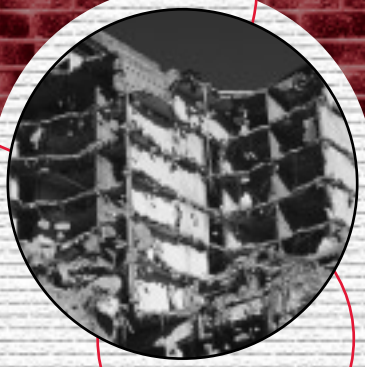
U.S. Department of Justice
National Institute of Corrections

A Guide to Preparing for and Responding to **Prison Emergencies**

Self-Audit Checklists • National Survey Results • Resource Materials • Case Studies



U.S. Department of Justice
National Institute of Corrections
320 First Street, NW
Washington, DC 20534

Morris L. Thigpen
Director

Larry Solomon
Deputy Director

George M. Keiser
Chief, Community Corrections/Prisons Division

Randy Corcoran
Project Manager

National Institute of Corrections
World Wide Web Site
http://www.nicic.org

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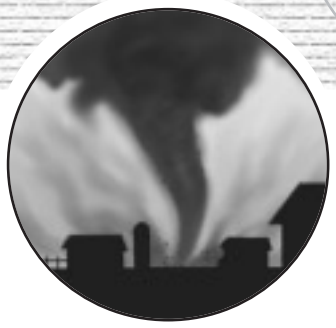

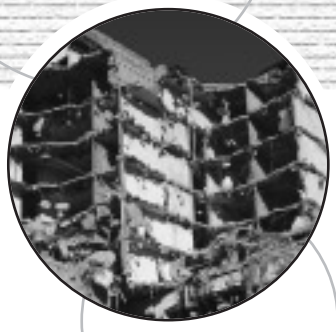

Jeffrey A. Schwartz, Ph.D.
Cynthia Barry, Ph.D.

LETRA, Inc.
Campbell, California

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Foreword

In 1996, the National Institute of Corrections (NIC) published its monograph *Critical Analysis of Emergency Preparedness: Self Audit Materials.* In introducing that monograph, I wrote:

> *Emergency preparedness is a crucially important topic for every state department of corrections and for every correctional institution. Large-scale inmate violence or a natural disaster can threaten the lives of both the institutional staff and inmates. In hours, a major emergency can cost a state 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.*

Nearly a decade later, those comments still ring true. However, the field of corrections has made a great deal of progress regarding emergency preparedness. A number of state departments of corrections have committed to comprehensive initiatives designed to improve their emergency readiness at both the departmental and institutional levels. As a result, substantially more correctional agencies are well prepared today for the possibility of a major crisis situation, and fewer remain complacent and/or unprepared.

Obviously, the world around us has changed dramatically in recent years. The bombing of the federal building in Oklahoma City, the events of September 11, 2001, the subsequent anthrax incidents, and, as this is written, the train bombings in Madrid, Spain, and the killing of hundreds of school children in Russia serve notice on American corrections about a whole new range of risks that cannot be ignored. Bomb threats or even the possibility of an outside assault designed to free an inmate are not new considerations for prisons or jails. However, the threat of concerted terrorist activity with sophisticated planning, coordination, and even munitions represents a challenge that is categorically different from our traditional concerns about situations involving inmate violence or natural disasters. It is NIC's hope that this new guide will help state and local correctional agencies continue to improve their preparedness for traditional emergencies and will also provide a starting point for considering the emerging realities of terrorist threats.

This guide builds on the self-audit instruments that were at the heart of the 1996 monograph. Those instruments, together with a related series of NIC-sponsored seminars, were designed to

help state departments of corrections evaluate their readiness, at both the institutional and departmental levels, to handle major crisis situations. The 1996 monograph proved to be extremely popular and useful, and NIC continues to receive requests for it to this day. One measure of its success is that department-conducted self-audits of emergency readiness have largely replaced what had been a growing trend of NIC-funded assessments conducted by outside experts.

We hope that this new guide will be even more useful. It is much more than a simple update of the earlier monograph. The self-audit materials have been substantially modified, refined, and expanded, and the rest of the guide is essentially new in scope and character.

Morris L. Thigpen
Director
National Institute of Corrections

Preface

It is instructive to review the introduction to the prison emergency preparedness self-audit materials published in 1996 as an NIC monograph. The monograph noted a number of positive changes that had occurred in the previous 20 to 30 years with regard to prison emergencies, and it also underscored several problems and challenges that remained widespread. The 1996 monograph reviewed the trend toward serious emergency preparedness at most state prisons and drew contrasts with earlier times when comprehensive emergency planning was the exception rather than the rule. It singled out the emphasis on prevention of crises and emergencies as another major improvement. On the other hand, the 1996 monograph was candid about the number of institutions and departments in which emergency preparedness was not taken seriously or existed only on paper, not in reality. The prevailing belief in such places was "it can't happen here." The monograph also noted a more specific problem: the tendency of departments and institutions to base their emergency planning almost solely on riot and hostage situations.

More than 8 years have passed since that monograph was published—not a long time in the evolution of a discipline like corrections. Predictably, many of the observations in the 1996 monograph still hold true today. However, some things have changed substantially, and a few have changed quite dramatically—as reflected in the content of this guide. One substantial change is the much broader appreciation today of the need to prepare for crises that arise not from inmate violence but from incidents such as fires, floods, and hurricanes. Thus, this guide includes a separate checklist for assessing prison readiness to deal with natural disasters.

With regard to dramatic change, terrorism has taken front and center stage. When the 1996 monograph was published, the events of September 11, 2001, were, for most people and most agencies, simply unimaginable. It is clear that since September 11, some things will never be the same. Considerations of terrorism now seem to be a part of our daily lives. Therefore, this guide includes a separate checklist for assessing counterterrorism efforts and planning in prisons—the first self-audit checklist of its kind, but likely not the last.

In today's world, the forces that define prison emergencies continue to change, sometimes very rapidly. Thus, this guide clearly cannot be the final word on prison emergency preparedness. The purpose of the materials in this guide is to help move the field of corrections forward in understanding the demands of prison emergency and crisis situations and in understanding current best practices with regard to emergency plans, policies, and practices.

The goals of this guide, then, are simple but important. It is hoped that the guide will result in improved prevention efforts, planning, and response, so that some emergencies may be averted entirely and others may be mitigated. If this guide helps prevent violence in just a few locations and if it minimizes injuries, deaths, or escapes during just a few prison crises, then it will have fully satisfied its objectives.

