staff out of hand. The leader must see to it that these matters are investigated promptly, thoroughly, and honestly. Although others may press the leader to say "staff did nothing wrong," that statement, combined with "The causes of the disturbance are still under investigation," clearly signals savvy observers that the "investigation" is actually a whitewash. The leader needs to support staff, particularly after a lengthy and emotional crisis. However, supporting staff does not mean exonerating them before the facts are known.

Driving the Agenda

The single most important principle to guide the leader in the aftermath of a major crisis is "drive your own agenda or someone else will drive theirs." Even if the leader is devastated and the institution is in shambles, the leader must develop a game plan and pursue it aggressively. Otherwise, other forces, usually external, will step into the vacuum, and the leader and the institution will find themselves in a reactive, rather than proactive, position. Driving the agenda, however, is easier said than done. It involves myriad tasks, including the following:

- Developing a thoughtful, detailed stepdown plan.
- Beginning a comprehensive inquiry into the events of the crisis itself.
- Initiating a careful study of damage control and establishing repair priorities.
- Taking firm control of media relations and establishing a proactive media plan.
- Holding staff briefings and attending to staff morale.
- Communicating frequently with the inmate population.
- Preventing staff retaliation.
- Briefing departmental officials and political decisionmakers frequently and candidly.

Energetically undertaking these and other deactivation tasks allows the leader to maintain control in the aftermath of the crisis. It also has a beneficial byproduct: staff are engaged and challenged and begin to reestablish their own balance and confidence.

Addressing Human Needs

Good emergency plans include comprehensive preparation for dealing with the special needs of staff and their families in a crisis and separate procedures for dealing with traumatized inmates and their families. Such plans should also provide for services or procedures to help the leader cope in the aftermath of a major crisis. Often, it is best if this assistance for the leader is kept separate from the rest of the department and the leader's colleagues, so the leader can work out personal issues privately. (Once again, the twin themes of the isolation of the leader in crisis and the extraordinary demands placed on the leader by the crisis are both apparent.)

Conclusion

Awareness of the issues discussed in this section can help prepare a correctional manager or administrator for leadership during a major institutional emergency. However, because every crisis is unique, even the most thorough preparation cannot guarantee a positive outcome. Recognition of that fact provides some of the realistic perspective the leader needs to function effectively during and after a crisis.

Prevention of Jail Emergencies*

An emergency in a jail is a serious matter. Even a relatively brief jail emergency can leave a wake of deaths, serious injuries, and millions of dollars in damage. Regardless of whether an emergency involves inmate violence, the stakes are always high, for obvious reasons:

- Population densities in jails are very high.
- Inmates typically are locked in their cells or living units or on the jail compound and cannot protect themselves in many emergency situations.
- In any kind of emergency, some inmates may attempt to capitalize on the situation, complicating matters and escalating risks.
- Efforts to respond to or control an emergency in a jail must be weighed against security interests and the jail's overriding mission of preventing escapes and protecting the public.

These issues are the rationale for a familiar adage in corrections: "The best way to deal with jail emergencies is not to have them in the first place." Although not every emergency can be prevented, serious prevention efforts can stop some crisis situations from occurring at all and will mitigate other incidents so they do not develop into full-scale crises.

This section discusses jail management's commitment to crisis prevention and then the question of whether jail emergencies can indeed be prevented. Specific measures designed to prevent emergencies and day-to-day operational issues that play a role in prevention are addressed.

Commitment to Prevention

Given the issues discussed above, it seems reasonable to expect a universally strong commitment to preventing emergencies and large-scale crises in jails. That is not the case. Certainly the rhetoric is there. Almost every jail administrator and/or sheriff talks about the importance of preventing emergencies. However, the level of commitment to prevention in most institutions and agencies, if measured by allocation of resources, management attention, or degree of accountability, is surprisingly low. This generally negative assessment has two significant qualifications, both related to current jail practices.

First, one of the most important ways to prevent jail emergencies is to be well prepared to respond to emergency situations and to situations that have the potential to escalate into emergencies. Today, some jails do engage in serious, broad-scale efforts to maintain a high level of preparation for emergency situations, but too many do not. Those that do are also engaging in important preventive activity.

Second, many jail practices have the effect of lowering the probability of a riot, a hostage situation, or some other major crisis involving

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inmate violence. However, jails engage in most of these practices because the practices represent good day-to-day operations and are recognized as effective ways to run jails—not because the practices have a preventive role.

It can be argued that such distinctions are unimportant—that as long as a desirable practice with a preventive effect is in place, it does not matter why it is in place. Evidence suggests, however, that prevention of major emergencies does not receive the priority it deserves. A number of jails have excellent inmate grievance systems, emphasize positive staff/inmate relationships, have moved toward direct supervision, and generally use day-to-day procedures that tend to reduce the probability of inmate violence. By comparison, efforts that are not common to day-to-day jail management but that focus narrowly and clearly on prevention are largely lacking.

Thus, prevention of major crises is far better today than it was 20 or 30 years ago, but primarily because today's jails are generally much better managed and because some of today's jails engage in comprehensive emergency preparedness. A great deal of room remains for increased emphasis and improvement with regard to pure prevention efforts.

Can Jail Emergencies Be Prevented?

This question is more complex than it first seems. The answer is "Yes and no."

Some jail emergencies obviously cannot be prevented. Most natural disasters (e.g., earthquakes, tornados, or tsunamis) fall into the "unpreventable" category. Even if a natural disaster conceivably could be averted (e.g., a flood), the necessary measures are generally beyond the influence or jurisdiction of correctional officials.

However, other kinds of large-scale crises and emergencies in jails are potentially preventable. The most common of these are situations that involve inmate violence—riots, disturbances, sit-downs, hostage incidents, etc. Fire is another common, potentially preventable emergency. (Forest fires are a separate matter. Although most jails are not at risk from forest fires, a small number of jails could be devastated by a serious forest fire. Some forest fires, such as those caused by lightning strikes, cannot be prevented; others can. However, the prevention of forest fires is not within the purview of sheriff's offices or departments of corrections.) A number of less common situations, ranging from staff job actions to food poisoning, are also potentially preventable. Finally, some crises fall into both categories. For example, jails may be able to prevent a toxic material spill within the compound but they cannot prevent a similar event outside jail property.

"Potentially preventable" is an important distinction. No emergency is completely preventable. Even the best run jail may have a hostage incident or a riot. A devastating fire can happen even if a jail minimizes combustible loading and ignition possibilities and conducts frequent, serious fire drills. Nevertheless, common sense dictates that even though many kinds of jail emergencies cannot be totally prevented, good prevention efforts can reduce the probability that they will occur.

Another important element of this discussion is mitigation. Good emergency preparedness can result in both prevention and mitigation. For example, an administrator may not be able to foresee a power surge that creates an electrical fire. If the fire starts in an area equipped with sprinklers, no emergency may ensue; good preparation has completely prevented a crisis. If the fire starts in an unprotected area and begins to spread, but the jail has minimized combustibles that would fuel the fire, and the jail's fire alarm system, fire-fighting response, and evacuation drills are all excellent, then the jail may experience a relatively minor emergency instead of an

institutionwide crisis or even a disaster; in this case, emergency preparedness has resulted in mitigation.

It is easy to envision hypothetical situations in which good emergency preparedness may mitigate a disturbance or a hostage situation. Even with unpreventable situations such as natural disasters, good preparation efforts can make it much easier for the jail to contend with the emergency. Hurricanes Katrina and Rita had a devastating and well-documented effect on jails in southeastern Louisiana. In the face of such overwhelming natural disasters, thorough and effective emergency preparedness—particularly with regard to comprehensive evacuation planning—could have made a profound difference in mitigating the effects of the hurricanes on those jails.

The importance of preparedness in preventing jail emergencies cannot be overstated. Preparedness may seem to be concerned primarily with responding to an emergency that has already occurred—at a point when it is too late to be concerned with prevention. Closer examination reveals this not to be the case. For example, after a jail riot in which lives have been lost and millions of dollars in damage has occurred, it may become clear that the crisis started with an unplanned fight among a few inmates, which escalated into a full-scale riot throughout the facility. Better emergency preparedness might have produced an earlier, better response. Perhaps the initial fight could have been stopped. Perhaps the disturbance could have been isolated within just one living unit or at least contained within one building. If the jail translates its experience into better emergency preparedness, it may be able to prevent a major riot in the future. In addition to prevention and mitigation, good emergency preparedness may also mean faster resolution of a major emergency and/or a more successful resolution.

Specific Measures Designed To Prevent Jail Emergencies

Measures designed specifically to prevent jail emergencies include training staff to recognize traditional early warning signs, avoiding agency-initiated crises, creating a prevention-specific intelligence function, being alert to hot issues likely to cause dissension among inmates, and implementing automated early warning systems. Proactive management, though less specifically related to prevention, also plays a critical role in emergency preparedness.

Traditional Warning Signs

This is the one prevention initiative that almost all jails use, and it is primarily a matter of staff training. Correctional staff have long recognized a number of warning signs of impending violence in a correctional facility. The list of traditional warning signs may vary somewhat, but almost all jails have such a list and teach it to staff as part of the recruit academy curriculum. Some departments revisit the list as part of inservice or refresher training.

Warning signs are part of many experienced staff members' sense and feel of the institution. When an experienced staff member walks into a familiar jail and notices that the noise level, inmate groupings, and staff-inmate interactions are out of the ordinary, the staff member quickly registers that something is amiss, perhaps without articulating exactly what led to that conclusion. (This and other aspects of "institutional tone" are further discussed below, under "Ongoing Operational Issues That Play a Role in Prevention of Emergencies.")

Training staff in the traditional warning signs of impending violence is an important preventive measure, particularly with new staff. The problem is that in many jails, it is the only initiative targeted specifically at preventing emergencies.

Traditional Warning Signs of Impending Violence

- Inmates hoarding food or canteen goods.
- Inmates refusing to go to recreation.
- Increase in requests for protective custody status.
- A sharp increase or decrease in the number of inmate grievances.
- Increase in racial grouping of inmates.
- Increase in inmate sick calls and attempts to be admitted to the infirmary.
- Inmates sending personal items out of the institution.
- A substantial change in the noise level in the institution.
- Inmates wearing extra clothing at recreation.
- Decrease in inmate visiting.
- Decrease in staff/inmate interaction.
- Inmates warning well-liked staff not to come to work.

Agency-Initiated Crises

A number of now-infamous crises in correctional facilities resulted from some change or other action by the facilities' administrations. For example, the 11-day hostage siege at the Southern Ohio Correctional Facility in Lucasville, OH, which resulted in the murder of one staff member and nine inmates, can be traced to a decision by the Ohio Department of Corrections (DOC) to conduct skin tests for tuberculosis on the entire inmate population in the department. Other jurisdictions can point to riots that began with an administration-level decision to introduce a no-smoking policy, to restrict visits or packages, to change food service providers, etc.

Unfortunately, too many jail and prison crises have been initiated by decisions at the facility or departmental level. The problem is not with the decisions themselves—although some may not have been the best choices (or even wise), they were properly within the authority of the institution or the department. The problem is that a negative and potentially explosive reaction from inmates was foreseeable, but nothing was done to prevent that reaction.

A good example is the decision by many jail administrators to designate their facilities as tobacco-free environments. Such decisions are a relatively recent phenomenon but may already be the classic example of an agency-initiated crisis. Some jails have decided to make the change, announced the decision and the effective date, done nothing else, and then had a serious inmate disturbance. Other jails have made the same decision but then developed plans for minimizing the impact on inmates and communicated frequently with inmates about the change. (Many jails in this latter group have used phased-in approaches and offered smoking cessation classes and/or cessation patches and gum, etc.) Very few institutions that engaged in preventive efforts had any serious problem making the change. The question appears to have been not whether those efforts were good, better, or best but rather whether the jail did anything at all.

The issues in this no-smoking policy example appear to apply to a broad range of policy decisions and other changes a jail may institute. Experienced correctional professionals can easily foresee which changes have a high potential for angering inmates. Once this potential is

recognized, it is often a fairly straightforward matter to plan ways of introducing the change that will make it more likely to gain inmates' acceptance. Still, it can be extremely challenging to find ways to soften the blow when a change is necessary but likely to elicit a strong emotional reaction from inmates. Even in these cases, what appears to be most important is that the jail recognize the situation in advance and make its best effort to communicate and implement the change as constructively as possible.

A Day-to-Day Intelligence Function

The term "intelligence" means different things in different institutions and departments. It may mean information from inmates, particularly from known informants. It may mean information about gangs. In some institutions, the staff member assigned to "intelligence" is the gang coordinator (or security threat group coordinator). In others, "intelligence" refers to the investigator or to the staff member who works with outside law enforcement agencies and with other institutions. These definitions are not mutually exclusive.

Intelligence, as it pertains to prevention of jail emergencies, is none of the above. Rather, it refers to a staff member (or group) responsible for reviewing security data and inmate information across the institution's areas, shifts, and functions. Many jails do not have this kind of intelligence function. For example, an incident that occurs on the day shift between two inmates in an education classroom may not be serious enough to require much attention. That same evening, another incident occurs in the gymnasium, involving one of those two inmates; that incident is also not particularly serious by itself. The next morning, a fight breaks out in the dining room involving inmates who are close friends of two of the inmates involved in the two earlier incidents. None of these three incidents is by itself surprising or predictive of a major problem. However, any experienced staff member in the institution, looking at all three incidents together, would have an "Oh no!" reaction and be quite certain that large-scale violence was likely. The question is whether the jail has assigned a staff member the specific responsibility to look for such patterns.

Some jails would answer "yes" but then go on to explain that recognizing dangerous patterns is the responsibility of the Jail Chief (or the Deputy), who sees all the reports and is responsible for everything. The problem with this response lies in the last three words of that explanation. The chief is responsible for everything and therefore cannot focus enough attention on incident reports and on information from staff and inmates to reliably identify patterns like the one in the example described above.

An effective intelligence function can be one of a jail's most important means of preventing large-scale crises and emergencies. However, the prevention-focused intelligence function must be something quite different from, and in addition to, investigations and gang information.

"Hot" Issues

Experienced correctional staff know that a few issues, if sufficiently mishandled, have the potential to start a riot or disturbance almost immediately. Food is one of them. Several years ago, for example, the Kansas DOC had three different prison disturbances occur concurrently because of a statewide change in food service and problems with the new food service provider immediately after the change. Clearly, food-related issues—changing inmates' food, feeding them too little, or feeding them food they hate—can easily cause a riot.

Several other areas—visitation, medical services, recreation, mail—are also highly sensitive issues for inmates. Jail staff, especially management, need to pay particularly close attention to any developing problems or incidents in these areas.

The "Turkey à la King Riot"

In Hawaii, "luau" food (Kahlua pig, lomi lomi salmon, poi, etc.) is the traditional fare on Hawaiian holidays, the most important of which is King Kamehameha's birthday. Many years ago, perhaps the most serious corrections riot in Hawaii history occurred on that holiday, when many jail officials had the day off. No one remembered to plan appropriate food, and the Oahu Community Correctional Center, Hawaii's largest jail, attempted to serve turkey à la king for dinner. The ensuing disturbance is still referred to as the "turkey à la king riot" in Hawaii.

As emphasized in the discussion of agency-initiated crises, quickly recognizing a problem in one of these hot issue areas appears to be the largest part of the battle. Once the problem is recognized, managers should usually find it a straightforward matter to either fix the problem quickly or communicate clearly and frequently with the inmate population about the problem and about the steps being taken to address it.

Automated Early Warning Systems

An automated early warning system is a software-driven computerized system specifically designed to crunch numbers, analyze data, and alert jail staff when the data indicate that trouble may be brewing. The earliest, most impressive work on such a system was carried out by the Pennsylvania DOC in the aftermath of the Camp Hill riots.