Jeffrey A. Schwartz, Ph.D.
Cynthia Barry, Ph.D.
LETRA, Inc.
Campbell, California

Acknowledgments

This guide is the result of a cooperative agreement funded by NIC. The guide could not have been developed without the efforts of many individuals and the active participation of the majority of state departments of corrections (DOCs) across the United States.

Seven consultants worked on this project: Rich Cruickshank of the Nebraska DOC; Richard (Dick) Franklin, now retired and most recently of NIC's Prisons Division; Bill Gentry, Director of Person County (North Carolina) Emergency Services; Brad Hansen of the Nebraska DOC; Richard Holder, retired from the Oregon DOC; Marty Jones, retired from the California DOC; and Charles Stewart of the North Carolina DOC. This group of consultants represents more than 150 years of experience in corrections. More importantly, each individual has a great deal of highly specialized experience in dealing with prison crises, major emergencies, and natural disasters. The collective wisdom of this group encompasses not only emergency planning and preparation but also firsthand experience in responding to and managing prison crisis and emergency situations. The consultants worked individually and in small groups to improve the self-audit materials from the earlier monograph, develop new materials, and critique drafts. We are indebted to them for their generous contributions to this guide.

Randy Corcoran of NIC's Prisons Division served as the Project Manager throughout the development of the guide. Randy monitored the progress of the project and handled a variety of administrative tasks for the Institute. Randy was an experienced warden in the Maryland DOC before he joined NIC's Prisons Division and was always willing to roll up his sleeves and make substantive contributions to the guide in addition to carrying out his administrative responsibilities. Everyone who worked on this project thanks Randy for his involvement, his patience, his commitment, and his many specific contributions.

Susan Hunter, the long-time Director of NIC's Prisons Division, became seriously ill and died in early 2004. She had been personally involved in this project from its conception. As with so many things at NIC, Susan's hand is upon this guide, and we are grateful for the time and energy she devoted to this project.

NIC developed this monograph through a cooperative agreement with LETRA, Inc., of Campbell, CA. LETRA is a nonprofit training and research organization with more than 30 years of experience in working with law enforcement and correctional agencies across the United States and Canada. Importantly, LETRA has specialized in developing comprehensive emergency systems for prisons and jails and in training prison staff on emergency preparedness for the last 25 years. A number of people associated with LETRA supported this project and made contributions to this monograph, and we gratefully acknowledge that assistance.

Dionne Niemi was LETRA's office manager throughout this project and had primary

responsibility for preparing draft materials, providing logistical support to project staff and consultants, and formatting the materials in the guide. She also carried out a wide range of other duties that kept the project moving forward.

Two of the project consultants made an important additional contribution to the guide. Brad Hansen and Rich Cruickshank, both of the Nebraska DOC, had collaborated with the Project Director and Deputy Director on the development of a training curriculum designed for managers at the level of warden and above. That curriculum was completed a few years before this guide was developed. Three chapters from the curriculum, "Leadership Issues During Crises," "Prevention of Prison Emergencies," and "Emergency Teams," are reprinted in section 5 of the guide, with the permission of the authors. We also want to express our gratitude to Harold Clarke, Nebraska's former Director of Corrections, and to the Nebraska DOC for their important contributions to that training curriculum in general and to the three reprinted chapters specifically.

Of the country's 50 DOCs, 33 agreed to participate in this project by sending emergency plans, policies, and/or procedures for review. These DOCs also responded to a lengthy written survey inquiring about emergency practices, policies, plans, and procedures within their prisons. (The guide includes a detailed report on the results of that survey, which was the first of its kind.) The DOCs' contributions to the guide are very much appreciated. On a related note, it is important to acknowledge that this guide reflects a much larger body of knowledge about large-scale crises and emergencies in prisons and that this body of knowledge is derived in large part from the practical experiences of a great many correctional professionals.

Publications are like fine food. Good ingredients are not enough: preparation and presentation are also essential. For this monograph, we were extremely fortunate that NIC provided the services of Aspen Systems Corporation of Rockville, MD. Lynn Marble and Janet McNaughton, both of Aspen, not only corrected grammar and punctuation and clarified syntax, they reorganized material and sometimes reframed discussions, always moving the monograph toward increased clarity. In addition, Lynn, Janet, and designer C. Denise Collins are primarily responsible for the cover design, the page layout, and the graphics in this monograph, and they suggested important format changes in the emergency checklists themselves, which made those instruments more "user friendly." This monograph has benefited in many ways, some obvious and some subtle, from the first-rate professional editing services of Aspen, and we are most grateful to them.

Jeffrey A. Schwartz, Ph.D.
Project Director

Cynthia Barry, Ph.D.
Project Deputy Director

LETRA, Inc.
San Jose, California

Section 1

Introduction

In This Section

Background

Prisons 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. Prisons, 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 the most serious prison emergency situations. Finally, the first priority for every prison is community protection, which means that even in the chaos of a major emergency, prisons must ensure against escape.

No prison is immune from large-scale emergencies. A minimum-custody facility housing short-term inmates may be at very low risk for riot and disturbance situations, but a minimum-security designation is no shield against fire, earthquake, chemical spill, or staff walkout.

A complicating factor is that the twin risks that an emergency will happen, and that it will go badly, are heightened by population overcrowding and decreases in staffing levels and other resources, as well as by the elimination of some programs that help stabilize prisons (e.g., earned good time). These conditions are ubiquitous in American corrections. As a result, most state prison systems are in a more precarious position with regard to major emergencies than they were 15 or 20 years ago.

Another factor affecting how prisons deal with major emergencies is the changing composition of the correctional 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, prisons promote staff much more quickly than once was customary. A captain may have 8 years of service now, whereas 20 years ago a "young" captain in the same department would have had 16 to 18 years of experience. In the absence of experience, agencies are far more dependent on policy, plans, and formal training. However, not everyone recognizes that reality.

If the likelihood and dangers of large-scale crises in prisons are widely acknowledged as real, does it not follow that almost all state prison systems would commit serious time, resources, and thought to emergency preparedness? In fact, that is not the case. The reasons are complex.

One reason that most prison systems have not placed high priority on emergency preparedness is that 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 looking at how the situations were handled—whether staff

performed properly, the right training and equipment were in place, policies proved valid, etc. In too many systems, no serious scrutiny or review takes place unless a situation ends in tragedy. Third, effective, comprehensive emergency preparedness is demanding and difficult to achieve. Fourth, some traditions in corrections work against effective emergency preparedness:

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

Assessing Emergency Readiness

Effective planning plays a crucial role in preventing major emergencies and, more commonly, 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 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 may go more badly than necessary.