The Pennsylvania DOC looked retrospectively at a small number of key indicators at the Camp Hill prison: the number of inmate-on-inmate and inmate-on-staff assaults per month, the number of grievances per month, the number of disciplinary reports, staff use of sick leave, etc. The research found dramatic changes in these indicators during the months leading up to the Camp Hill riots.

Based on this research, Pennsylvania developed a software-driven system in which each of the state's prisons collects data on critical indicators every month and sends the data to the DOC's central office for entry into a database. Because the data are monthly numerical totals, this process is quick and easy. The software then analyzes the data from each prison, measuring changes from previous months and, since some indicators follow a cyclical or seasonal pattern, from the same month of the previous year. The software flags any indicator with a significant change and produces a printed report for review by department administrators and prison managers.

In some cases, indicators might be flagged for predictable reasons. For example, a major increase in grievances about food service might result if an institution remodels its kitchen and changes to two cold meals a day until the remodeling is completed. If the prison took steps to communicate these changes to inmates in advance and to mitigate the impact of the changes on the inmates (thereby avoiding an agency-initiated crisis), the flag may not be cause for concern, because some inmates will file grievances under these circumstances no matter what steps the prison takes. However, if several key indicators are flagged at a high-security prison, and the warden, in discussions with departmental officials, cannot identify any particular incident or change that might have caused a dramatic shift in those indicators, then actions designed to get additional information and steps to prevent a crisis should begin immediately.

This approach has great potential for preventing institutional crises. Experienced jail staff like to think they understand everything that is going on within the institution, but no one can make sense of so much information all of the time.

Institutional Climate Scales

A number of state departments of corrections now use some form of institutional climate (or atmosphere) scale to evaluate the "tone" of prisons* on a weekly or, more commonly, monthly basis. These scales are closely related to the early warning systems discussed in this section, but there are important differences.

The primary difference between institutional climate scales and automated early warning/critical indicator systems is that the climate scales tend to be subjective. With an automated critical indicator system, the number of inmate grievances filed in a month, for example, is what it is—it generally is not subject to interpretation. With an institutional climate scale, a prison manager's evaluation of the quality of staff-inmate interactions over the course of a month is profoundly subjective. The authors have toured state prisons in which wardens "filled in" climate indicators in the same way month after month after month, an empty exercise that predicts nothing.

Requiring jail managers to evaluate changes in institutional climate over time has real merit. Such evaluations can produce information that might not emerge from a computer-driven early warning system. Both approaches may be important in predicting and preventing jail emergencies. However, the process for measuring prison climate must involve more than a warden writing "acceptable" next to every indicator every month. Promising methods share the following attributes:

- Combining objective measurements with subjective judgments.
- Requiring staff to assess detailed aspects of jail operations rather than making a broad judgment about the overall climate in the jail.
- Involving the perceptions of at least several staff members from different levels and locations within the institution.

Jails across the United States have been slower to experiment with either institutional climate scales or with early indication systems, and there is little jail work to review in either regard. Both approaches hold substantial promise for prevention of crisis in jails.

*Institutional tone is also discussed below, under "Ongoing Operational Issues That Play a Role in Prevention of Emergencies."

Computerized methods for regularly analyzing crucial information may bring to light serious, imminent problems that otherwise would be overlooked.

Pennsylvania's automated early warning system is a true prevention initiative. It is important to note that some departments collect data on almost every aspect of prison operations, and some then enter all of that information into large databases. Although valuable for documentation, accreditation, management review, and other purposes, that approach is not particularly useful for early warning purposes and should not be confused

with software-driven critical indicator or early warning systems. In a comprehensive database, too much information operates like no information. It is impossible to sort the wheat from the chaff. With hundreds of indicators, most will have nothing to do with predicting a riot or disturbance. Further, when data are collected on many different dimensions, some of those dimensions will show unusual changes each month simply as a matter of statistical probability, and those results will be indistinguishable from any results that are true positives. An effective early warning system should be quick and easy to use and should track fewer than 10 key indicators.

Proactive Management

Proactive management is the least specific of the methods that may be used to prevent emergencies in jails. It may not be a specific initiative at all. Nevertheless, the quality of leadership in a jail is a crucial factor in every area of management and operation, and prevention of emergencies is no exception. In fact, without proactive management, a number of the more specific prevention initiatives discussed above may be rendered useless.

The relationship between proactive management and emergency prevention is neither ambiguous nor theoretical; it is direct and practical. Two examples may illustrate that relationship. When staff morale is low and employees are angry because of a bad incident, proactive management engages employee groups and works to rebuild communication and trust; in the same situation, status quo (laissez-faire) management does little as the situation deteriorates and perhaps an employee job action then throws the jail into a major crisis. When a jail faces escalating racial tension, proactive management aggressively pursues conflict resolution, whereas status quo management denies the problem exists until a race riot occurs.

Proactive management is closely related to the operational issue of early intervention as a philosophy and a skill set for supervisory and frontline staff. This related concept is one of the issues discussed in the next section.

Ongoing Operational Issues That Play a Role in the Prevention of Emergencies

In addition to measures designed specifically for the purpose of preventing emergencies, many elements of day-to-day jail operations play a role in prevention. These elements include day-to-day security practices, inmate classification, early intervention, the tone of the institution, and staff professionalism.

Day-to-Day Security Practices

Good day-to-day security practices are crucial in preventing jail crises such as riots, disturbances, and other incidents involving inmate violence, both planned and unplanned. For example, were it not for a series of cascading security breaches and mistakes, the 1993 inmate takeover of the "supermax" unit at the Montana State Prison in Deer Lodge, Montana, would not have occurred. That incident, which resulted in the murder of five inmates, was planned by inmates based on their knowledge of chronic security lapses by staff.

Fortunately, planned riots and disturbances are relatively uncommon. Far more common is the unplanned situation that escalates into a riot or disturbance. Here too, the role of day-to-day security practices is central. In many cases, a security error creates an opportunity that initiates the entire incident. In others, a security error allows what should have been an isolated incident to escalate into an institutionwide crisis. In both cases, the end result is a riot or disturbance that is truly a crime of opportunity, the opportunity being a lapse in security.

Common Myths About Jail Security

Myth: Maximum-security facilities and units have the best security practices. Fact: It is not difficult to find examples of very good and very bad security at all kinds of units and institutions—minimum, medium, and maximum security.

Myth: Security is the responsibility of the jail's uniformed (custody) staff. Fact: In a correctional institution, security must be every staff member's first priority.

Myth: A natural tension exists between good security practices and an emphasis on inmate programs and services. Fact: Effective inmate programs and services complement good security practices. Poor or inconsistent security undermines programs and services and forces inmates to worry about their own safety. Good inmate programs and services reduce idleness and anger and provide inmates with incentives to comply with security practices.

Myth: Staff will be able to tighten security as soon as they realize they are in a major emergency situation. Fact: If staff security procedures are sloppy day to day, they will predictably be sloppy during a crisis or major emergency.

It is tempting to assume that most jails are very good with basic security procedures and practices. That is a myth. While many jails have well-designed security procedures and follow those procedures consistently and in detail, many do not. It is beyond the scope of this discussion to attempt to identify specific security practices that are important but frequently violated. However, even the most superficial review of some jails will reveal problems such as poor or nonexistent key and/or tool control, munitions stored in areas where inmates could gain access, sallyport doors operating on override rather than interlock, poor escort procedures—the list goes on. Given such opportunities for unnecessary incidents to occur and for incidents to escalate unnecessarily, the mystery is why major inmate disturbances are not more common.

It is important to emphasize that staff must follow security procedures consistently, and those procedures must be well-designed and effective. Poor implementation is far more common than bad procedures, but bad procedures do exist. Furthermore, despite an emerging national consensus about what constitutes good security practices (a byproduct of the proliferation of security audit processes), specific areas of disagreement remain. In addition, many jails maintain security practices on the basis of custom rather than reason.

Finally, the centrality of the security audit in maintaining or improving security practices has become increasingly clear. A particular institution may have exceptionally good security without conducting audits. However, in general, jails that perform external security audits or even self-audits annually or biannually have substantially better security practices than those that have no means of comprehensive security assessment.

Classification

Good classification practices—a key component of effective jail management—are a foundation

of emergency prevention. Two problems—misclassified inmates and mismatches between inmates and institutions—can lead directly to crisis situations. If many inmates are classified at a higher security level than a facility's design, staffing, and operating procedures were designed to handle, serious problems may be inevitable. Another very serious warning signal is frequent overrides of classification rules.

Early Intervention

Early intervention is conceptually related to proactive management. It is a matter for front-line and supervisory staff rather than a management-level concern. Early intervention is to some extent a result of institutional culture, but it is largely an issue of training.

In short, the issue is whether staff attempt to deal with inmate conflicts, confrontations, and personal crises as early as possible or whether staff wait until a problem escalates into a fight or some other clear disciplinary issue. When low-level problems are not dealt with, some may simply go away but others will not. Those that do not tend to escalate in intensity and scope. Yesterday's argument is today's fight. Today's fight is tomorrow's stabbing. Tomorrow's two-inmate confrontation is the next day's gang war. Today's race riot may have its roots in yesterday's conflict between two inmates of different races, even though the conflict itself had nothing to do with race.

Despite these clear connections, some correctional administrators hesitate to commit substantial resources to developing early intervention skills and practices because the payback is not visible. Hesitant administrators may ask, "If an inmate disturbance does not occur because of our investment of training and other resources, will anyone recognize that it would have occurred without the investment?" Jail administrators should keep in mind that an early intervention philosophy is a worthwhile objective not only because it helps prevent major emergencies but also because it produces two highly visible results: a better running facility and increased staff professionalism.

Tone of the Institution

The "tone" of a jail is also referred to as its "atmosphere" or "climate." ("Institutional culture" is quite different; it refers to a more abiding set of attributes, although some overlap exists between an institution's culture and its tone, atmosphere, or climate.)

An institution's tone is complex, but, as mentioned in the earlier discussion of traditional warning signs, it is something that experienced corrections staff register quickly (if subjectively). Many staff are certain that they know when something is wrong or substantially changed within a minute of entering a jail. Is it the noise level? Partly. The way inmates are speaking to and dealing with other inmates? Again, partly. Does it also have to do with the nature of staff-inmate relationships? Absolutely. Most staff (and most inmates) believe they can feel the difference between a tense and a relaxed jail.

A jail's tone also has to do with the way the facility is run. In a jail operated much more restrictively than necessary, where staff are heavy handed, distant, and quick to write disciplinary reports, the tone will differ dramatically from that in a facility operated as openly as possible for its security level, where staff-inmate interactions are low-key, informal, and generally positive.

Unlike an institution's culture, which generally transcends any single turn of events to remain relatively stable over time, its tone can change dramatically because of an incident, a policy change, or even external events. Thus, a jail's tone, which can predict the likelihood of large-scale inmate violence (see earlier discussion of institutional climate scales), can also **cause**

crisis situations. A hostage situation or some other major disturbance is far less likely to occur in a jail that is clean, quiet, and run within the boundaries of constitutional requirements than in a jail that is dirty, noisy, and run without regard to the constitutional rights of inmates. It is the overall tone of the jail that may produce violence in one case and a secure and constructive environment in the other.

Staff Professionalism

As is true with many of the factors and issues discussed in this section, staff professionalism does not exist in a vacuum. It contributes to and reflects the tone of the institution. It is enhanced by proactive management and strengthened by skills such as conflict resolution, and it helps the institution achieve consistency in security practices. Beyond these considerations, however, staff professionalism itself plays a direct role in preventing jail emergencies.

In most jails, even though inmates interact far more frequently with other inmates than with staff, they depend on staff when something is wrong. Staff intervene before an inmate is seriously injured in a fight, arrange for medical assistance when an inmate appears to be in immediate distress, and provide counseling when an inmate has a serious personal problem. In a jail that values and rewards professionalism, staff take these kinds of responsibilities most seriously; in doing so, they avert more dangerous problems.

Inmates also rely on staff for many day-to-day functions. In a minimum-security facility, inmates with outside jobs may live relatively independently but still depend on staff to let them in and out of the facility. Staff take inmates to probation or court, track their release dates, and arrange for family visits, among many other tasks. In a high-security unit, inmates depend on staff for most of the necessities of daily life—food, clothing, showers. In part because of these dependent relationships, inmates are sensitive to lack of professionalism—to the officer who practices verbal "one-upmanship" as inmates eat or shower or who plays favorites and makes a point of writing up an inmate for personal reasons. Staff members who behave unprofessionally toward inmates may never know that their own behavior initiated an institutionwide disturbance. When viewed in this light, it is clear that staff professionalism can help prevent inmate violence (among a number of other obvious benefits) and is also a major factor in staff safety.

Conclusion

As noted at the beginning of this section, some jail emergencies cannot be prevented. However, serious prevention efforts can stop some crisis situations from occurring and will mitigate other incidents so they do not develop into full-scale crises. A surprisingly wide range of initiatives have excellent potential to prevent jail emergencies, and many of these initiatives have been underutilized in jail management. In addition, many aspects of a jail's day-to-day operations—especially, perhaps, its security practices and overall tone—are important preventive factors.

Good prevention efforts are an important part of good jail management. The old adage bears repeating: "The best way to deal with jail emergencies is not to have them in the first place."

Emergency Teams*

Emergency teams are critical to emergency preparedness in any correctional facility. The three types of teams discussed in this section—tactical, hostage negotiation, and crisis intervention—deal with life-and-death matters. Tactical teams, sometimes at great personal risk, have rescued hostages who otherwise almost certainly would have been killed. Hostage negotiation teams have worked out nonviolent surrenders when almost every observer predicted a bloodbath. Crisis intervention teams have saved staff and their families from long-term mental anguish and the kind of downward spiral depicted so poignantly by Joseph Wambaugh in *The Onion Field.* Lives have been lost when a department lacked one or more of these crucial functions. However, while there should be no debate about the importance of these teams, a few management mistakes can turn an emergency team into a high-profile liability (in the words of some jail administrators, "Emergency teams—can't live with them, can't live without them").

Clearly, the subject of emergency teams is important. This section is directed to institutional CEOs and departmental administrators and focuses on strategic, organizational, and management issues associated with emergency teams—with particular emphasis on the problems and pitfalls that may confront a manager or administrator.

A wealth of material is available on the training of negotiators and tactical teams. Many emergency teams have voluminous policies and procedures. This section does not attempt to synthesize training or procedural materials for the various types of emergency teams, nor is this section intended as a how-to manual.

Background

Terminology

Most medium-sized and large local jails and most state DOCs have one or more emergency teams. However, different departments have different names for their teams, and terminology can be a major barrier to thoughtful discussion.

The most common of the three general types of emergency teams is a **tactical team.** This section uses "tactical team" as a generic name for various units—disturbance control, Special Operations and Response Team (SORT), Correctional Emergency Response Team (CERT), Special Weapons and Tactics (SWAT), and many others—that are specially trained in the use of sublethal and/or lethal force.

The second most common type of emergency team is a **hostage negotiation team.** Other terms for these teams include "SitCon," "crisis negotiation team," and "crisis intervention team."

The third type of emergency team is most commonly known as a **crisis intervention team,** although some departments use that term to refer

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to hostage negotiators. Crisis intervention team members are specially trained to provide some combination of support, postincident debriefing, peer counseling, and posttrauma care to staff and staff families. These teams have the broadest range of names, such as "peer counselors," "critical incident debriefing team," and "posttrauma team."

To summarize, this section refers to a use-of-force team as a tactical team, to hostage negotiators as a hostage negotiation team, and to a group that provides psychological services and/or support to staff during and after an emergency as a crisis intervention team.