If a state department of corrections (DOC) does not have the level of emergency preparedness that it wants or needs, assessment is the logical first step. Traditionally, administrators have either asked their own people to conduct an assessment or contracted with outside consultants to do the job. Both approaches have drawbacks.

Involving the management staff of an institution or a department in evaluating the strengths and weaknesses of their own 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 "the Emperor has no clothes." Even if they are objective, in-house staff may not notice obvious problems because they have lived with 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 the 50 state correctional systems. In addition, politics and personalities can impede an internal assessment.

A different set of problems arises if external consultants are engaged. First, consultants 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 firefighting systems, others with CERT and SWAT, and still others with training hostage negotiators—but very few people in the country have indepth experience and expertise with the entire gamut of comprehensive emergency preparedness issues. Third, management staff may see outside consultants as "walk-through experts" and not take them seriously. Finally, political rather than purely constructive motives may govern how a department or institution uses a consultant's report.

The 1996 NIC Self-Audit Monograph

Since many DOCs rely heavily on self-audit procedures in other areas of their operations, it followed that a well-designed self-assessment

Validating the 1996 Emergency Preparedness Self-Audit Checklist

Three states participated in a validation study to compare self-audit results with findings from an evaluation by experienced consultants. Each state selected one maximum-security institution and one minimum- or medium-security institution for the study. The state administered the NIC self-audit materials at the two institutions and at the departmental level. Then senior project staff members and project consultants conducted an onsite evaluation of emergency readiness, touring each institution and reviewing institutional emergency plans and departmental policies, emergency equipment, emergency staffing and specialists, etc. Project staff reviewed the results of their onsite evaluations with top departmental and/or institutional managers. These findings were then compared with the results of the self-audits.

In general, the two methods—self-audit and consultant review—produced remarkably similar results. Both methods quickly identified institutions that had little emergency readiness. Both methods also consistently found a much better state of readiness in institutions that demonstrated a strong commitment to emergency preparedness and significant work on emergency issues. The two methods also tended to agree at a much more detailed level. For example, both methods revealed any lack of provisions for hostage negotiation or tactical capacity for hostage rescue.

Some important differences between the two methods did emerge:

- The self-audit checklists proved more detailed and thorough than the consultant evaluation. Even when two experienced consultants spent a full day reviewing a moderate-sized institution, they did not have time to inquire about every area covered in the self-audit checklists. The consultants also skipped some of the details contained in the checklists.
- The consultant evaluation did a better job of identifying when things were in place but substandard, or when appearance and reality differed sharply.
- At institutions with minimal involvement in emergency issues, a review meeting with outside consultants appeared to motivate management to consider the results of the evaluation seriously, whereas the self-audit materials did not. Clearly, self-audits will not be effective unless management is committed to conducting an honest and rigorous evaluation.

instrument to analyze emergency preparedness could be extremely useful. Such an instrument could help to address some of the drawbacks of self-assessment mentioned in the preceding section. Thus, the primary focus of NIC's 1996 monograph on emergency preparedness was the development of a detailed, comprehensive self-assessment instrument for evaluating emergency preparedness in both state DOCs and individual correctional institutions. Further development of this tool remains one of the central objectives of this guide.

NIC has received substantial feedback about the self-audit materials in the 1996 monograph. Almost all of the feedback has been extremely positive. The monograph continues to be frequently requested and used, and its popularity suggests the need for new, improved self-audit materials that reflect the many changes in the correctional environment since 1996.

Prison Emergencies and the National Incident Management System (NIMS)

Some correctional administrators are already familiar with NIMS or with the Incident Command System (ICS). Both are generic, multi-agency systems for responding to major emergency incidents (although NIMS is generally a broader approach than ICS). A brief review of NIMS and how it relates to prison emergencies and to this guide provides important context for the guide's users.

Background

Prior to the 1970s, there was no nationally recognized system for managing emergency incidents or natural disasters. ICS was developed by fire departments in the early 1970s as a system for coordinating the response of multiple agencies to the same fire or group of fires. The heart of ICS was a command-and-control system, and ICS was intended to overcome many of the traditional problems associated with multiple-agency responses, such as ambiguous or unclear lines of authority, incompatible communication systems, and lack of standardized equipment and terminology. From its inception through the 1980s and 90s, offshoots of ICS evolved in some agencies and states. ICS was also adapted for use by law enforcement agencies in a number of state and local jurisdictions.

After the events of September 11, 2001, a primary concern of the newly established Department of Homeland Security was coordination among agencies that would potentially respond to a terrorist event. A presidential directive charged the new department with establishing standards for a national emergency system. That system, called NIMS, is largely an outgrowth of ICS. NIMS represents a major step forward: for the first time, the nation has a unifying system for coordinating the response to incidents as diverse as a forest fire, a tornado, or a terrorist bombing.

How NIMS Relates to Prison Emergencies

For corrections officials, and for this guide, the key question is: what is the relationship of NIMS to prison emergencies? The answer is that NIMS is both a help and a challenge.

NIMS is a help in several obvious ways. When a correctional agency assists in the response to a community disaster, radio frequencies of the various responding agencies are more likely to be compatible, and information about the emergency is more likely to be shared in plain English rather than in codes. Jurisdictional issues are more likely to have been worked out in advance. Coordination and planning may well have been tested during drills and exercises. The same issues of coordination, planning, communication, command, and logistics also apply when a correctional agency has a major emergency itself and needs assistance from fire, police, and other external agencies. Thus, correctional agencies clearly should embrace NIMS and become familiar with its concepts and terms.

The challenge for corrections officials is to recognize that NIMS is a generic interagency structure; it is not procedural, and it does not speak to specific correctional issues. Nothing in NIMS tells a correctional institution how to evacuate the segregation unit of a large prison (just as nothing in NIMS tells a fire department

how to put out a petroleum fire). Thus, while NIMS provides important and necessary assistance in areas such as interagency coordination, resource allocation, and planning, a correctional agency still needs all of the corrections-specific expertise that has traditionally existed within a correctional emergency system.

An analogy may be in order. To compose a document on a computer, you use a word-processing software program that determines how you move text and format the document. However, you also need another software program: the computer's operating system. Although it has little to do with the specifics of composing the document, the operating system sits above the word-processing software and allows it to run on the computer. NIMS is like an operating system in that it provides the framework and architecture in which all of the corrections-specific emergency provisions reside.