Clarifications

Correctional institutions often have special teams trained to do cell extractions (also commonly referred to as "forced cell moves"). In some institutions, cell extractions are performed by the tactical team (whatever that team may be called). Other institutions may have a cell extraction team (or teams) and a completely separate disturbance control team, CERT, or the like. This section does not address cell extraction teams or the cell extraction responsibilities of tactical teams.

Confusion also may arise about nomenclature and organization of duties in tactical teams. Tactical teams can be viewed as having two general levels. This section uses "disturbance control team" to indicate the first level—a tactical team trained for some combination of application of sublethal force, mass arrests, and use of riot formations. The term "CERT/SORT team" is used to indicate the second level—a tactical team trained for hostage rescue missions, dynamic entries (a surprise forced entry into a barricaded or locked position, typically using firearms to take control of the situation inside as quickly as possible), and use of semiautomatic weapons. Some agencies have a single level or type of tactical team that performs all of these functions; others have two levels. Departments with two levels often make successful participation in the disturbance control team for a period of time (e.g., 2 years) a prerequisite for joining the CERT/SORT team. Generally, that has worked well for selection.

Finally, this section does not address "first responder" systems. (These systems are designed to provide a controlled response to an alarm or an officer's call for assistance while maintaining some secondary response capability. Typically, first and second responder staff are identified at the beginning of each shift.) First responder systems are becoming increasingly common in prisons throughout the country, and less so in jails, but their function is not within the scope of this discussion.

Emergency Teams and the Small Jail

It may be impractical for a small or moderate-sized jail to maintain one, two or all three types of emergency teams described in this chapter. However, even the very small jail may encounter a crisis in which one or more of these functions is an absolute necessity. If a jail cannot have, or chooses not to have, some or all of these emergency teams, it is that jail's responsibility to arrange for emergency teams from a nearby agency through mutual aid agreements. Such an arrangement does not absolve the jail of responsibility for the issues discussed in this chapter.

General Management Issues

Coordination

Jail administrators should ensure that emergency teams understand each other's missions and the potential importance of each team in resolving an emergency. Without such understanding, one team may lack respect for another's role (e.g., a CERT/SORT team responsible for hostage

rescue may regard the hostage negotiation team as a weak and unacceptable alternative). All team members must clearly understand their own roles and be committed to overall departmental policy.

Preparing teams to function effectively and seamlessly in an emergency requires coordination. Ideally, a management-level person will be assigned responsibility for coordinating all three types of teams throughout the department. This person needs the authority to ensure that teams are properly trained, follow departmental policy, and maintain a positive team culture. That person should not be a member of, or the leader of, any of the three teams.

Membership and Selection

The qualifications of emergency team members are extremely important, and the department should have a strict policy on membership requirements for each team. Membership should be voluntary. The goal is to attract the very best individuals—those who are concerned about saving lives and who understand what it may take to respond to an emergency in a controlled manner. Applications for team membership should be reviewed and approved by the team leader, the institution's security administrator, and the warden or a jail chief.

Applicants for emergency teams should have at least 1 year of experience in the correctional field. This requirement allows the applicant to become accustomed to the correctional environment and familiar with the department's mission and philosophy, and it allows the department to observe and evaluate the employee's demeanor, professionalism, and approach to handling inmates in difficult situations. Applicants should not hold positions with other emergency-related responsibilities (e.g., commander, intelligence officer). In addition, applicants should demonstrate the following:

- Emotional maturity, ability to function under stress, and willingness to defer decisionmaking to higher authorities.
- Total commitment to the department and team philosophy.
- A good job history, free of disciplinary infractions (especially excessive use of force).

Diversity

Emergency team composition should reflect the importance of diversity as a workforce issue. Hostage negotiation teams traditionally recruit for diversity (i.e., participation by women and minorities) because it is well established that in some situations a female negotiator, for example, may be effective where a male negotiator will not. However, some tactical teams have not wanted diversity—especially if the department has not emphasized diversity in its overall recruiting and selection practices. A tactical team's mission may place extraordinary physical demands on members. If that is the case, the department should specify those demands and the related selection requirements. However, departments should eliminate any membership requirements that are not essential and that tend to work against diversity of team membership (a minimum height requirement, for example).

To select the right type of employee for membership on an emergency team, psychological evaluations may be conducted. However, a psychological evaluation may not be helpful if a thorough evaluation and background investigation of the employee are conducted. The question is whether a psychological evaluation adds value to

the selection process. If an employee has a clean work history of several years with the department and is in all other ways well qualified, should that employee be eliminated because of a score on, say, the Minnesota Multiphasic Personality Inventory (MMPI)? On the other hand, psychological testing sends an unmistakable message about the importance the department places on psychological stability in these positions. This is not an open-and-shut decision and is one of the reasons a time period should be established before a new employee can apply to become a member of the team. That allows the supervisor and the administration to focus on the employee's behavior and attitude rather than on a test that may or may not predict that behavior and attitude.

Tactical Teams

The Importance of Strong Management

The best tactical teams have a most impressive degree of professionalism in addition to their technical skills. Even tactical teams that have not been well equipped or thoroughly trained have sometimes been able to resolve life-and-death situations because of their bravery and commitment. However, of the three types of emergency teams, tactical teams present the greatest risk for management. There are many well-documented situations in which a tactical team has embarrassed its agency, or worse. Tactical teams have engaged in and covered up excessive or unauthorized use of force, worn unauthorized uniforms and carried unauthorized equipment, harassed and provoked inmate populations, alienated themselves from the rest of the correctional work staff, threatened to quit en masse if they did not get their way (and carried out the threat), conspired to create false overtime or training records, created incidents that made front-page news, and initiated incidents that led to court judgments or settlements in six and seven figures.

Why are problems with tactical teams so frequent and so serious? The answer is simple: inadequate management or, more frequently, complete lack of management. Tactical teams require strong, active management in addition to strong leadership. The team leader's role is crucial, but the leader is a member of the team and cannot also be its manager. Some administrators fail to actively manage the tactical team because they lack the necessary technical background and feel intimidated by the team. Other administrators are themselves "wannabe" tactical team members and go too far in trying to please the team. Regardless of the underlying reason, if top management at the institutional and departmental levels is not actively involved in directing the tactical team, serious problems are inevitable.

Ideally, management would start from scratch with its tactical team, defining and planning the mission, philosophy, structure, leadership, training, incentives, and management oversight. In most departments, however, tactical teams have been around for years and are not the result of an analytic process. A team may have been the pet project of a well-known (and long since departed) administrator, or it may have simply managed to stay beneath management's radar until a well-publicized incident places it in the spotlight. If a department or institution does not have the opportunity to design its tactical teams, it needs to work with existing teams to ensure their professionalism and effectiveness.

Team Culture

A clear understanding of mission and philosophy—shared by the team members and leader, institutional managers, and department administrators—is fundamental for any tactical team. Managers can and should insist on a tactical team that reflects the values of the overall agency rather than behaving as a rogue "organization-within-an-organization." An example from the law enforcement field illustrates the difference.

Why Management Matters

Management presence and involvement are essential in properly maintaining a tactical team. Even if team leadership is excellent, management involvement is important for several reasons:

- Motivates team members.
- Provides opportunities for the manager to transmit personal values directly to the team and reinforce the values of the organization.
- Allows the manager to personally assess the team's style, culture, and tone—without the team leader's "filter."
- Refines the manager's knowledge of the team's capacities, equipment, training, and procedures—knowledge that may prove invaluable in an emergency.
- Establishes an informal open-door between the manager and individual team members.

One of the authors worked on a project involving a large police department and a large sheriff's office in the same county. At the time, the police tactical team had been on many consecutive assignments in which no shots were fired, and the team took great pride in that record. Conversely, the sheriff's tactical team regarded any assignment in which no shots were fired or force used as frustration or failure. The two teams, which were similar in terms of equipment, staffing size, training hours, and budget, had totally different levels of professionalism, as reflected in their attitudes, appearance, language, demeanor, and more subtle attributes.

Management has many ways of defining the culture and professionalism of its tactical teams. In addition to emphasizing a positive, professional statement of team mission, philosophy, and values, management must also scrutinize leadership, selection, and training.

In sheriff's jails it is common to find that the CERT/SORT team is part of the patrol division and that its orientation is focused entirely on "street" situations. If that same team is to serve as the jail's tactical team, it is imperative the team members become familiar with the jail and that some of the team's training and exercises reflect jail situations. These same principles will apply to hostage negotiation teams.

Leadership

Managers of correctional facilities tend to think that the tactical team leader should be one of the physically toughest officers in the institution. Often, however, such an officer may not be the best candidate for the job. Integrity, character, judgment, and intelligence are more important qualities for the tactical team leader than physical strength, familiarity with weapons, or training in martial arts. The leader must be able to deal rationally with team members' pressures to use heavier weaponry, make the team more elite, increase shooting time during training, engage in "wilder" training simulations, etc. It takes character not to bow to such pressures to appear tough and loyal to the team.

Elitism and Anonymity: The Twin Scourges of Tactical Teams

The twin scourges of tactical teams are elitism and anonymity. A good tactical team will have strong identity, cohesiveness, and pride. However, these must not be achieved by team members setting themselves apart from the rest of the workforce. This can be a difficult balance to maintain.

There is nothing wrong with an identifying patch on the uniform, or a ribbon or the like. More than one identifying insignia on the uniform should sound warning bells, and different uniforms should not be permitted unless they are a necessity during training or during actual assignments. If that is true, then the different uniforms should be worn for training only or when on assignment as part of the tactical team; the rest of the time, the members of the tactical team should wear the same uniform as other officers.

Similarly, it is not a good idea to organize tactical teams in such a way that between tactical assignments they perform other specialized duties as a team. Although this is a common way to operate a tactical team, team members do not do "regular" correctional officer work, elitism is hard to control, and team members get comfortable talking tough to inmates from behind smoked-glass helmet visors.

As a manager, you know you are in trouble when you notice that your tactical team uniforms are black (the rest of the department wears gray and green) and they rather resemble Ninja outfits. Another bad sign is when the team seems to spend most of its time in its basement ready-room, telling apocryphal stories, talking "trash" about other staff, and otherwise being "special."

A mark of a good tactical team is support for accountability as a team and as individuals. However, tactical team members often resist the idea of individual accountability, usually by pushing for anonymity. Team members may argue against having their names stenciled on helmets or jumpsuits as is done for other staff, claiming that inmates will retaliate against them after an incident. Team members may even rebuff the idea of using identification numbers or letters on their uniforms. If a manager permits anonymity, a team member may escape accountability for even the most blatant malfeasance. Perhaps more importantly, when team members know they are identifiable and accountable, it often works as a deterrent, preventing problem behaviors.

Training

Training tactical teams is a tricky business. Training needs to instill a set of values in team members, prepare them for the dangers they face (without making them paranoid), and develop multiple skills.

If possible, a department should conduct its own training for tactical team members. Too often, external training will not reflect the department's values and needs. Even if a department has a policy stating that any contradictions between external training practices and departmental expectations will be resolved in favor of the latter, external training can be more detrimental than helpful. For example, in the early 2000s, a Midwestern state DOC was sending its tactical team members to a larger neighboring state for initial training at a "CERT Academy." After complaints from new team members that the training was sometimes abusive and humiliating, and after managers observed that the new team members had developed an extreme, military combatant philosophy, the department committed the time, money, and other resources to develop its own tactical team training.

Training should not focus on terrorist incidents. It should not be "warmed over" police training. Nor should it be designed to make team members paranoid. Rather, tactical team training should be practical and varied. It should emphasize skill building, discretionary decisionmaking, and professionalism. Exercises and simulations should reflect the range of crises, emergencies, and disasters that the jail might realistically expect to confront.

The initial training for tactical team members is especially important. If new team members receive training that sets false expectations, the team probably will develop a culture that is not what management wants and needs. Initial training for tactical team members is not Marine boot camp. It should not include hazing. Instructors should not scream at, swear at, intimidate, or otherwise demean trainees. Unnecessarily harsh treatment does not develop mature, thoughtful, independent decisionmakers. Initial training for new tactical team members should always begin with a strong emphasis on ethics and professionalism and then establish the mission and philosophy of the tactical team and how that supports the mission of the institution and department. Initial training can then go on to develop basic skills, communication methods, contingency plan familiarity, and weapons proficiency.

Tactical team members need a high level of competence with a relatively broad range of skills. In addition to physical fitness (and, for CERT/SORT members, weapons training), teams must know how to use various other authorized instruments of force and/or chemical agents. Tactical team members typically need a higher level of training in CPR, first aid, and HAZMAT procedures than other staff. Their training often also includes mass arrest techniques and various formations and disturbance control procedures. Their firearms training should go beyond qualifying scores on the firing range to include weapons familiarity, "shoot/don't shoot" contingent decisionmaking, and overall use-of-force policy. Tactical team members also need substantial understanding of tactics and strategies in crisis situations.

Incentives

Most tactical team members are highly motivated with regard to their team duties. Typically, that is true even for bad tactical teams, although there are certainly some exceptions. Many tactical team members would serve gladly without any incentives; however, management should still attempt to provide incentives, both to attract qualified applicants and to demonstrate the importance management places on the team's function. The question of incentives is tricky and a matter of balance: bad decisions can lead to development of team elitism and individual prima donnas. Reasonable incentives may consist of a small pay increment, overtime for training in an agency in which overtime is rare, comp time, or other more creative solutions. If the incentives are too great, the rest of the workforce will resent them and the team may develop unrealistic expectations. On the other hand, if the incentives are trivial, team members will regard them as an insult and the agency would do better to provide no incentives at all.

Team Size and Structure

With regard to structure and function, several management issues are worthy of exploration. There is little or no consensus among tactical experts about the appropriate size and structure for tactical teams. Thus, emergency teams come in a wide variety of sizes and shapes. Teams sometimes consist of two to four subordinate squads with squad leaders, an assistant team leader, and an overall team leader. Some teams do not have squads. Where there are squads, they may have specialized functions (e.g., a chemical agent squad), or every squad may include every team function. This guide does not endorse any particular team size or structure, although it is recommended that each tactical team include a medic and a video camera operator.

The number of tactical teams and the total number of staff trained for tactical team duty will

vary with the size and geographic location of the jail. The key questions are usually "What is the minimum number of people we will need assembled for the team to be effective?" and "How long will it take to assemble that many specially trained staff?" (The same questions are, of course, equally relevant for hostage negotiation teams.) Similarly, there is no general rule about whether various emergency teams should be facility-based, or departmentwide. That decision will depend on the same set of factors described above. It is not uncommon for departments to have institution-based disturbance control teams and departmental CERT/SORT teams.

Weapons Assault and Marksman (Sniper) Capacity

A jail cannot avoid the possibility that it will need to use a weapons assault team. Similarly, it cannot deny the chance that it may need a marksman (sniper). Situations where hostage rescue teams must handle the incident using firearms are, fortunately, very rare in American correctional institutions. Situations that require the use of marksmen are far more rare. Still, either is possible. (For sheriff's jails, it may be that the patrol or enforcement side of the agency has trained marksmen/observers, in which case they will serve the jail as well). The jail that does not want to develop and maintain either of these capacities must decide in advance which law enforcement agency it would call on for that kind of help. It must then work out any policy and jurisdictional issues with that law enforcement agency. For example, if the law enforcement agency's policy requires that its tactical team commander have overall control of the entire crisis situation, that would not work for the correctional department. Such dilemmas should be resolved in advance. Further, the correctional agency should conduct joint training with the law enforcement agency to further ensure a common understanding of the working relationship and effective coordination.