A correctional agency has two alternatives with regard to NIMS. It can adopt NIMS and then set about developing its own corrections-specific policies, procedures, and other emergency system requirements, tying all of that to various components of NIMS. Or it can adopt NIMS and use a comprehensive correctional emergency system within NIMS to provide the substance and content that make an emergency system useful in a prison. If it chooses the second alternative, it must take care that its emergency system is consistent with the NIMS framework. For example, the Nebraska DOC has worked with LETRA's corrections-specific emergency system for 10 years, but it has also been identified as the state's lead agency for homeland security and is in the process of training staff on NIMS. Nebraska's experience is that the two systems—NIMS and a corrections-specific emergency system—are compatible, not contradictory.

How This Guide Relates to NIMS

Users of this guide will find that it is consistent with NIMS. In particular, the three freestanding self-audit checklists that constitute the heart of the guide (see section 3) include items that cover every aspect of NIMS, ranging from risk assessment to interagency coordination to requirements for drills, exercises, and simulations. The checklists include even more items that are corrections specific and are not part of NIMS. For example, the general emergency preparedness checklist includes many questions about hostage negotiation teams and tactical teams. Almost all of these questions are corrections specific; because NIMS is generic, it does not provide policy direction for a hostage negotiation team or direction for operating a tactical team.

In summary, this guide is consistent with NIMS, and it directly addresses a number of key provisions and concepts within NIMS. However, it is comprehensive with regard to expertise about correctional emergencies and should not be regarded, directly or indirectly, as a systematic presentation of NIMS issues.

Development of This Guide

Why the Guide Was Developed

Two primary reasons prompted the development of this guide. The first was that the success of the 1996 monograph suggested the need to improve on that earlier publication by expanding the scope, building on experience with the 1996 checklists, and generally updating the materials. The second reason was the need to account for changes since 1996 in the conditions that give rise to emergencies and crises in prisons, most particularly with regard to terrorism.

Improving the Materials

As correctional professionals became familiar with the 1996 self-audit materials, a number of criticisms, suggestions for improvements, and ideas for reorganization emerged. The authors had informally kept track of these suggested changes, and other updates and modifications resulted from the process of drafting and reviewing this guide (see "How the Guide Was Developed").

Reflecting Changes in Conditions

When the 1996 monograph was drafted, today's pervasive concern with terrorism could not have been foreseen. After the events of September 11, 2001, no publication on emergency preparedness for prisons would be complete without comprehensive consideration of counterterrorism strategies. In addition, developments since 1996 point to the need for greater emphasis on natural disaster preparedness. For example, the Federal Emergency Management Agency (FEMA) and its state and local derivative agencies have become an increasingly sophisticated and unified system of emergency planning and response. That system's heavy emphasis on natural disasters is not reflected in the 1996 monograph. In addition, situations involving hazardous materials, covered briefly in the 1996 monograph, have become the focus of fines and other enforcement actions at some jails and prisons.

How This Guide Differs From the 1996 Monograph

This guide is very different from the 1996 monograph. In fact, the guide is more accurately viewed as a new document than as a revised edition of the earlier work.

The 1996 monograph included two generic emergency preparedness self-audit checklists: one designed for correctional facilities and the other designed for the state DOC's central office. This guide combines these two generic checklists into a single generic emergency preparedness self-audit checklist that is designed primarily for institutions but includes a section on departmentwide issues. This change was made because the single checklist is more efficient and avoids the redundancy that characterized the two previous checklists. In addition, experience with the 1996 monograph demonstrated that the checklists almost always were used by institutions and seldom were used solely at the departmental level.

How the Guide Was Developed

The checklists in the 1996 monograph provided the foundation for the new checklists in this guide. Those earlier checklists were mailed to all seven project consultants and the NIC program manager, along with suggestions for additions and other changes that the authors had accumulated since the publication of the 1996 monograph. All members of the project team were asked to review the existing materials and the suggestions for changes and to consider potential reorganization of the checklists at a global level, changes in format, specific modifications of individual checklist items, and any other revisions that seemed justified.

A 3-day project planning meeting was then scheduled at LETRA's offices in Northern California, and all members of the project team attended. Each individual offered a number of suggestions for changes and additions, some global and some very detailed. The team discussed the central questions of the guide's scope and organization at length. Almost all decisions were arrived at by consensus. Practical questions about the layout and use of the checklists received extensive consideration, in part because most team members had actually used the 1996 checklists and had strong feelings about what should be kept and what needed to be changed. During the meeting, team members reviewed the 1996 checklists item-by-item. At the end of the meeting, the project consultants were split into two- and three-person teams and given responsibility for creating initial drafts of the natural disaster/hazardous materials (HAZMAT) checklist, the counterterrorism checklist, or the general emergency preparedness checklist.

As the subgroups within the project team completed their draft checklists, the drafts were sent to all other team members for comment and review. The project director and deputy director then integrated all of the responses into working drafts of each checklist. In a parallel process, the project director and deputy director distributed drafts of the guide's four resource papers to the other members of the project team. Three of these papers came from LETRA's recent training program, and one was written specifically for this guide. The director and deputy director also completed the section presenting results from the national survey of 50 state DOCs on emergency preparedness policies and practices and distributed it in draft form to the project team members.

The working drafts of the checklists and other sections were then sent to NIC for review and modification by the NIC project manager in consultation with the project director and deputy director, all of whom then reviewed a final draft at a meeting held at NIC offices in Washington, DC. NIC publications manager Georgette Walsh coordinated the final phase of the preparation of the guide, working with editing and graphics specialists from Aspen Systems Corporation and the project director and deputy director.

A Note About Field Testing: No "field testing" was conducted with the checklists in this guide. That is because they were developed from the 1996 checklists, which were field tested and used extensively across the country. In a sense, then, the checklists in this guide have received extensive field testing—because the field experience with the earlier checklists contributed to their development.

The guide also adds two new freestanding self-audit checklists: one on natural disasters, HAZMAT incidents, and fire; the other on counterterrorism. The natural disaster/HAZMAT/fire checklist is intended for use by individual institutions. The counterterrorism checklist is appropriate for institutions and for state DOCs.

Natural Disaster/HAZMAT/Fire Checklist

The decision to present natural disaster and related items in a separate checklist rather than incorporating them in the generic emergency preparedness checklist reflects several important considerations:

- This format underscores the importance of planning for natural disasters. Many prisons have done substantial work planning and preparing for inmate violence (disturbances, hostage incidents, etc.) but have not paid serious attention to the possibility of a natural disaster.
- With a freestanding checklist, natural disaster and HAZMAT issues will not be camouflaged by the more dramatic, traditional prison concerns with inmate violence.
- The level of preparation required to achieve reasonable readiness to handle natural disasters and HAZMAT situations is extensive. The freestanding checklist makes that immediately apparent and focuses attention on extremely challenging issues, such as offsite evacuations, that are unlikely to arise in an emergency involving inmate violence but have a much greater probability in response to a natural disaster.
- If natural disaster and HAZMAT items were added to the generic emergency preparedness self-audit checklist, that already-large document might become too cumbersome to be useful.