Backup Planning: The Key to Handling Simultaneous Emergencies

If the department has more than one correctional facility, the department should have policies and procedures in place to govern how tactical teams will back up each other in a crisis. In general, when a team is called out, at least one other team should be called out as backup. (The same logic applies to hostage negotiation teams.) A good approach is to have all institutions agree to a predetermined backup/relief plan that goes into effect at the outset of a crisis. The plan immediately mobilizes the team at the affected institution, sends the team at the next nearest institution as backup, and places a specific team at a third institution on standby. If the department operates a single jail, the "back-up" function for emergency teams must be a part of the jail's interagency agreement. Such an arrangement can be crucial if emergencies break out at two or more institutions concurrently, which has happened on a number of occasions across the country.

Traditionally, a two-person marksman/observer (sniper) team is assigned to the hostage rescue team. Because of the architectural design of jails, this team is much more likely to be relied on to observe hostage-taker activities than to take a shot to end a situation. Marksman/observer teams generally have extensive training in accurate long-range shooting but much less training in how to observe situations and provide essential intelligence to the commander. Departments should ensure that policies and procedures are

Why Marksman Capacity Is Necessary

If a jail refuses to consider the possible (though unlikely) need for a marksman, the consequences could be dire. Here is one scenario. An inmate takes hostages, kills one or more of them, and then becomes visible in an area where a marksman could take a shot and end the situation. But the agency has no marksman on hand, either from its own staff or through arrangements with a law enforcement agency. The hostage taker then retreats out of sight and kills more hostages. The agency would find it difficult to explain (or live with) this outcome.

unmistakably clear about authorizing a shot by a marksman. Similarly, policy and training need to be clear and consistent about how long the two-person team can be in place before being relieved by another team and about how frequently the marksman and observer should switch roles. (It is well established that snipers must be cross-trained for both positions and that one should not remain "over the gun" for very long—usually a matter of minutes—at a time.) These details and procedural issues, although not treated comprehensively here, require consideration in great detail.

Hostage Negotiation Teams

Team Size and Structure

Like tactical teams, hostage negotiation teams come in many varieties. A team may have two to seven members, or even more. (Here, "team" refers to the actual working group assembled to deal with a specific hostage situation, not to the total number of trained negotiators available to the department or institution.) Often, the size and structure of a negotiation team reflect recommendations that original negotiators received during their initial training. When this is the case, the administration and the negotiators may be unaware of the major differences among various approaches to negotiator training, and the department probably has never considered alternatives to the current structure of its negotiation team.

The most crucial negotiating functions are almost always handled by a two-person unit: the active negotiator (or "negotiator one") and the coach (also called the "passive negotiator" or "negotiator two"). The team may also include an intelligence officer, a communications officer, a recorder, and other positions. It must be clear that all other positions exist to support the two team members—the active negotiator and coach—who are conducting the actual negotiations with the hostage takers. All team members must be cross-trained, so that the first two who arrive on the scene and are briefed can immediately make contact with the hostage takers, without waiting for the rest of the team to assemble.

Reporting Relationships

In hostage negotiations, the reporting relationship is essential. The hostage negotiation team must report directly to the situation commander. Not long ago, law enforcement hostage negotiators often were attached to the tactical team and reported to the tactical team's commander. Fortunately, that is no longer common, and one has to look no further than the FBI handling of the Branch Davidian siege at Waco, TX, for compelling evidence. To weigh options for resolution as carefully as possible, the situation commander must receive information firsthand from both the hostage negotiation team and the tactical team. Even with a coequal reporting structure, commanders have a strong tendency to rely on the tactical team over the negotiating

team. A number of factors play into this tendency: Tactical information is often more dramatic than negotiation updates, and planning for an assault and dynamic entry can be very seductive. Unlike on television and in the movies, real-life hostage negotiations are often lengthy, "two steps forward, one step backward" affairs. Finally, most people's gut reaction to a serious hostage incident is that it will not be resolved by talking. If, in addition to these factors, the hostage negotiation team reports to the commander through a tactical team leader, negotiation most certainly will receive short shrift as a realistic alternative for resolving the crisis.

A great deal of attention has rightfully been placed on the rapport and chemistry that develops between the negotiators and the hostage takers. However, the chemistry between the commander and the negotiators is also important, and that is often ignored. There is a good reason why modern hostage phones have provision for a remote speaker or earphones in the command post. At some points in a hostage situation, there may be no adequate substitute for allowing the commander to listen to the tone and quality of the negotiations firsthand. The same logic suggests that the commander needs unfiltered access to the pair of negotiators. Most departments that rely on two-person negotiator teams do not use a negotiation team leader concept. However, departments that use five-person, seven-person, or larger hostage negotiation teams typically do include the position of team leader. Where there is a team leader, he or she may report to the command post. If the commander's information about the negotiations always comes by way of a team leader, then it will reflect that person's judgments, values, and subjective perceptions to some unknown degree.

The Stockholm Syndrome

The phenomenon in which hostages begin to identify with their captors, and vice versa—the so-called "Stockholm Syndrome"—is well documented. This syndrome can also have a profound impact on hostage negotiators. Part of the negotiation coach's role is to make sure the active negotiator does not overidentify with the hostage takers. If the department uses a team leader position, that individual is also responsible for making sure that the two-person negotiating team is not "losing distance." However, the commander bears the ultimate responsibility for determining whether the negotiating team is overidentifying with the hostage takers and beginning to blur its allegiances. That is an important reason for the commander to assess negotiations firsthand.

Training

Too often, a department or an institution decides to have a team of hostage negotiators, chooses the team members, arranges for their initial training, and then forgets they exist. With promotions, transfers, and retirements, the list identifying which negotiators are available at which institutions becomes increasingly inaccurate over time. If the department or institution is fortunate enough not to have any situations requiring a hostage negotiation team, individuals on the list may grow cynical and bitter about their decision to volunteer and about the effort they put into their initial training. In other words, they may burn out without ever having taken part in a hostage negotiation. Perhaps more importantly, if a hostage situation arises 3 years after the initial training, the negotiation team is unlikely to be able to perform in accordance with that training. Hostage negotiators do not need as much (or as frequent) refresher training as tactical teams, but they do need regular, serious, well-planned refresher training.

Conducting some hostage incident simulations or full-scale exercises that provide training for both the negotiation team and the tactical team is an excellent idea. However, because their training needs are different, the two teams should not always train together. Varying the outcomes of joint simulations and exercises is also important. If the sessions always end with an assault by the tactical team, negotiators will come to believe they are irrelevant at worst or a diversion at best, and the tactical team will get the wrong message—i.e., success in an emergency means a weapons assault. This state of affairs is demoralizing for the negotiating team and counterproductive for the department or institution, but it is surprisingly common.

Negotiators need experience, and because actual hostage incidents fortunately are quite rare, much of a new negotiator's experience must be achieved through training. Some of that training can take the form of having new negotiators participate in critical incidents that do not involve hostages, such as cell extractions and group confrontations. The negotiators can develop their skills in establishing rapport, communicating within limits set by the person in command, and avoiding making decisions themselves. The jail may then benefit from their increasing expertise in resolving volatile situations without violence. Some managers regard negotiator training as entirely a matter of experience ("just get used to doing it—there are no rights and wrongs, it is all judgment"). However, negotiators also need specific skills, and some of their training must identify what is right and wrong, what is good, better, and best. This requires specific skill training, including rigorous critiques of actual incidents.

Communication Equipment

The hostage negotiation team's most basic equipment is the hostage phone. Many kinds of phones are available, including throw phones (the handset or part of a hostage phone sent or thrown into the hostage situation to be used by the hostage takers), phones with recording capabilities, phones that make it possible to hear and/or see what is happening inside the hostage area, and phones that can detect chemical agents. Prices for hostage phones vary widely, but none are cheap.

In selecting a hostage phone system, a department must decide what capabilities it needs and what funds are available. Ideally, the phone system is easily operated, requires minimum maintenance, can record conversations, and can be used as a freestanding phone or connected to the institutional phone system. Other capabilities such as listening devices and cameras can be helpful, but they are not necessary for successful negotiations. In fact, some agencies have found that additional technologies increase the likelihood that the phone will malfunction.

If an agency purchases technologically sophisticated hostage phones, it must be able to deploy this equipment quickly to any institution. More importantly, hostage negotiators must train with the equipment to the point that its use becomes second nature and "transparent" (i.e., the negotiators can "look through" the equipment and focus entirely on the hostage takers at the other end of the line).

Incentives

Negotiation teams, like tactical teams, deserve recognition and incentives. Compared with tactical teams, the negotiators' assignment is more reflective, and their motivation may be more internal and less dependent on *esprit de corps.* Whereas management must watch that tactical team identity does not go overboard, the challenge with the negotiation team is to develop cohesiveness and pride. Despite the differences between the two teams, management often can use the same types of incentives for both (see "Incentives" in the section on tactical

teams). As with tactical teams, management's involvement constitutes a strong incentive for negotiation teams to perform well, and it also keeps management in touch with the team's capacities and limits.

Crisis Intervention Teams

Crisis intervention teams are not as common as tactical or hostage negotiation teams, but they are quickly coming into wider use. These teams vary far more in structure, mission, and procedures than the other two types of teams. In some departments, consultants or local mental health professionals, rather than a staff team, primarily fulfill the crisis intervention function.

The starting point in developing a crisis intervention team is to define its mission and specify how and when the team will operate. This entails answering a number of questions:

- Will the team screen employees for post-traumatic stress disorder (PTSD) after an incident?
- Will the team treat PTSD?
- Will the team interview (debrief) involved staff after an incident, to give staff someone to talk with?
- Will team members refer to or coordinate with professional resources?
- Do the psychology and psychiatry staff who work with inmates have a role in the crisis intervention team?
- Is it mandatory or voluntary for staff to see the crisis intervention team or a team member after an incident?
- Can the team guarantee anonymity?
- When is the team mobilized—at the outset of a crisis, in the midst of a crisis, or after a crisis has been resolved?

These questions have important implications. Although detailed answers are beyond the scope of this section, some recommendations are in order.

Recommendations

After a large-scale jail crisis or other potentially traumatic event, psychological screening for staff should be mandatory. However, psychological treatment should be voluntary. That is, the department has a right to ensure that staff are able to work. It has a responsibility to determine whether some staff need professional assistance and provide related information to the staff involved. However, it is the right of individual staff to decide whether to accept treatment and to determine what kind of treatment they will receive, just as would be true of a medical situation.

In most jurisdictions, uniformed correctional staff will need an alternative to a local or state employee assistance program (EAP) for assistance after a crisis. Some staff will not use the EAP even if their need is acute. They may question the program's confidentiality or they may want to deal with professionals who have experience in a correctional environment. Uniformed staff also may be unwilling to accept treatment from professional staff who treat inmates. However, some jurisdictions have had success with this approach when front-line staff and supervisors acknowledge the credibility and expertise of treatment staff.

A few more specific recommendations may prove useful:

- The crisis intervention team's mission is best defined broadly.
- The team's mandate should include both staff and their families.
- The team should be mobilized at the outset of a crisis or a major emergency, not after it is over.

- Team members should have no other specialized role in emergency response.
- Attention to ethics and confidentiality is crucial for crisis intervention teams and must be strict and ongoing.

As with hostage negotiation teams, crisis intervention teams typically are more effective when they are used frequently, in a broad range of situations. Thus, it makes sense to extend the use of crisis intervention teams from traumatic incidents and major emergencies to day-to-day situations involving staff trauma and crisis (e.g., a terminally ill staff member). Clearly, however, a team of this kind can be crucially important both to staff and staff families during a critical incident and in its aftermath.

Conclusion

As noted at the beginning of this section, jail emergency teams—tactical, hostage negotiation, and crisis intervention—all deal with life-and-death matters. Properly managed, these teams save lives and offer correctional staff paths for recognition and professional growth. The issues discussed in this section provide institutional and departmental leaders with food for thought in managing these emergency teams so as to ensure that they make a positive, professional, and effective contribution to the department.

Section 6

Case Studies

In This Section

Exhibits

Maury County Jail Fire

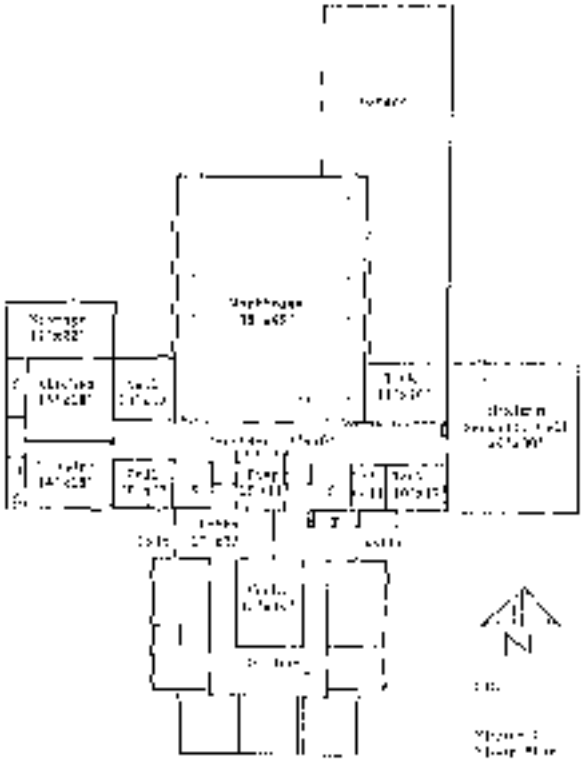
Maury County is a rural area in middle Tennessee. The county seat is Columbia, TN, a city with a population of 38,000, approximately 45 miles south of Nashville.

On Sunday, June 26, 1977, a fire broke out in a padded cell in the Maury County Jail in Columbia. The jail was just under 12,000 square feet and was rated for 58 inmates. On the day of the fire, the population was at 40. There were 42 fatalities from that fire—33 prisoners and 9 visitors. Twenty-nine others were injured.

The Maury County Jail was originally built in the 1960s, opening in 1964. It was a single-story building in the shape of a cross with four wings. The north wing of the building was referred to as "the workhouse" and consisted of five single cells on each side of the area. Steel picnic tables were fixed to the poured-concrete floor in the center area, referred to as the dayroom The entire perimeter was a walking corridor, separated from the workhouse by heavy iron or steel fencing. The roof of the jail was 4-inch-thick, steel-reinforced poured concrete. The workhouse ceiling was below the building's roof deck and comprised of heavy fencing material as well. The workhouse was used primarily for trusty housing.

The south wing of the jail was given entirely to administrative offices and some mechanical areas. The west wing included the kitchen, the laundry, and two maximum-security, two-person cells. These cells were of the same construction and layout as other cells in the jail but were highly visible because of their location on either side of the main jail corridor. The east wing of the jail included a single padded cell for agitated or disruptive inmates, and it was also used when juveniles were locked up. The east wing also had a restricted drunk tank intended primarily for combative drunks, but that area could also be used for juveniles if necessary. Finally, the east wing also had the main large drunk tank,

Exhibit 6–1 Maury County Jail



an open area the size of three or four cells with a floor drain, and two eight-person cells, one of which was medium-security male and the other designated for the female housing area (a diagram of the jail as it existed at the time of the fire is provided as exhibit 6–1). A dispatch office was at the center of the cross, with reasonably good visibility into cell areas.

Although the jail did have portable fire extinguishers, there were no smoke detectors, sprinklers or other type of automatic extinguishing system, and no fire alarm system of any type. Also, and there was no emergency lighting and fire exit routes were not posted within the jail.

Sunday was visitation day in the jail, and trusties were free to visit with family members in the outer lobby or on the grass outside the jail. The standard procedure for visitors was to enter the jail and then walk down either the main corridor or the corridor forming the perimeter to the workhouse area until they were in front of the cell or housing area holding the inmate they wished to visit. Visitors would then stand in the corridor visiting and often pass food, cigarettes, and sometimes contraband to the inmate they were talking to through the steel bars or grating.

Jail deputies operated all cell doors in the jail individually and manually, although they could also operate them from remote locations. That is, a jail deputy could lock and unlock a cell door in the workhouse from an area outside the workhouse, but the deputy required a key and could operate only one cell at a time. There were only two sets of jail keys. The Sunday in question, the sheriff had one of those sets with him when he went to church and afterward, when he went to dinner at a restaurant about 20 miles outside of Columbia. There were no cell phones at the time and the restaurant the sheriff was at happened to be in an area that was out of radio range from the jail and the sheriff's headquarters.

The jail typically was staffed by two deputies on each shift. (The total staff of the sheriff's office numbered 14.) It is likely there were times when a single deputy may have been responsible for the entire jail, but that was not the case on June 26, 1977—two deputies were on duty. The sheriff had a chief deputy within his organization, but no one was specifically responsible for the jail. On any given shift, the senior of the two staff assigned to the jail typically would be in charge. The operation of the sheriff's office was more ad hoc and informal than policy-driven in those days. For example, there was little designated patrol or "preventative patrol" in the community; instead, the sheriff's office responded primarily when they received calls. Further, the sheriff's office had no reserve deputy program at that time. The county-wide picture was of elected officials in a largely political patronage system. There was no civil service system and all employees in the sheriff's office were "at will" and appointed. The rest of the county political organizations were similarly based on patronage.

Visiting began that Sunday at approximately 12:30 p.m. The jail's padded cell held a 16-year-old juvenile male runaway from Wisconsin who had been picked up hitchhiking on the highway outside of town. He had no visitors, but he asked other visitors in the hall outside his cell for cigarettes and matches. A visitor gave him several cigarettes and a book of matches. The juvenile then attempted to set fire to the padding of his cell.

The cell walls were concrete and went all the way up to the concrete roof deck of the building but the walls were covered from the floor to about the 6-foot mark with padded foam. The foam was backed by plywood and protected by nylon-reinforced material over the front of the foam itself. This foam also covered the inside of the cell door. The foam padding was labeled "fire retardant." The foam was approximately 4 inches thick. Evidently, the foam and its covering

material had been repaired at least twice since the original construction. Laboratory tests conducted after the fire found that the original foam was butadiene-styrene, and the original covering material was neoprene with nylon reinforcement. The foam used in the later repairs was polyurethane and the covering for the repairs was a PVC material with nylon reinforcement. Research indicated that no appropriate test methods or performance criteria existed at that time for evaluating foam materials for fire resistance.

The juvenile's first few attempts to set fire to the foam padding failed, but after three or four tries the matches were successful in setting the material afire. Once started, the fire spread very quickly. The material burned almost explosively, with an audible roar, and at least one witness described it as burning "like gunpowder."

Once the fire started, the juvenile tried to move away from the intense heat and fell to his hands and knees and began yelling. Initially no one paid attention because yelling was not uncommon in the jail. Very soon, the juvenile was screaming at the top of his lungs and a thick plume of black smoke was coming out of the padded cell.

The heating and ventilation system in the jail had no dampers built into the ducts. (In fact, it was this fire that led to a requirement for dampers in HVAC systems, a requirement that is now almost universal in modern fire standards and building codes.) There happened to be an intake air supply grill high on a corridor wall very close to the door of the padded cell. Witnesses described watching the thick plume of black smoke coming out of the padded cell go directly into the air supply duct. The thick black smoke was then pumped out of vents throughout the jail.

A deputy reached the padded cell quickly and was able to open the door, pull the juvenile out, and drag him through the jail corridor and out the door into the outer lobby to safety. The juvenile survived with only second-degree burns.

While dragging the juvenile to safety, the deputy was jostled by visitors trying to run through the corridor and find safety; in the process the deputy dropped the only available set of jail keys. They slid across the floor, and in the darkened atmosphere created by the smoke, they were not relocated. All five of the cell area doors had to be opened to release the inmates, and none were.

When the fire began, none of the visitors was much more than 50 feet from the door to the main corridor and the door from the main corridor to the outer lobby. Once in the outer lobby, the smoke was less incapacitating, and it was not difficult to get across the outer lobby and out the main jail doors to the outside and to safety. In spite of the short distance involved, many visitors were unable to escape the fire because of the speed with which the smoke filled the facility and reduced visibility to zero. One of the vivid descriptions from someone who survived the fire was that it was "like someone pulling down a black curtain."

Because most of the inmate trusties were outside the jail or in the outer lobby when the fire began, most of them survived. Fortunately, the noon feeding had been completed and laundry work was usually done in the morning, so there were no inmate workers in the laundry or kitchen areas at the outbreak of the fire. The nontrusty inmates, locked in cells and tanks, were not so lucky.

Some inmates took towels and soaked them in toilets or sinks and tried to use them to prevent smoke from entering their cells or, more commonly, to cover their heads and faces as makeshift masks. Other inmates got in the shower and turned the showers on, hoping that the flow of water would counteract or serve as a barrier to the smoke. Those tactics may have worked for a very short period of time, but the oily smoke contained not only strands of carbon and other thick particulate matter, but also cyanide. In something of a final irony, the main water intake pipe to the jail

passed through the ceiling of the padded cell. The pipe was aluminum and its joints were soldered. The extreme heat of the fire bent the pipe, and the solder turned molten. A soldered joint in that ceiling broke, and no water could reach the taps or outlets to the jail. When firefighters and other emergency personnel finally did gain access to the jail, they found inmates huddled in the corners of showers, wrapped with towels. All were covered with the fire's black oily residue. Thirty-three of the forty inmates in the jail that day perished. All of the fatalities from the fire were due to smoke inhalation.

Sheriff's personnel tried unsuccessfully to contact the sheriff. He had left word about his restaurant destination and, when he could not be reached, someone was sent to find him and bring him back to Columbia. Even if the sheriff had been somewhere in the downtown area in Columbia, it almost certainly would have made no difference in the outcome of the fire. All of the fatalities probably occurred within 3 to 4 minutes of the first recognition of the fire.

Fire personnel had responded almost immediately upon being called. (The city fire station was only two blocks away.) The breathing apparatus that they were using allowed only 2 to 4 minutes of breathing time in a smoke-filled environment. With no keys and no visibility, fire fighters were stymied from any comprehensive attempt at rescue. When fire fighters and emergency personnel first arrived on the scene, they were able to rescue a few visitors—those who had not been completely overcome by the smoke but were moving around inside the building trying to find the exit door and those who had found corners or other areas where the smoke was not as thick.

The jail was in a heavily populated area of the city, and on this early Sunday afternoon with a lot of sirens in the air, a crowd of hundreds quickly formed across the street from the jail. One sheriff's deputy was posted with a rifle and riot gear on the roof of the building next to the jail, more as a preventative measure than to take any specific action. That aroused the ire of many in the crowd and people yelled complaints about the sheriff's office posting deputies on rooftops rather than trying to rescue people from the jail. In fact, a rescue operation was impossible.

Fire personnel still needed access to the jail to vent the building, to extinguish the fire and to search for any potential survivors. Fire personnel went to the roof of the jail with jackhammers and tried to create venting and an entryway, but the 4-inch thick reinforced concrete stymied their efforts. After a substantial amount of time, all the jackhammers were able to accomplish was one very small hole through the roof deck. Finally, a D-9 Caterpillar was brought to the jail and successfully used to knock a large hole in the external wall of the jail and provide ready access. The fire was eventually extinguished by hose lines run down the main jail corridor and by a hose stream from the roof directed into a roof vent of the padded cell.

Columbia, TN, is a small town today, and it was smaller at the time of the fire; it seemed that everyone knew people who had been killed or injured. In the aftermath of the fire, immediate public reaction was one of shock and horror. Surprisingly, some of the community reaction quickly hardened into "Well, if they hadn't gone to jail they wouldn't have had that problem." Perhaps that was part of the community's psychological defense mechanism, but that is speculation. In reality, of the 40 inmates in the jail at the time of the fire, only 1 was a serious criminal.

The other 39 were alcoholics, bad check writers, fathers who had failed to pay child support, and the like. And, of course, there was one runaway juvenile.

There was no critical incident review or comprehensive inquiry. There were many lawsuits. One of the only things that went right for Maury County about the whole situation was that their insurance turned out to be first rate and covered almost all of the damage as well as almost all of the costs of the civil suits. The extent of the costs is unknown because many of the civil suits were settled prior to trial and with confidentiality clauses or sealed agreements under court jurisdiction. Unfortunately, the manufacturer of the foam padding (labeled "fire retardant") that had burned so vigorously and produced the toxic smoke could not be held liable because there were no relevant consumer protection statutes that could be applied to the facts of the case at that time. In short, there were no laws then about misrepresentation in labeling material.

A few comments are in order by way of epilogue. The sheriff did not receive great criticism in the aftermath of the fire and continued successfully as sheriff. As this case study was written, he had been retired and continued to live in Maury County. The jail building where the fire occurred continues to stand in Maury County and is today the home of the County Government archives. On the 25th anniversary of the fire, the Maury County historian prepared a retrospective newspaper article about the fire. He located a phone number for, and called the individual who had started the fire. When the county historian identified himself and said he wanted to ask about the jail fire, the individual hung up.

Lessons Learned

1. A relatively small fire can kill a large number of people. (LJ I.C.8.b) (SJ II.A.7)

2. A relatively small and localized fire can fill a large building with life-threatening smoke in 2 or 3 minutes.

3. The smoke a fire produces can almost immediately reduce visibility within a building to zero, so exit routes that may appear easily accessible can no longer be found. (LJ XII.D.8) (SJ I.D.4)

4. In jails and prisons, backup sets of emergency keys must be quickly accessible at all times on all shifts. (LJ XV.G) (SJ VI.F)

5. There is no substitute for realistic, full evacuation fire drills. Staff must prove they can successfully evacuate all inmates from a building filling with smoke, and they must know how long the evacuation will take. Then they must practice regularly. (LJ XV.F.4–XV.F.6) (SJ I.D.4)

6. The fact that a building is constructed of concrete and steel does not mean that lethal fires cannot occur. (LJ XV.F.12.a,b) (SJ II.A.7)

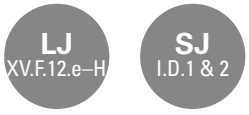
7. Controlling the type of combustible loading ("fire loading") in a building may be more important than source of ignition. (LJ XV.F.12.b) (SJ II.A.7)

8. Realistic jail fire plans must include provisions for emergency access from the outside by fire department personnel. (LJ XV.F.11) (SJ III.D)

Note: LJ = Checklist for Larger Jails
SJ = Checklist for Smaller Jails

9. Jail staffing at all hours must be adequate to effect an immediate and complete building evacuation.

10. Lifelines and utilities can fail, including those that may be relied upon to prevent or help suppress fires (in this case, the main water supply). Jails cannot rely on mechanical, electrical, or electronic systems of fire detection or fire suppression completely (for example, an electrical short that has itself incapacitated smoke ejectors may cause an electrical fire that produces thick smoke).



Disturbance and Escape at a New Direct Supervision Jail*

Rensselaer County, NY, began studying alternatives for a new jail in 1987. In 1990, the county legislature committed to build a new, direct supervision jail designed to hold 238 inmates. That capacity was larger than the county anticipated it would need for its own prisoners, but the county's decision was based in part on its expectation of boarding inmates from other jurisdictions to generate revenue. Approximately 18 months before the new jail opened, the sheriff appointed a five-member transition team composed exclusively of custody staff. The transition team met infrequently, but its members did attend National Institute of Corrections (NIC) training seminars on operating a direct supervision facility and opening a new jail. In October 1991, the transition team requested $241,346 to support a procedure development and training unit, but the sheriff did not support or transmit that budget request.

A new sheriff took office in January 1992. He met with the transition team on several occasions and, in March 1992, requested $100,000 to $200,000 from the county legislature for transition to the new jail. In May of 1992, a four-member transition team was assigned on a full-time basis, with the jail administrator operating as a fifth member. The team was tasked to produce, among other things, a comprehensive operations manual for the new facility and a training program for staff. The team produced an inmate handbook and preliminary, though incomplete, staff post orders. Emergency preparedness procedures were not completed until December 1992, when the facility operations manual was first sent to the printer. Thus, there were no working copies of the operations manual available to staff when the facility was completed in November 1992 or upon its opening on December 28, 1992, nor were copies available through January and February of 1993. Staff had neither training nor familiarity with the emergency procedures in the manual. The transition team was disbanded when the county's entire inmate population was transferred from the old, linear jail facility to the new building in December 1992.

The transition to the new, direct supervision jail was poorly planned, funded, and executed. Staff were unfamiliar with the new computer-based security system. Staff had little training on the operation of the new systems. Many of the computerized systems had not been tested adequately prior to the building's occupancy. Faulty door sensors and false alarms on unsecured doors led to staff frustration and alarms were frequently not reset. Key control was inadequate, and some crucial keys were unavailable to the staff at the time of the building's occupancy. For example, there was only one key available for all fire extinguisher boxes, forcing staff to leave those boxes unlocked and accessible to inmates. The sewage system was not working properly and sewage would back up into adjoining cells, leading inmates to block ventilation

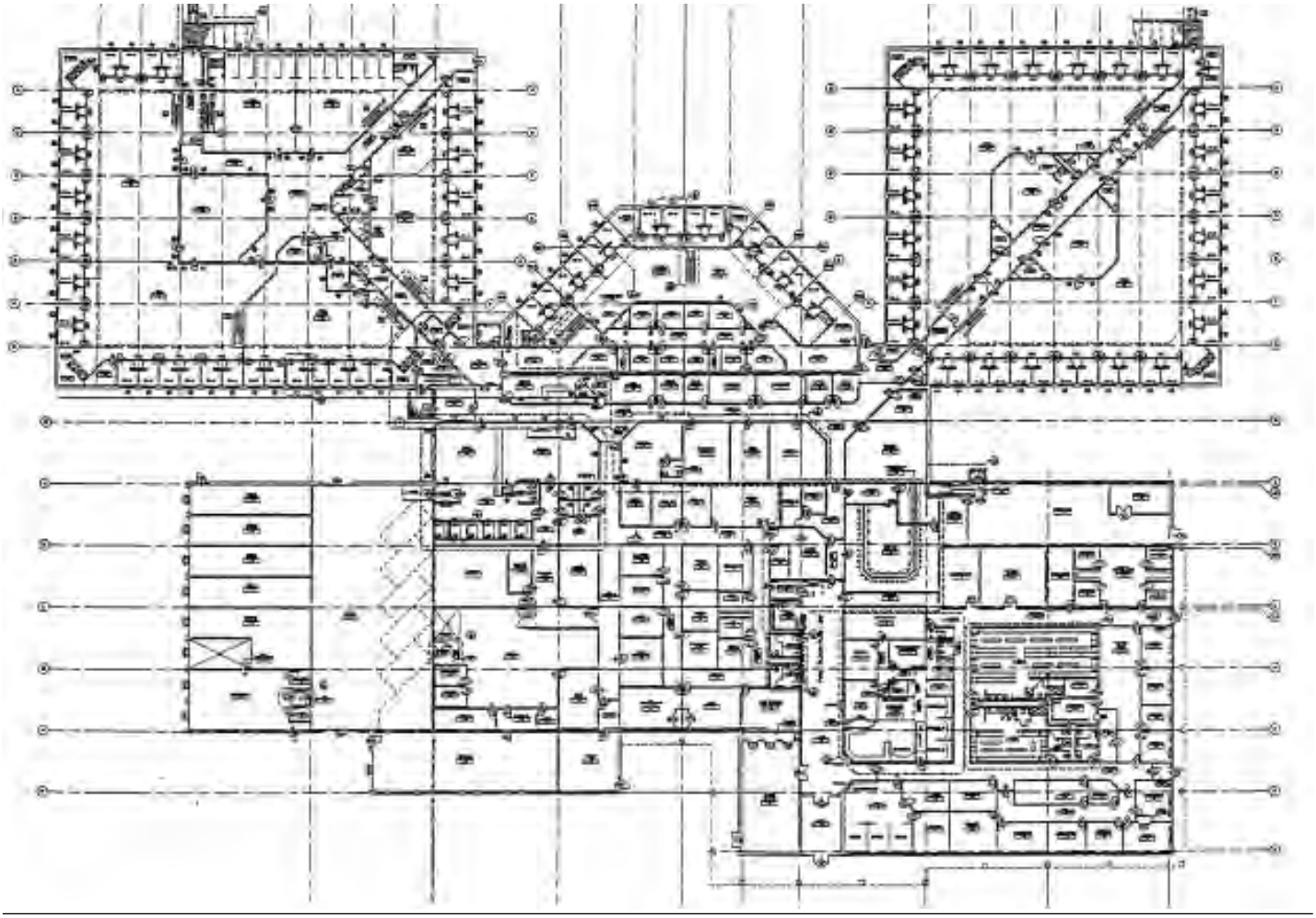
*Abstracted from "Investigation Into the Disturbance and Escape from the Rensselaer County Jail on February 14, 1993" by the New York State Commission of Corrections; June, 1993.

ducts, preventing some sewage odor but impeding adequate ventilation. No written food service procedures were available for the new jail. There were not enough uniforms for inmates—each inmate had only one uniform and was without outer clothing while that uniform was laundered. The recreation equipment planned for the new facility did not arrive by the time the building was opened, contributing to excessive inmate idleness.