Redundancy

A clear drawback to presenting the natural disaster and counterterrorism checklists as freestanding documents is the potential for redundancy with the generic emergency preparedness checklist. Arguably, to be complete and logical, the two new checklists would need to include almost everything from the generic checklist. That strategy would make the new checklists so large that their specialized focus would be lost. It would also cause extensive repetition. On the other hand, some items in the generic checklist are so central and relevant to the specialized checklists that their omission would make the specialized checklists less than meaningful. Thus, although some repetition is necessary, it is minimal. The vast majority of items appear in just one checklist. Only items that are essential for logic or continuity are repeated. The individuals who use this guide will judge whether, as hoped, the relatively small amount of repetition is necessary and helpful.

In addition to these practical considerations, a philosophic issue guided the decision to create a separate checklist for natural disasters. The generic emergency preparedness checklist makes no attempt to provide detailed coverage of every kind of major emergency that might befall a prison. It is intended to reflect overall planning, preparation, and response for emergency situations and crises. If the specifics of natural disasters, HAZMAT situations, and fire

safety were added to that checklist, why then would the checklist not also include equally specific treatment for other types of prison emergencies (bomb threats, epidemics, explosions, etc.)?

Counterterrorism Checklist

The creation of a freestanding checklist on counterterrorism was guided by similar concerns but was, perhaps, an easier decision. Unlike natural disaster issues, counterterrorism matters are quite new to most prisons. Additionally, in a high-threat-level environment, counterterrorism efforts could potentially redefine the entire operation of a prison. Even the potential risks and threats associated with terrorism are quite different in nature and scope from those posed by more traditional prison emergencies. The freestanding self-audit checklist on counterterrorism helps a prison or a state department of corrections focus on its policies, procedures, plans, and general readiness in this relatively new area.

Checklist Format and Content

Those familiar with the earlier checklists will note several modifications of the format and content.

- **More items.** Many new items have been added to the generic emergency preparedness checklist.
- **More space for comments.** Many users of the earlier checklists said the space for comments next to individual items was inadequate. The checklists in this guide provide substantially more room for comments.
- **Portrait instead of landscape format.** The 1996 checklists were in landscape format, which proved cumbersome. The checklists in this guide are all in portrait format.
- **Standards vs. criteria.** Individual items within the checklists are now referred to as "criteria" rather than "standards." This change is important because NIC does not promulgate standards. Some national organizations do issue correctional standards. Local, state, and federal correctional agencies may chose to adopt nationally available standards, to develop their own standards, or not to acknowledge any particular set of standards—that is an agency-by-agency decision. Referring to each checklist item as a criterion more accurately reflects NIC's objective of providing "food for thought" to help state and local agencies conduct their own evaluations, without implicitly or explicitly suggesting that NIC is proposing a set of standards.
- **Verifying methods.** The checklists ask the audit team not only to make a judgment about the status of each item ("meets criterion," "partially met," etc.) but also to state the method used to verify that status ("document review," "staff interview," etc.).

Survey Report

A survey of emergency preparedness was conducted in 33 of the 50 state departments of corrections. The guide presents detailed findings from this survey, which was the first of its kind. Readers will find a wealth of data on common (and less common) approaches to emergency readiness, the extent to which agencies commit resources to emergency preparedness, how many agencies train and maintain their own tactical teams and negotiators, and many other aspects of current practices.

Resource Materials

The "Resource Materials" section offers four important new papers on leadership during crises, prevention of emergencies, prison emergency teams, and counterterrorism. These new papers are very different from anything offered in the 1996 monograph.

- ***Leadership Issues During Crises.*** Although this paper specifically concerns leadership in prison crises and emergency situations, much of its discussion could apply to crisis management in any setting. Furthermore, experienced prison wardens who have read the paper have noted that the issues discussed are relevant not only during crises but also during day-to-day operations.
- ***Prevention of Prison Emergencies.*** This paper argues that although prison administrators commonly talk about preventing emergencies, often little is being done specifically for that purpose. The paper demonstrates the scope of measures that can decrease risks and potentially reduce the likelihood that a major crisis will happen.
- ***Emergency Teams.*** This paper discusses the most common types of specialized teams required in prison crisis and emergency situations: tactical teams, hostage negotiation teams, and crisis intervention teams. Rather than considering the specifics of organizing, training, equipping, and operating such teams, the paper attempts to provide a high-level management perspective, exploring potential strengths and common pitfalls and focusing on requirements for successfully managing these teams.
- ***Prisons and Counterterrorism.*** This paper discusses terrorism threats and incidents as they relate to prisons. Before the events of September 11, 2001, U.S. prisons had little reason to be concerned about terrorism. Thus, even the basic concepts of the subject may be unfamiliar to correctional staff. Now, terrorism is a "hot topic" in international news and in novels, motion pictures, and television dramas. Unfortunately, neither news reports nor fictional accounts translate into practical measures a state prison should consider as part of a counterterrorism strategy. The decision to include both a counterterrorism checklist and this paper in the guide was prompted by the urgent need for prisons to gain familiarity with this topic.

Case Studies

The last section in the guide presents seven case studies illustrating how prisons have responded to different types of emergency and crisis situations. Four of the studies—Helicopter Intrusion/Escape (Colorado DOC), 1993 Midwest Floods (Missouri Loses Renz Correctional Center), Hurricane Andrew (Florida DOC), and Fire in a New Institution (Taney County, MO)—are updated carryovers from the 1996 monograph. The other three—Morey Unit Hostage Incident (Arizona DOC), Lucasville Prison Riot (Ohio DOC), and Riot at Max (Montana DOC)—are new in this guide.

Section 2

Conducting an Audit

In This Section

Purpose and Philosophy

Purpose of an Emergency Preparedness Audit

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

An audit **validates a comprehensive emergency preparedness system.** For a prison, comprehensive readiness for crises, natural disasters, and major emergencies is no easy matter; it is a far-reaching effort that can take years to fully develop 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 prison's emergency system is necessarily large and multifaceted, nothing short of a systematic audit procedure will effectively evaluate the system. An institution's emergency preparedness coordinator may be familiar with several substantial problems and may also have several initiatives awaiting funding or management commitment. However, the coordinator is inevitably too close to the system—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 institution'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 prison's CERT program may have become more and more expensive because of costs associated with increased training time and shooting practice, while its hostage negotiators have stopped training regularly and have not worked together for more than a year. It may be time for the institution'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 the correctional leader **identify tendencies toward complacency and "cutting corners" in critical practices.** Audits can also offset the dangerous consequences of faster turnover in management and supervisory positions. Rapid turnover means a loss of knowledge and experience in important areas. Without regular audits, an institution'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, and institutions often need to reinforce an individual policy or check on how it is being followed, the best way to ensure compliance with policies, standards, and written procedures in a broad area such as emergency preparedness is to conduct an areawide audit.