Jail staff received 24 hours of training on the new facility's operation (none of that training was based on the facility's operation manual). At the time, the NIC recommendation for staff opening a new facility was 160 hours of in-service training.

At the time the new jail opened, the inmate population was 111, including 13 federal prisoners and one from another New York county. The county actively sought additional inmates for the new, larger capacity jail and had increased the number of "contract" inmates to 26 by mid February. Seventeen of the twenty-six contract inmates were federal. They posed a particular problem because they were generally longer term and higher risk than most of the county inmates, but the county had no criminal history information on the federal inmates and

Exhibit 6–2 Rensselaer County Jail



were unable to use normal classification procedures with them. Instead, the facility administrator placed most of the federal inmates in a single housing area (E-1) and the rest in a second housing area (E-2) based on his belief that it would be better to limit these inmate problems to one portion of the jail.

In January and February of 1993, the many problems that had been apparent when the new facility was populated in December 1992 continued and were largely unabated. There were other serious operational problems. The inmate grievance system was functionally inoperative and produced inmate frustration rather than problem identification or resolution. Inmate discipline was markedly inconsistent and in some cases unreasonably harsh. For example, the jail had initiated a no smoking policy in December 1992 and an inmate with contraband matches was given 30 days in segregation as was another inmate with cigarette papers and a lighter. An inmate request for outdoor smoking areas was denied, although staff were permitted to smoke outdoors on their breaks. Staff–inmate communication was poor and staff chain-of-command protocols within the new jail were noticeably inconsistent. The jail administrator met with an inmate council on a weekly basis and repeatedly assured them that major problems were being addressed, but as the weeks went on, no visible changes were apparent.

On January 15, 1993, inmates in housing area E-1 refused to lock down for morning count, complaining that the breakfast they had just been served was cold and inedible. The captain (or "facility administrator") examined the food and confirmed that the complaints were valid. The captain then directed that new breakfast meals be served. Although this confrontation ended peaceably, staff were upset that the captain had not demanded that the inmates "lock in" as a prerequisite for replacing their breakfast meals and that no disciplinary action was initiated.

On February 10, staff of the New York State Commission of Corrections were present in the jail for a training session on direct supervision. They toured the jail and interviewed inmates and staff. They found that inmate attitudes were belligerent and that staff were not touring the facility or "working the floors" but rather confined to work stations. They described officers as "overwhelmed, ineffective, and not in control of the housing areas." In providing feedback to the captain, one commission investigator specifically asked whether the captain was concerned that the jail might lose control of housing area E-1. The captain insisted there was no risk of losing control of any portion of the facility. That same day, members of the Correctional Officers Union met with members of the county legislature and complained of security problems at the facility, including lack of trustee accountability, faulty radio reception, and computer-based gate and door malfunctions. When these complaints were transmitted to the sheriff by the chairperson of the legislative subcommittee, the sheriff gave assurances that the facility was secure.

On February 11, facility managers met with shift supervisors, and the captain announced that all housing area security posts would be reassigned in 2 days, on February 13, in response to the problems observed on E-1 by commission staff. Supervisors expressed concern with the concentration of federal hardcore felony prisoners on E-1 and asked that they be dispersed among other areas. The captain refused. On February 12, an inmate informed a correctional officer that the inmates on E-2 were going to refuse to eat breakfast on Monday, February 15. The next day, the same correctional officer overheard inmates on E-2 talking about how the E-1 and E-2 inmates were going to have to "stick together." The correctional officer reported both of these incidents to supervisors. One supervisor later denied knowledge of either intelligence report. Another supervisor acknowledged receiving the report from the officer, but he said he

was unable to confirm the intelligence after interviewing an inmate and did nothing further with the information.

On Sunday, February 14, the inmate count was 154. At 6 a.m. the E-1 cell doors were opened, but few inmates left their cells. When the breakfast cart was delivered, no inmates took food trays. The inmates told the correctional officer on the unit that they were staging a boycott. The E-2 inmates also refused to eat breakfast. The sergeant on duty was advised, and he phoned the operations lieutenant, reporting that the inmates in the E-1 and E-2 units would not eat and were refusing to lock back into their rooms. By 7:15 a.m., it became clear that the 67 inmates in E-1 and E-2 were staging a sit-down demonstration. Although the 11:30 p.m. to 7:30 a.m. shift was still at the facility, and the morning shift was just coming in, neither the sergeant nor the lieutenant directed the evening shift to remain at the facility. (Had the evening shift been held at the facility and the rest of the jail locked down, there would have been approximately 23 officers and supervisors available to deal with the situation on E-1 and E-2. Investigators could later find no evidence that those alternatives were contemplated or discussed at that time.) A lockdown of the rest of the facility was not ordered. The lieutenant, on the phone from his home, told the sergeant that he would respond to the facility and that he would inform the captain. The lieutenant arrived at the facility at 7:25 a.m.

The inmates on E-1 and E-2 told staff they did not want to speak to the captain and were tired of the "lies by the administration." The captain arrived at the jail at 7:45 a.m. and was briefed. The captain did not believe a show of force was an option because staff had no protective equipment, batons, chemical agents or training in the use of chemical agents or batons. He also believed a use of force would have compromised staff with regard to their subsequent ability to manage the facility. The 8 a.m. shift change occurred and, because of the facilitywide change in assignments 2 days before, the correctional officer sent to E-1 was an individual who had a total of 6 weeks' experience as a correctional officer. At 8:20 a.m. the captain phoned the new sheriff and briefed him. He called the sheriff back 10 minutes later to report that the situation had escalated and advised that the sheriff come to the facility. The sheriff arrived at 9:56 a.m. At 9:45 a.m. the captain ordered the other housing areas locked down. The captain decided to cancel visits to E-1 and E-2 inmates at 10 a.m. and conveyed that message over the intercom. The inmate response was openly hostile and threatening. The sheriff withdrew the officers from E-1 and E-2 at 10:30 a.m., leaving that side of the jail (the east side) in control of the inmates. (The inmates had exclusive control of that housing area for almost 4 hours, from 10:30 a.m. until 2:15 p.m.) At 10:35 a.m. additional staff were ordered to the facility. At 11 a.m. the Troy Police Department was notified, but police did not establish a security perimeter around the facility nor did they establish listening or surveillance posts.

Inmates on E-1 and E-2 went on a destructive rampage, throwing furniture, destroying computer hardware, and tearing out sections of the ceiling on E-1. Damage on E-2 was less severe. The sheriff opened direct negotiations with the E-1 inmates while Troy Police Department Emergency Response Team members and correctional officers assembled into assault teams in a garage outside the facility. Water to the east side of the jail was turned off. Through an inmate in direct negotiations with the sheriff, the E-1 inmates agreed to return to their cells and the sheriff agreed to meet with a delegation of three E-1 inmates. E-1 was secured between 2 and 2:15 p.m. At 2:25 p.m., it was discovered that two unidentified inmates had escaped from E-1. E-2 inmates still had not been locked into their rooms, and they became agitated when they saw the E-1 inmates were being served

lunch at about 4:15 p.m. At about that time, the operations lieutenant and a squad of correctional officers equipped with batons went to the E-2 entrance, but the corporal in the area convinced them that he could manage the E-2 inmates and that they should leave. The E-2 inmates were given lunch and were locked into their cells at 4:40 p.m. At 8:45 p.m., the 17 federal detainees were transferred to another facility and the remaining E-1 inmates were housed in other areas of the jail.

When staff reentered E-1, inspection of damage to the mezzanine ceiling in the area revealed that a suspended ceiling had been pulled down and that a concrete block wall extending above the suspended ceiling had been breached. No inmate count had yet been initiated; a commissioned staff member recommended an emergency count be conducted immediately. Within a few minutes of staff reentry into E-1, an E-2 inmate told the operations lieutenant that two inmates had escaped from E-1. The lieutenant notified the captain and then ran outside the facility to look for clues. He found footprints in the snow leading away from a fire escape toward the fence surrounding the facility. The standard 8-foot high cyclone fence had no barbed wire or razor ribbon on top, nor did it have a cantilevered top. In short, it was not a security fence and was easy to climb. At 2:40 p.m. the Troy Police Department was notified of the escape. At 3 p.m. the emergency count revealed the identities of the two escaped inmates. Commission investigators reconstructed the escape and estimated that it had occurred at approximately 12:50 p.m., about 2 hours earlier than the notifications.

After pulling down suspended ceiling panels, inmates saw that the cement block wall did not extend to the roof but that there was a 2- to 3-inch gap filled with fiberglass insulation. Inmates then used a fire extinguisher tank and a mop wringer to knock out the ceiling panels, loosen the cement blocks and remove them. The breach in the ceiling wall then led to a mechanical equipment chase that led to an access corridor and a fire escape door. The fire escape door had a built-in alarm, but it was not working. Inmates in control of E-1 and E-2 had tampered with computer equipment and produced a steady malfunction alarm during the insurrection. The system could have been reset with a single command, but most correctional staff were not familiar with that procedure.

In examining the escape site, it became obvious that the cement block wall in the ceiling that had been breached for the escape had neither reinforcing steel nor poured concrete, although it was a key portion of the only secure perimeter. Records revealed that the jail had originally been designed with reinforced concrete walls in the mezzanine ceilings of the housing areas. However, when the county required the design group to reduce the cost of the new facility by approximately 5 percent (from $22.8 to $21.8 million), one of the cost-cutting measures agreed to by the county engineer, the architects, and designers was to forgo reinforcement of those walls. That change accounted for a specific savings of $72,000. When the construction was actually bid, the winning bid for the new facility was approximately $17 million but none of the cost reduction measures were then added back into the modified design. An additional post-escape finding was that one of the two federal inmates who had escaped was known to be a high-escape risk, with a prior felony conviction for escape, but that information had never been made available to the county jail. Fortunately, both inmates were apprehended relatively quickly—one the next day, on February 15th, and the other, 2 days later.

Lessons Learned

1. Planning to open a new correctional facility is a lengthy, complex, and demanding task. Planning failures escalate security risks in the new facility.

   LJ VII.A, D & E — SJ II.C.6

2. If a new correctional facility uses different operational concepts than existing facilities, extensive staff training is a necessity.

   LJ X — SJ II.C.6

3. A new jail should be opened and populated in stages, beginning with low-security inmates. However, none of that should be initiated before the facility has been thoroughly tested with staff walk-throughs.

   LJ I.C.13.b — SJ II.C.6

4. Emergency procedures for a new jail must be developed and staff trained to use them before the facility is opened. These emergency procedures must not be limited to situations such as fire and evacuation but must also anticipate crises involving inmate violence, such as disturbances and hostage incidents.

   LJ I.C.13.b — SJ III.C.2

5. The lure of external revenue does not compensate for accepting inmates without adequate knowledge of their backgrounds and criminal histories.

   LJ V.D & E — SJ II.B.1 & 2

6. Redundancy is a key concept in facility security. Checks and balances are built in because it is unsafe to assume that any single protective measure is infallible.

   LJ I.D

7. Emergency response must be anticipatory rather than reactionary. Extra staff should be called in during an emergency before they are needed. Do not wait until they are already needed. The same concept holds for notifying top administrators, reinforcing a facility's security perimeter, equipping staff for a show of force or an assault, etc.

   LJ VIII.A.1–5 — SJ III.C.1

8. Poor inmate–staff relations can escalate security risks sharply.

   LJ V.A.4–6 — SJ II.A.4

9. An effective inmate grievance system can be invaluable in identifying pervasive or chronic problems, and it can allow the resolution of many low-level conflicts.

   LJ V.G — SJ II.D.1 & 2

10. Poor or inadequate inmate programs and services can contribute to or cause major facility emergencies. Poor staff communication combined with management failure to respond to increasing belligerent inmate attitudes is a recipe for disaster.

    LJ V.A.5–D — SJ II.A.5

11. It is dangerous to assign the least experienced staff to supervise the most difficult inmate housing areas.

    LJ V.F.11

12. When a "sit down" develops without weapons or hostages, it makes little tactical sense to abandon the area and allow inmates to organize and escalate into a full-scale disturbance or riot (unless staff have no capacity to intervene at that time and no realistic choices).

    LJ IX.B — SJ II.A.3

Note: LJ = Checklist for Larger Jails
SJ = Checklist for Smaller Jails

13. Staff in a relatively small jail still need access to batons, chemical agents, body armor, a disturbance control team and training in the use of those. Additionally, they should have hostage negotiators or interagency agreements with surrounding law enforcement agencies to use their hostage negotiators or other mutual aid. Those mutual aid agreements should involve joint training sessions and drills or exercises on a basis specified by policy or agreement.

LJ I.C.5.b SJ IV.A

14. Shift supervisors and facility managers should be well trained in emergency preparedness procedures. In this case study, the lack of early decisionmaking about holding in the night shift and locking down the unaffected areas of the facility, along with the lengthy periods of delay in notifying the sheriff and the police, appear in retrospect to be unjustifiable.

LJ I.B.2 SJ I.C.5.a

Hurricane Andrew and the Florida Department of Corrections

On August 21, 1992, U.S. Weather Service information suggested that Tropical Storm Andrew was taking a route that might hit the Bahamas and then south Florida. The Florida Department of Corrections (DOC) sent out a teletype advising managers throughout the DOC to monitor the storm's progress. It also advised each facility within the DOC to designate a contact person in case the threat worsened. At Dade Correctional Institution (Dade CI), the superintendent directed the duty officer, the shift officer in charge (OIC), and the control room officers to monitor the storm's development by weather band radio, TV, and commercial radio.

On Saturday, August 22, the tropical storm strengthened into Hurricane Andrew. Its projected path continued to target Florida's southeast coast. At Dade CI, the superintendent and assistant superintendent went to the institution to supervise the securing of the compound. Inmate workers removed loose items from the ground and tied down or otherwise secured equipment. The superintendent also organized a contingency plan for a DOC Department heads meeting at 9 a.m. the following day to discuss evacuation plans.