An audit may also be an excellent **staff development tool** and increase staff awareness of crucial issues related to emergency preparedness. This function of the audit applies not only to the audit team members but to the institution'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 readiness, the institution's staff read the message clearly: management thinks 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 are likely to have greater impact because of the staff's heightened awareness of emergency issues. Further, employees who have not understood why some procedures were necessary for emergency readiness may come to appreciate the rationale for those procedures. Finally, the audit offers the institution staff a chance to learn "best practices" with regard to emergency preparedness.

All of these reasons point to the same conclusion: an audit of an institution's emergency preparedness system provides an opportunity to improve the 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 state DOCs and of the individual institutions within those departments. An audit of emergency readiness is entirely consistent with that mission. In fact, with the exception of some highly specific aspects of prison operations such as perimeter security, one would be hard pressed to find an activity more closely related to protecting the public than evaluating the institution's readiness to handle large-scale crises and major emergencies.

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

More specifically, an audit should be a "win-win" approach to improving emergency readiness. A prison's level of emergency readiness is what it is, and an audit 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. Worse, if administrators regard the audit as an opportunity to assign blame for the prison's 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.

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 institution. Wardens and other administrators often speak proudly of such scores ("we got a 99.2% and that is the highest score any institution in our state has ever received"). For the emergency preparedness audits presented in this guide, however, such a view of scores 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 institutions probably will place different weights and values on the 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 an NIC monograph on security auditing, "It is quite possible to drown in a river that has an average depth of six inches."

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 institution in general and the institution'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.

Preliminary Considerations

Deciding To Audit

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

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

- **What else is going on in the institution?** 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 compromised.
- **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. The most important work in the audit

Audit Decisions at the Department Level

If a state department of corrections simply mandates emergency preparedness audits at all prisons in the state 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 institution 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 department administrators to involve facility-level management in the decision to conduct emergency preparedness audits statewide.

process doesn't 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.

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 general emergency preparedness audit, it may be acceptable for an individual, even the institution's emergency preparedness coordinator, to conduct one or both of the more specific audits (natural disasters and counterterrorism). Optimally, however, all audits will be completed by a team.

It is not necessary that an institution conduct all three audits, at least not simultaneously. In fact, often it will be most productive to first complete the general emergency preparedness audit, wait a few months or more (until the general emergency preparedness issues have been resolved), and then complete the other two audits. Further, some institutions may not think the counterterrorism audit is a high priority, or even necessary.

Although having a single team complete all of an institution's audits may be the most efficient approach, using a different team for each audit has distinct advantages. Most obviously, more staff develop interest in and ownership of emergency readiness; secondarily, the institution benefits from two or three independent assessments, which may reveal problems that would not have come to light had a single team been used.

The audit team should have two to four members. Management should appoint one member as team leader. If the institution has an emergency preparedness coordinator, 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 institution.

Ideally, at least one member of the audit team will be from another institution within the department or from the department's central office. 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 the institution's 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 institution's CERT team leader, armory officer, emergency preparedness coordinator, and chief negotiator).

The audit team members should meet with the institution'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. 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."

Standards for Auditors

As noted earlier, the self-audit checklists do not attempt to impose standards for emergency preparedness but rather provide criteria by which prisons 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 institution's top management only. How the findings are disseminated from that point should be determined by the administration of the institution and the department.
2. **Be considerate.** To the extent possible, auditors should not interfere with the ongoing operation of the institution. They should respect other staff responsibilities.
3. **Report dangerous situations.** If auditors encounter an imminent life-threatening condition or situation, they should report it immediately to the warden or superintendent.
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 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.
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 ("would you show me the insulin syringes so we can verify the count against the inventory balance in the log?") and "setting up" staff (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 institution if they assume something is acceptable without verification, gloss over problems, or "give the institution 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. Observation

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 factfinding, 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 found 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 prison audits in general:

- This audit system does not represent advice from NIC about what an institution's emergency system should or should not include. That is a decision for the institution and its department of corrections.
- The self-audit checklists in this guide are not the only method for evaluating emergency readiness in a prison. 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 prison. 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 about institutional security, for that matter). A prison may "pass" all of the emergency preparedness items on a national standards audit and yet be woefully unprepared for a large-scale crisis.
- Institutions and agencies 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 an institution passes a policy audit, the staff may assume all is well when in fact the institution has 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.)

Overview

The intent of the self-audit checklists in this guide is to help a state department of corrections or an individual institution evaluate its readiness to contend with a major emergency. The three checklists—general emergency readiness, natural disaster/HAZMAT/fire, and counter-terrorism—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 agency or institution. The ultimate decision about what is important in emergency preparedness must be the province of each individual department or institution.

Similarly, *the fact that an institution does not meet some of the criteria in the checklists does not necessarily mean that the institution is wrong or in jeopardy.* For example, if the institution has thoughtfully decided not to purchase certain equipment or not to include certain policies or procedures, there may be an excellent reason for that decision. Conversely, however, if the institution 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 checklists 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 institution or department 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 department or institution 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 department or institution review highly important areas. The audits should be a source of ideas and constructive change, not criticism.

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 prison. (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 institutions, 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). The point is that 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 readiness is often a greater challenge for the small or minimum-security institution than for the large, high-security prison that has far greater resources.

- The old computer adage about "garbage in, garbage out" holds true for these self-audits. If they are not done carefully and accurately, the results will be misleading. If auditors are unsure about an item, they should check it out or leave it blank. 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 institution involved. Without such meetings, a department or institution might 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 largest checklist ranged from 8 hours to 2 days.

What will actually be needed to conduct a self-audit? Each of the three audits will require two to four assigned staff (see "Who Should Conduct the Audit" for staff qualifications). Auditors will require 1 to 2 days of uninterrupted time to complete each checklist. They will need full access to all areas of the institution, 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 self-audits will not require any specialized equipment or unusual resources.

A Note About Sections 4–6 in This Guide

Reading the sections that follow the checklists—National Survey of Emergency Readiness in Prisons, Resource Materials, and Case Studies—is not a prerequisite for completing the self-audits. 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 prison emergencies. However, because terrorism is a relatively new concern for prisons, correctional decisionmakers and auditors should find it useful to read the monograph "Prisons and Counterterrorism" (see section 5, Resource Materials) before undertaking a counterterrorism self-audit.

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

Getting Started

1. The guide contains three assessment documents (self-audit checklists). The first is for individual institutions and departments of corrections to use in assessing/evaluating general emergency readiness. The second is for individual institutions to use in evaluating preparedness for natural disasters, HAZMAT situations, and fire. The third is for institutions and departments to use in measuring preparedness for terrorist threats or incidents. Each checklist is separate and freestanding. Make sure you have the right document.
2. Make as many photocopies of each checklist as needed. For example, if you will be auditing seven institutions and you want two copies for each institution, plus some extras, you may want to start by making 20 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 institution may need fewer or more, depending on how many items are "partially met," "not met," or "not applicable" (see below). Note that the format of the summary sheet is the same for all three checklists, but the title at the top is different for each, to prevent confusion.
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 enough in the organization to be aware of all necessary information. The selection should send the appropriate message to staff regarding the importance of the audit to the institution or department.
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 a checklist, read the "Glossary of Terms" that follows these directions. Every department has some unique terminology, and the same term may mean two different things in two different departments. 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.
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 should, however, be subject to further discussion and review.

   Substitutes. If the institution 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 just because a group of related items are scattered throughout procedural manuals (where they would be of little use during an emergency). The institution or department 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 institution'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 institutions, 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 institution'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 warden or other top manager is in and out of the review meeting and appears superficial, 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

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
2. Does policy or departmental regulation specify all approved types of weaponry, chemical agents, ammunition, and other defensive equipment?	MC	DR	Policy 04.5.12 List contained in Reg. 237 (5/21/03). NC#
3. Does policy or departmental regulation specify minimum quantities of each such weaponry, chemical agents, and other defensive equipment?	NM	DR	No minimums specified in policy for the institution NC# 46
4. Is the armory currently in compliance with these policies and procedures?	PM	OB DR	Most equipment in compliance Old Winchester 12 ga. shotguns not on current list. New OC grenades not on list. NC# 47
5. Is the armory secure from rioting inmates?	MC	OB SI DR	Key in tower. Backup in Main Control. Two security doors. Reinforced concrete construction per "as built" plans NC#
6. Are armory keys restricted from inmate areas?	MC	OB SI	Yes. NC#
7. Do on-duty staff have immediate 24-hour access to the armory?	MC	OB SI	Yes. Key in tower. CERT, shift Commander, Armory Officer, Training officer may access, per policy. NC#
8. Is the armory inventoried at least monthly?	PM	DR SI	Policy requires monthly inventory No inventory found since 1/14/05 Armory officer says 2X/YR. NC# 48

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 instruction 13.

AUDITOR: Capt. S. Brown DATE: 5/30/05

EP-42

Completed Summary of Noncompliance Items

SUMMARY OF NONCOMPLIANCE ITEMS
Emergency Preparedness Self-Audit Checklist

AUDITOR: Capt. Stephen Brown, Team Leader PAGE 10 OF 16
DATE: 6/2/05

NC #	Item Description	Reason for Noncompliance	Assigned To	Due Date	Apprvd By	Apprval Date
46 Status: NM Method: DR	Does policy specify minimum quantities firearms, chem. agents?	No such policy. Decision: Keep as is. Varies by institution.	N/A	—	A.W. Smythe	6/9/05
47 Status: PM Method: OB, DR	Is armory in compliance with these policies?	some equip. in armory not on approved list. (old shotguns, new OC grenades).	James Strothers	7/9/05		
48 Status: PM Method: DR, SI	Armory inventory monthly?	Only done 2X per yr.	Cpl. George Burton	8/1/05		
49 Status: NM Method: OB, SI	Armory inventory discrepancies reconciled?	No. Found inoperable handguns not on inventory. 37 mm. launcher on inventory, not present or checked out.	Cpl. George Burton	8/1/05		
50 Status: NM Method: DR, SI	Management review of armory quarterly?	No policy. No actual review/inspection in last 2 yrs by management.	James Strothers	7/9/05		

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

NAME: Gregory Smythe, A.W.
SIGNATURE: Gregory Smythe DATE: 6/9/05

EP-Noncompliance Summary

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 institution 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 institution experiencing the emergency and is the place from which the commander works.

Commander:

> **Initial commander:** The person in charge of the institution 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 institution 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 institution 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: 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-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 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 risk with equipment, supplies, or specialized procedures.

Desert island operations: A plan to operate an institution 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 where 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 regional 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 only exists in an emergency, or for a function that is different during an emergency than it is day to day.

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): By law, each state must maintain a state emergency management agency that coordinates with FEMA, the federal agency charged with building and supporting the nation's emergency management system. The names of the various state emergency agencies differ markedly.

Fireloading: The amount of potentially combustible material available to contribute to the growth of a fire. In prisons, 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, storerooms, 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. It 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 institution. 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 institution.

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. For a prison, 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 an institution's relative exposure to various types of emergencies. Determines which emergencies are most probable and which areas of the institution are most vulnerable. See also **vulnerability analysis**.

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

Special Weapons and Tactics (SWAT) team: See **tactical team.**

Step-down plan: A plan for how an institution will return to normal operations after an emergency. 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.

Table-top exercise: An emergency simulation involving a small group of staff and conducted verbally or with paper and pencil but without any role playing or use of actual prison facilities or extended agencies. Essentially, a hypothetical problem given to staff to work on in an office setting.

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), CERT (Correctional Emergency Response Team), or some similar acronym.

Tone: The "climate" or interpersonal atmosphere of an institution, sensed by experienced staff when walking through the institution.

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 an institution'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 readiness and natural disasters.