On Sunday morning, the hurricane was so imminent that the state government activated its Emergency Operations Center and began to evacuate low-lying areas along the southeast coast. A meeting was called at the DOC headquarters, with key personnel beginning to prepare the facilities that were within the likely path of the hurricane. An immediate decision was made to direct a small facility in the Florida Keys—Big Pine Key Road Prison—to evacuate north to Lantana Correctional Institution. The evacuation was completed without incident over the course of the next 9 hours.

At Dade CI, the DOC heads and supervisors reported for the 9 a.m. hurricane preparation meeting. The superintendent decided to evacuate the work camp with its 293 medium- and minimum-custody inmates to the main prison unit. Two inmates were moved to a local hospital because of the seriousness of their health problems.

By midday Sunday, Hurricane Andrew carried winds of over 150 miles per hour and seemed highly probable to strike Florida at Florida City, which would subject Dade CI to the full force of the center of the hurricane. Dade CI is located 20 miles west of the coast, but it is only 6 feet above sea level. The force of hurricane winds was expected to create a coastal water surge of 12 feet or higher that could travel many miles in from the coast. At 2 p.m., the DOC decided to evacuate all inmates from Dade CI to other state institutions.

To accommodate the 1,000 inmates from Dade CI, the DOC located space at 5 other state prisons. Two of these potential transfer sites were eliminated because they were themselves close to the storm's projected path and in potential danger. The Central Florida Reception Center was added to the list of receiving institutions,

and all available transfer buses and vans within the DOC were dispatched toward Dade CI to begin transferring inmates among the following facilities: 100 inmates to Glades Correctional Institution, 150 inmates to Martin Correctional Institution, 450 inmates to the South Florida Reception Center, 250 inmates to the Central Florida Reception Center, and approximately 50 inmates to another state facility.

The DOC also decided to evacuate 76 inmates from the small Copeland Road Prison to Hendry Correctional Institution. The DOC quickly assessed the evacuation situation as a timing problem. The DOC had adequate transportation and other resources, and adequate space to house the relocated inmates on an emergency basis, but it was not immediately clear that the appropriate resources could be put in play in time to stay ahead of the approaching hurricane.

At Dade CI, classification staff began to sort inmate transfers by custody level and psychological profiles. The decision was made to move all close-custody inmates first, with minimum- and medium-security inmates to follow. Inmate folders and medical records were gathered and prepared for transporting along with the inmates. Vehicle security was arranged at the rear gate of the institution, and additional perimeter security was added. The institution's business manager provided security staff with maps outlining the travel routes to the various receiving institutions. Security staff were divided into teams for screening inmates, searching inmates, and escorting them to the departure area. As the last of the inmates were evacuated out of Dade CI, staff members at the institution began to prepare for the hurricane. Emergency supplies were gathered, and staff prepared to ride out the hurricane in the administrative offices and the medical area.

At 10:30 p.m. on Sunday, August 23, the last inmates being evacuated arrived at the Central Florida Reception Center. Approximately 1,000 inmates had been moved, all over the southern half of Florida, on short notice, without any injuries to staff or inmates and without any escapes. At Dade CI, the superintendent sent staff home to evacuate their own families. A small number of staff volunteered to stay at the institution to prevent possible looting or post-storm damage. At the South Florida Reception Center, staff were called to the institution and helped maintenance staff tie down or secure equipment that was judged vulnerable to wind damage. Food and water were stockpiled within the dormitories, and handcuffs were distributed because transport to segregation housing would not be possible during the storm.

When the hurricane hit, the storm damage was very severe at Dade CI. Sections of roof were ripped away, and the wind-driven rain soaked large areas of the facility. Windows were broken and the perimeter fence and some outbuildings were destroyed completely. At the rest of the DOC's facilities, storm damage was moderate. No other facilities were rendered uninhabitable.

Late Monday, August 24, some Dade CI staff returned to the institution from the South Florida Reception Center to try to help the remaining staff get to safety. They organized a convoy to get staff out of the institution to their own homes. The superintendent and assistant superintendent toured the institution grounds with other staff, assessing the damage, and then attempted to make contact with the DOC headquarters or another institution to request help. A correctional officer arrived from Broward Correctional Institution. He had been sent to find out the status of Dade CI and had walked 5 miles to get to the institution because of the condition of the roads.

On August 25, the day after the storm, the Secretary of Corrections, along with the Assistant Secretary for Operations and the Inspector General of the Department, arrived at Dade CI to thank the staff for their efforts in completing the evacuation and to pledge support

and assistance with the many personal problems staff were experiencing. (In addition to the institutional damage, approximately 400 DOC staff members found that their homes had been completely destroyed by the storm.)

That same day, the Civil Air Patrol established a radio communications post at the institution. The state's fire marshal arrived, and a National Guard unit set up camp on the grounds to provide perimeter security. The DOC initiated a number of recovery programs, including providing free gasoline, water, ice, clothing, food, and household goods as available to staff. The administrative building of the main unit of Dade CI was kept open as a shelter for staff and family members who were without housing. Tools, roofing materials, electric generators, etc., were made available to employees at no charge. The DOC also coordinated FEMA applications and established a toll-free number for staff and their families to use in arranging assistance.

The DOC began to identify temporary housing locations for homeless staff. It also made a major effort to coordinate the staff who were on special assignments with other institutions. The DOC coordinated donations of money to assist the 1,000 homeless staff and families.

On August 26, a meeting was held at the DOC's Central office to begin developing plans for rebuilding the Dade CI work camp and the main prison. Actual reconstruction on Dade CI and the Dade CI work camp was initiated within 48 hours after a damage assessment was complete.

Lessons Learned

1. The department's comprehensive emergency planning system provided an appropriate framework for responding to the specifics of the hurricane.

   LJ VI SJ III.C.2

2. With some emergencies, particularly with some types of natural disasters, the aftermath may be more challenging than the response to the disaster itself.

   LJ XV.J–N SJ I.C.7.a

3. No emergency is completely predictable and the sequence of events during an emergency may preclude commonly accepted response protocols. During Andrew, the uncertainty of a hurricane's path, and the risks involved in trying to evacuate large numbers of high-security inmates made it impractical to evacuate several institutions, or to evacuate days before the storm hit. This placed a huge premium upon fast, clear decisionmaking and leadership at the department level.

   LJ XIX.A SJ V.A & B

4. Staff performed admirably at many locations throughout the state, in spite of great stress on some individual staff members. Individual acts of bravery and compassion were common. Staff must give first priority to their duty to the department and the state, even in cases where their homes are threatened or the fate of loved ones is uncertain. Staff must be willing to volunteer for particularly hazardous duty, such as remaining behind and riding out the effects of a natural disaster.

   LJ XVIII.S SJ I.D.1–3

5. Inmate cooperation was apparent throughout the hurricane and its aftermath and was essential to the evacuation and to the operation of partially disabled facilities after the hurricane.

   LJ XIX SJ III.C.3

6. After disaster strikes, communication to the most seriously damaged areas of a state may initially be impossible and remain very difficult for a long time.

   LJ XVIII.T & U

Note: LJ = Checklist for Larger Jails
SJ = Checklist for Smaller Jails

7. After the hurricane, the problems of dealing with large numbers of homeless staff were more difficult in many ways, and took more creativity, than the formidable problems of repairing badly damaged facilities. An emergency plan should include a contingency for a search team in the aftermath of a disaster. Some 2 weeks after the hurricane, 22 staff from Dade CI still had not reported to the institution or the DOC. The DOC instituted search teams in a matter of days to search for the missing staff.

LJ XVIII.A.3 SJ III.G

8. Because of the difficulty in establishing communication after a natural disaster, it makes sense to establish a date, time, and place for staff to report before they leave during an evacuation. For similar reasons, it makes sense to pre-establish and disseminate a toll-free number for staff and their families to call for emergency assistance.

LJ XV.0 SJ I.C.7.a

9. A mechanism for tracking employees temporarily assigned to different facilities would be a useful addition to a department's emergency plan.

LJ XVIII.A.3

10. Unlike most flood and earthquake situations, cellular telephones may be knocked out of service by a hurricane because so many transmitter and repeater locations can be damaged over such a wide area.

LJ XIX.K SJ III.G

11. When a large-scale evacuation of inmates is anticipated, it is useful for the department to authorize an emergency inmate processing and receiving policy, so that the receiving institutions have flexibility in intake procedures.

LJ XV.K.8 & 9 SJ I.C.7.a

12. Inmate medical records should, whenever practical, accompany inmates in an evacuation to the receiving institution. As a backup, it is helpful if basic inmate medical information is available in a database or online for access from any institution.

LJ XV.K.5 SJ I.c.7.a

13. Lack of potable water will become a crisis for an institution long before food delays or cold food may produce serious problems. It is also far easier to arrange for emergency food from external sources than for quantities of potable water during a communitywide emergency. Be prepared to move food items from one facility to another and, if possible, have at least one vehicle (a 24-foot truck, for example) designated for food service use only.

LJ XII.D.17 SJ III.H

14. Emergency plans should include provisions for an expert team that can evaluate food items for contamination and spoilage in the wake of a natural disaster.

LJ VIII.L

15. A department may be in a difficult position to issue paychecks in the absence of attendance and leave records. It may also be challenging to distribute paychecks to employees in the aftermath of a communitywide disaster. In such emergencies arrangements need to be made to pay in cash rather than through paychecks. Even with electronically transferred funds, bank accounts may not be available. This was the case in Florida during the aftermath of Hurricane Andrew.

LJ XVIII.A.1

16. Emergency purchasing authority may be an absolute necessity following a large-scale disaster.

LJ XVIII.V SJ III.I

Riots at Camp Hill State Correctional Institution*

The Pennsylvania State Correctional Institution at Camp Hill was constructed in 1937 as a juvenile facility. As a result of a 1975 Attorney General ruling that Camp Hill was no longer suitable for juvenile commitments, it was designated in 1977 as an adult male institution. Camp Hill's institutional function was modified to serve as one of three diagnostic and classification centers. The prison was originally accredited and reaccredited by the Commission on Accreditation for Corrections in December 1984 and October 1987, respectively.

Six general population cell blocks were located at the southwest side of the facility. Four cell blocks located on the northeast side of the facility were used for a general population unit, a restricted housing unit, a special needs unit and a diagnostic center. Designed for juvenile offenders, the original cell walls consisted of hollow core glazed block. The walls and ceilings were not reinforced with steel stabilizing rods or mesh. Program and support service buildings—including an infirmary, eight modular dormitory units, a chapel, an education building, a food service building, a gymnasium, an auditorium, and a laundry—were located between the housing areas. Camp Hill's administrative building and central administration building for the Department of Corrections were located on the compound outside the security perimeter.

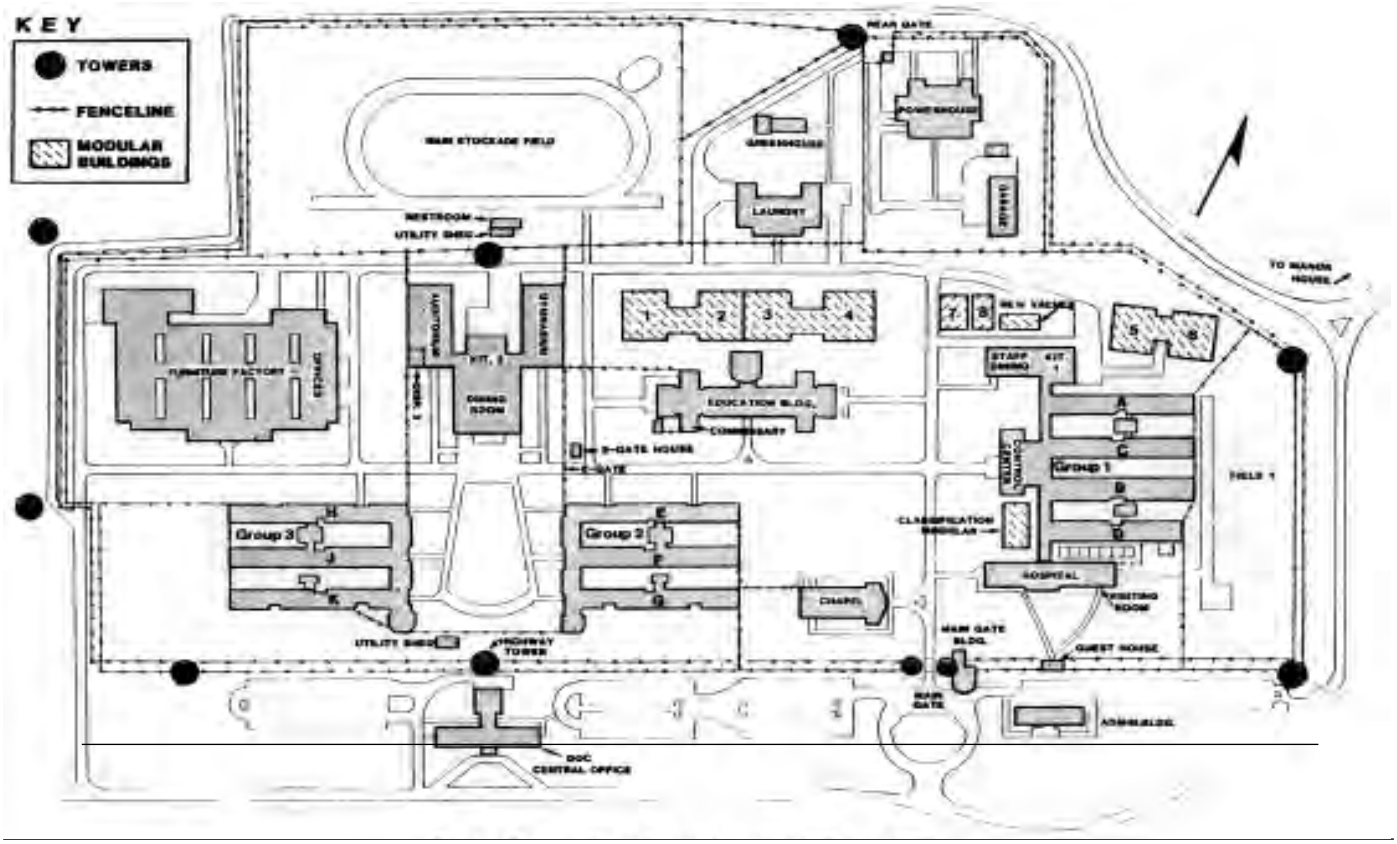
The institution consisted of 1,414 single cells in 10 different cell blocks. The rated capacity in October 1989 was 1,825 beds, but Camp Hill's population had reached an unprecedented level at 2,656. Camp Hill was severely understaffed. Resulting from the shift-bidding procedures, the 2 to 10 p.m. shift was frequently staffed with the youngest and least experienced officers. Camp Hill's staff training programs were not in compliance with accreditation standards.

Correspondence from the Camp Hill superintendent in September 1989 suggested that the administrative staff recognized the strain the growing offender population was placing on the facility. In addition to describing the level of overcrowding, the correspondence outlined short- and long-term plans and resources necessary to address the overcrowding, including increased bed space and program expansion.

Reports of an inmate disturbance at Camp Hill began to emerge in the summer of 1989. Inmates were frustrated by overcrowding, food quality, inoperative and overcrowded showers, inadequate educational and vocational opportunities because of understaffing, and limited law library privileges. Policy changes enacted in September 1989 that altered the procedures governing inmate family visiting days and sick calls further fueled inmates' frustration. In the weeks preceding the disturbance, inmates made verbal reports of a potential disturbance to several officers. The

*This case study is based on the Adams Commission [the panel charged by the Governor of Pennsylvania (PA) with examining the causes and events of the Camp Hill riots] report, now out of print; the report of the PA Attorney General's Office on those same riots, also out of print; and the NIC 1990 technical assistance report examining emergency readiness in the PA Department of Corrections by Jeffrey A. Schwartz, John Lum, and Si Mariano.

Exhibit 6–3 Camp Hill State Correctional Institution



most specific reports indicated that members of the Fruits of Islam (FOI), a Muslim sect, were attempting to organize an institutional disturbance. In addition, some staff interviewed after the disturbance noted that inmates demonstrated unusual behavior immediately before the disturbance, including changes in the dress of Muslim inmates, en masse requests for sick call, intentional misconduct by an inmate informant so he could be transferred from the general population, and reduced noise and activity by inmates in the Restricted Housing Unit. There was considerable frustration prior to the disturbance, particularly among correctional officers, which may have also contributed to the institutional unrest.

On October 25, 1989, at approximately 2:50 p.m., 3 correctional officers were moving approximately 500 inmates in the main stockade yard between housing groups 2 and 3. An inmate, without provocation, reportedly struck an officer stationed at E Gate after the officer requested to see the inmate's movement pass. Officers responding to the assault were then chased and assaulted by other inmates in the yard. Some inmates went back to housing units and began assaulting officers in the blocks. Around 4 p.m., the rioting inmates began to set fires and loot the kitchen, commissary, and auditorium, which were accessible from the main stockade yard.

Between 3 and 4 p.m., approximately 300 inmates moved about in the main stockade yard. No apparent inmate leadership was identified. At approximately 3:15 p.m., a dozen unarmed

correctional officers arrived at E Gate and remained near E Gate for almost 10 minutes until inmates sprayed them with a fire extinguisher retrieved from the cell blocks.

As the officers attempted to retreat to the control center, inmates gained access to E Gate using a key obtained from an officer taken hostage. The inmates then poured through the gate and into the compound. Three unattended vehicles were parked in an area adjacent to the education building. Officers made no attempt to remove these vehicles following the assault and subsequent disturbance in the main stockade yard. An inmate hotwired a truck and attempted to run the vehicle through an interior perimeter gate. Unsuccessful in his attempts, he drove the vehicle wildly through the main stockade field and succeeded in breaching the inner perimeter fence but not the outside perimeter fence. Through the penetrated inner fence gate, inmates gained access to the correctional industries building, which they ransacked, obtaining wood and other flammable materials that were used to set fires in the E Gate gatehouse and in a dispensary. Inmates destroyed the culinary manager's office and caused minor damage to two modular housing units, basements in two cell blocks, a kitchen, and the furniture factory. They also pillaged the commissary portion of the education building and set it on fire.

Several correctional officers who were trapped in "switch boxes" (small rooms with barred windows that serve as the cell block offices) in two cell blocks were taken hostage as inmates broke through the hollow block walls around the switch boxes. Hostages were paraded around the main stockade yard as inmates threatened to beat them with shovels and other objects. Directly below a perimeter tower, a group of inmates repeatedly beat one hostage in full view of staff watching the disturbance unfold from windows in the department's administrative building overlooking the main stockade yard. After an unspecified period of time, the tower officer fired his shotgun into the air to chase the inmates from the officer. In total, 18 officers and other institutional personnel were taken hostage.

Correctional officers, Camp Hill Correctional Emergency Response Team (CERT) members, municipal police, and approximately 100 state police gathered at the sallyport in the rear of the facility intending to move in and gain control of the modulars, education building, and commissary while allowing inmates the opportunity to get out. They established sufficient presence to regain control of E Gate. E block was reported to be seriously damaged; H block, which still had officers inside, was burning; and the four housing units in group 1 were locked down (Administrative Log, 1989). At approximately 5:05 p.m., police regained control of the education building, the chapel, and four modular units. Inmates were moved from the modular units to the main stockade yard, where a skirmish line was established to keep inmates in the yard between two housing units.

Throughout the disturbance, inmates obtained radios, cell block keys, and personal property from their hostages. Using radios and telephones, institution representatives began to negotiate with an inmate, and at approximately 6:45 p.m., a negotiation table was set up in the education building. The negotiation team consisted of six Camp Hill staff members including the deputy for treatment. The inmate negotiation team consisted of six Muslim inmates led by a known FOI leader who had previously established contact with the Control Center via radio. Inmates focused on concerns regarding overcrowding, revisions in the family day and sick line policies, medical procedures, the general condition of the facility, lack of inmate programs, and poor staff morale. Although no concessions were granted during the 2-hour negotiation session, hostages were gradually released as a sign of good faith.

At approximately 7:30 p.m., inmates began returning to their housing units for lock down pursuant to an agreement by the institution administrators to meet with inmate representatives the following day at 1 p.m.

At approximately 9 p.m., officers in a Pennsylvania State Police helicopter circling the facility where inmates had set up camps instructed them to return to their cells. At approximately 10 p.m., a large contingency of institutional and state police officers moved through E Gate and began to sweep the main stockade yard to secure the facility.

During this sweep, officers conducted pat-down searches of some inmates as they returned to the cell blocks from the adjoining exercise yards. These inmates, however, were not actively involved in the disturbance. There was no reported shakedown of cells in groups 2 and 3 where the disturbance occurred, and debris and weapons were reportedly strewn on the floors.

At 10 p.m. and again at 11 p.m., prison officials released press announcements that the facility was secured. As a result of the disturbance, 45 injuries were reported, including injuries to 36 staff, 7 inmates, 1 firefighter, and 1 state police officer.

In the early morning hours of October 26, the superintendent, the deputy and director for treatment, and the deputy for operations met to assess the damage to the facility. They decided against conducting a shakedown, in part because they believed the facility was secure and also because following a previous disturbance, staff had retaliated against inmates during a shakedown.

All was not secure, however. Officers feared that the cell door locking systems were not working following the lockdown, as they heard cell doors being opened and closed and saw several inmates out of their "secured" cells moving about the cell block between 2 and 3 a.m. on October 26. Additionally, there were reports of critical damage to the locking mechanisms in the cell blocks, as some of the security panels were removed and were lying on the floors in the blocks. The shift lieutenant reported these concerns to the captain. Supervisors and officers in the blocks suggested using padlocks and chains to secure inmates in their cells, but institution administrators rejected that recommendation.

At 1 p.m., per the agreement reached on October 25, the institution administrators met with inmate negotiators for an hour. The same concerns noted in the first night of negotiations were raised again, with the addition of poor scheduling and lack of commissary items. Though no decisions had yet been made, at 2 p.m., institution administrators ended negotiations so the superintendent could report to a prescheduled briefing at the Central Administration Building. Upon leaving the negotiations, the inmate representatives, apparently disgruntled about the lack of movement on their concerns, reportedly made verbal threats about burning the institution. Correctional officers reported these threats to their supervisors; however, it is unclear whether this information was forwarded to the administration.

Only 15 of 24 officers on the 2 p.m. to 10 p.m. shift reported for duty due to injuries sustained in the first disturbance. No officers from the previous shift were retained, and no additional officers were called to supplement the depleted officer ranks.

At 3 p.m. on October 26, institution administrators conducted a press conference for local media news. In a prepared statement, the superintendent reported that inmate negotiations had been held, that further meetings were scheduled for the following day, and that the facility was secure. He also stated that he did not believe the inmate negotiators were representative of the inmate population and that none of their demands had been met. He further stated that the normal staff complement was on duty, no

additional staff had been called in, and almost all state police had left the institution. These comments reportedly incensed those inmates who watched the news conference from their cells.

At approximately 7 p.m., while staff were distributing dinners in E and F cell blocks, inmates began to throw items from the tiers. They were observed reaching through their cell bars toward the locking devices left exposed by the missing security panels. Staff reported hearing inmates scream "Turn your lights off" after which inmates from all six cell blocks located in groups 2 and 3 were seen pouring into the courtyard between the housing areas. They ran through E Gate, which, despite its strategic security importance in separating groups 2 and 3 from the other housing and program buildings, had not been repaired following the riot the previous day. Inmates proceeded to group 1 housing blocks and modular units and released others. Fires were started in modular units 1 through 6; the education building; and E, F, and H blocks. Five staff members were taken hostage.

As inmates proceeded through E Gate, they chased staff and nonrioting inmates, who locked themselves in the Control Center. Rioting inmates broke windows and entered the Control Center by removing a window air conditioner, and then they set fires on the first floor. (Staff and nonrioting inmates trapped in the Control Center had moved to the second floor and contacted the main gatehouse for assistance.) A contingent of 25 Pennsylvania state police and a municipal police officer arrived at the front gate in response to a radio distress call from a state police officer trapped in the Control Center. After a delay at the main gate, the officers were permitted to enter the institution, established a skirmish line between the main gate and the Control Center, and used a ladder to rescue all staff and nonrioting inmates from the second floor of the burning Control Center. Following the rescue, state police issued a call for assistance and attempted to move inmates back through E Gate.

Within several hours, nearly 900 state police officers arrived at the institution. Throughout the night, they attempted to sweep the institution, one section at a time, to force inmates back into the main stockade yard. Municipal police encircled the perimeter.

At approximately 10:45 p.m., state police negotiators and institution staff threw a telephone with a long cord over the fence and began talks with an inmate representative in the K block. Negotiations continued throughout the evening of October 26. The same issues raised at earlier negotiations were emphasized. The inmate expressed his desire to speak with the commissioner, the superintendent, and the Governor. Although those demands were not granted, two hostages were released during the negotiations, communication decreased as the evening progressed.

At approximately 5:45 a.m., a large water cannon was used to dislodge barricades inmates had constructed at E Gate. State police then activated the plan that would regain control of the facility. The plan included diversion and entry, use of a fire crash truck, tear gas, and warning and defensive shots as inmates resisted. Four inmates were wounded, but none were killed. The last inmate surrendered at approximately 9 a.m. on Friday, October 27.

Although Camp Hill had an emergency plan prior to the riot, it was not used during the event itself. The emergency plan was not well known to most staff and was not practical. It referred to equipment and procedures that were no longer in use or no longer available. It had not been tested, nor had it been reinforced through training. During the second night of rioting, 66 injuries were reported to staff and inmates. Thirty-seven individuals, including the five officers who had been taken hostage, required transport to local

hospitals for treatment. No deaths resulted from the incident.

Damage from the 2 days of rioting at the State Correctional Institution at Camp Hill was monumental.

- Fifteen of the facility's 31 buildings were substantially damaged or destroyed.
- Six of eight modular housing units and a new, unused modular office unit were destroyed; the two therapeutic community modular units suffered moderate damage.
- Significant damage was reported to modular units 7 and 8, the Control Center, the greenhouses, the education building, the staff dining room, H-block basement, the gymnasium, kitchens I and II, the furniture factory, and dispensary II.
- Substantial damage was noted in the group 1 cell blocks as inmates broke through walls to access the plumbing chases.

Over the 2 days of rioting, upwards of 100 staff were injured and 24 staff were taken hostage. Approximately 130 staff, including 70 correctional officers, took disability leave for injuries sustained during the disturbances. As noted by the Senate Judiciary Committee in 1990, "Camp Hill was on the verge of disaster, and all involved must count it fortunate that no lives were lost." The monetary loss from the Camp Hill disturbances was staggering. In Pennsylvania State Police estimates, physical damage to the facility was more than $15 million, and costs associated with staff overtime and disability leave were $40 to $50 million.

Approximately 700 inmates were transferred to other institutions on October 27 and 28. By October 29, staff began returning the remaining inmates to the cell blocks. Cell doors were chained and padlocked because their locking mechanisms were unusable. On October 30, state police and institution personnel continued to sweep the facility, its underground utility passageways, and remaining structures. By the sweep's completion on October 31, the institutional count still failed to account for five inmates.

On November 1, 7 days after the first disturbance occurred at E Gate, the superintendent was suspended. In late January 1990, the superintendent and deputy of operations were terminated, and the deputy for treatment was transferred. The major of the guard had previously retired.

Lessons Learned

1. A number of broad predisposing factors evidently set the stage for this riot. The following factors did not cause the riot directly, but likely added to the possibility that an individual incident would escalate into a major insurrection:

   LJ V.A.6–D SJ II.A.1–6

   a. Overcrowding.
   b. Understaffing.
   c. Decreased access to inmate programs.
   d. Poor labor management relations and poor staff morale.
   e. Failures in the inmate disciplinary process.
   f. Housing large numbers of maximum-security inmates in a facility that was at best appropriate for medium- and minimum-security inmates.
   g. Lack of interaction and communication between the administration and frontline staff and between the administration and the inmate population.

2. Against these general conditions, the actual provocation for the riot appears to have been two policy changes imposed on the population:

   LJ V.G.4

Note: LJ = Checklist for Larger Jails
SJ = Checklist for Smaller Jails

a. Family members could no longer bring food into the institution on family day.

b. Inmate sick call was reduced to every other day rather than daily.

3. Management did not respond to some of the classic signs of impending disturbance or attempt to deal with inmate leaders appropriately.

LJ V.A.3 SJ II.A.3

4. Like many prison disturbances, the first day of rioting was spontaneous, but the entire prison was nevertheless lost because staff failed to mount an appropriate response to the initial disturbance.

LJ XVIII.F SJ VI.C

5. Leadership was problematic throughout the two days of rioting, and the lack of strong, decisive leadership was an integral part of many of the other problems at Camp Hill.

LJ I.C.1.a–d SJ I.C.5.a

6. Emergency plans were inconsistent from institution to institution in Pennsylvania prior to the riot, and it was impossible to coordinate resources effectively, such as CERT teams from other institutions when the riot occurred.

LJ VI.A SJ IV.A

7. Coordination between the institution and external agencies such as the Pennsylvania Emergency Management Agency and the Pennsylvania State Police was similarly ineffectual, primarily as a result of lack of prior planning.

LJ XI.A.1–9 SJ III.D

8. In spite of the extent and seriousness of the second day's rioting, state police regained control of the institution in a few minutes as soon as it was clear to the rioters that they would face lethal force.

LJ XIV.P SJ I.C.3.b

9. Individual officers were not prepared through training or supervision to follow the department's use of force policies. They also lacked appropriate weaponry. Some staff might not have been taken hostage and/or beaten if force had been used appropriately.

LJ XII.C.12.a SJ VI.D

10. If the aftermath of an emergency is not handled competently and stepdown plans are not realistic with regard to issues like security, then an institution may face a second emergency that can be more destructive than the original situation.

LJ XVIII.U & V SJ III.C.3

11. Institutional managers and administrators must recognize that media coverage and the course of the event are interactive, and that the coverage can dramatically affect the course of the event.

LJ I.C.4.a SJ I.C.4.a & b

12. After an emotional situation has been resolved, some staff may think about retaliation against the inmate population. It is a management responsibility to prevent such retaliation, and the primary issue will be leadership.

LJ XVIII.R SJ I.C.5.a

13. Poor day-to-day security procedures such as lack of key control, leaving motor vehicles

LJ V.F SJ II.C.1–7

unattended within a prison compound, poor control of heavy tools, etc., are likely to haunt an institution if serious trouble occurs.

14. A prison control center or main control room located inside the security perimeter of a medium security, close custody, maximum security or super-max institution must itself be as secure as is practically possible.

LJ VIII.P SJ III.I

15. Communication failures and failures of an intelligence operation during a disturbance can lead to security lapses that increase the chance that the disturbance will re-escalate or spread.

LJ XVI.G SJ I.C

16. An institutional emergency plan will likely prove close to useless during an actual emergency if it is:

LJ VI SJ III. A. & B

    a. Impractical.
    b. Written to reflect resources that no longer exist or never existed.
    c. Unfamiliar to most institution staff.
    d. Unavailable during an emergency.
    e. Written to reflect procedures that the department does not use.
    f. Not reinforced with training simulation and exercises.

17. Even when almost everything goes wrong in a disturbance at an institution that has not been running well, a large measure of good luck combined with the good work and experience of some of the staff and external agencies may result in avoiding both loss of life and increased risk to the community.

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