Section 3

Self-Audit Checklists

In This Section

Emergency Preparedness Self-Audit Checklist: Outline

Emergency Preparedness Self-Audit Checklist

INSTITUTION(S): _____ 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. Is there a statement of the institution's goals or objectives in major emergencies?			NC#
C. Emergency Policies *1. Command* a. Does policy specify who is in initial command of the institution in an emergency?			NC#
b. Does policy specify who is in ultimate (final) command of the institution in an emergency?			NC#
c. Does policy specify the institutional chain of command in an 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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (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* a. Does policy specify the notifications to be made by the institution in a major emergency?			NC#
b. Does policy include a priority level or order in which those notifications will be made?			NC#
c. Does policy mandate notification of the department's central or regional office in the event of a major emergency?			NC#
d. Does policy specify the role of the central office during an emergency and the relationship of the institution to the central office during an 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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
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 institution may engage in the planned use of lethal force during an emergency?			NC#
c. Does policy state the conditions under which the institution may engage in the planned use of sublethal force during an emergency?			NC#
d. If planned use of lethal force is necessary, does policy state who will use such force?			NC#
e. If planned use of sublethal force is necessary, does policy state who will use such force?			NC#
f. Does policy specify minimum standards (training, equipment, etc.) for individuals who may engage in planned use of lethal force?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
g. Does policy specify minimum standards (training, equipment, etc.) for individuals who may engage in planned use of sublethal force?			NC#
4. Public Information a. Does policy identify who at the institution will deal with the media during an emergency?			NC#
b. Does policy specify who at the institution has the authority to release information during a major emergency?			NC#
c. Does policy explain how media operations will be coordinated between the institution and the department's central or regional offices during an emergency?			NC#
d. Does policy identify who will manage rumor control during an emergency?			NC#
e. Does policy identify who will be responsible for communicating with the local community in an 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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (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 [PIOs], 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?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Audit Checklist (continued)

Criterion	Status	Method	Comments
b. Does policy outline responsibilities of a staff member if he/she is ordered to deviate from policy in an emergency?			NC#
7. Does policy require that one individual at the institution have overall responsibility for emergency preparedness?			NC#
8. Does department policy require one individual to be responsible for emergency preparedness departmentwide?			NC#
9. 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#
10. 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#

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 instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
b. Is there a policy statement listing nonnegotiable items?			NC#
11. Employee Job Action a. Does the institution 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#
b. Is each institution required to keep its plan for employee job actions confidential and to distribute the plan only to a designated group of top managers?			NC#
II. Role of Central Office During Emergencies			
A. Does the department's central office have its own emergency plan for an institutional emergency?			NC#
B. Does the plan outline rules and responsibilities for various individuals in the central office?			NC#
C. Are interagency responsibilities detailed in the plan?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
D. Does the central office's emergency plan include a public information plan?			NC#
E. Does the central office's emergency plan include a resource allocation plan?			NC#
F. Does the plan specify how the central office will communicate with unaffected institutions during the emergency?			NC#
G. Does the central office's plan outline responsibilities for communicating with the Governor's office and the legislature?			NC#
H. Does the central office's plan include a duty officer system or other 24-hour notification method?			NC#
I. Emergency Operations Center (EOC) 1. Does the central office's plan call for establishing an EOC during an emergency?			NC#
2. Is the location of the EOC specified?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
3. Are an adequate number of telephones (or telephone jacks) at that location?			NC#
4. Is adequate radio communication available at that location?			NC#
5. Can an open phone line be maintained between the EOC and the institution experiencing the crisis?			NC#
6. Are current emergency plans for each institution available in the EOC?			NC#
7. Is the EOC equipped with diagrams of each institution?			NC#
8. Does the EOC have broadcast and cable television, an am/fm radio, and a video recorder?			NC#
9. Does the central office's plan outline EOC security procedures?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
10. Is the EOC large enough for the number of individuals necessary to staff it?			NC#
J. Does the central office have a separate plan or plans for an emergency that occurs in the central office (fire, natural disaster, etc.)?			NC#
III. Emergency System Review			
A. Audit Procedure 1. Is there a departmentally specified procedure for auditing each institution's emergency system?			NC#
2. Does the institution conduct an annual review or audit of its emergency preparedness system?			NC#
3. Does that review or audit team include individuals from outside the institution?			NC#
B. Emergency Tests/Drills 1. Is there a standard for how often the institution must run emergency tests/drills?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Audit Checklist (continued)

Criterion	Status	Method	Comments
2. If yes, has that standard been met during the last 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. Are monitors trained to evaluate tests/drills and provide both verbal and written assessment?			NC#
6. Do policies or procedures require monitors and/or evaluators to debrief staff involved in drills and exercises, pointing out strengths and weaknesses observed?			NC#
7. Are written evaluations of every test/drill required from those monitors?			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 instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
8. Are recommendations required as part of each monitor's evaluation?			NC#
9. Are the monitors' evaluations and recommendations of emergency tests/drills routinely reviewed and approved by someone in authority?			NC#
10. Does policy require that some emergency tests/drills be conducted on evenings and weekends and on all shifts?			NC#
11. Is there a requirement that emergency tests/drills be based on a wide variety of emergency scenarios and based on the risk assessment?			NC#
IV. 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#

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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Audit Checklist (continued)

Criterion	Status	Method	Comments
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 institution?			NC#
7. Does each institution top manager visit and review all areas of the institution at least twice per month?			NC#
8. Are visits by institution top managers to various areas of the prison documented?			NC#
B. Are all staff trained to recognize the traditional signs of impending trouble (stockpiling commissary items, more racial grouping than usual, etc.)?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
C. Does the institution use a "critical indicator system" (mathematical/ statistical charting of trends in inmate grievances, assaults, etc.)?			NC#
D. Is there an institutionwide formalized intelligence function (as distinguished from security threat group operations or institutional 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#
4. Is there an intelligence file containing names and pictures of those inmates likely to plan serious violence or likely to become inmate leaders during an insurrection?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
F. Security			
1. Does the institution do random urinalysis testing of inmates for illegal drugs?			NC#
2. Is there some other (other than urinalysis testing) specified drug interdiction program?			NC#
3. Does the institution define contraband?			NC#
4. Does the institution perform random cell searches for contraband?			NC#
5. Is there a minimum standard for the number of random cell searches performed in a given time period?			NC#
6. Has that cell search standard been met during the last 12 months?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
7. Is there a log for the institution or for each area that lists all random searches of cells or areas of the prison?			NC#
8. Does the institution perform random security inspections of cells (bars, locks, vents, etc.)?			NC#
9. Is there a minimum standard for the number of random security inspections of cells performed in a given time period?			NC#
10. Has that cell security inspection standard been met during the last 12 months?			NC#
11. Is there a log for the institution or for each area that lists all random security inspections?			NC#
12. Are day-to-day security issues monitored closely and regularly by managers and supervisors?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
13. Are supervisors and managers required to file written reports regularly evaluating security practices?			NC#
14. Are staff held accountable for security lapses through the use of corrective actions, remedial training, counseling, or discipline?			NC#
15. Is security equipment organized and maintained in good working order?			NC#
16. Are there inspections of the internal and external areas of each housing unit on a daily basis?			NC#
17. Are such daily housing unit inspections logged or otherwise documented?			NC#
18. Is there a standard specifying the frequency of inspections of the perimeter security checks, vehicle and pedestrian entrances, gates, sally ports, visiting areas, control centers, and administration areas?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
19. Are all of those security inspections logged or otherwise documented?			NC#
20. If there is such a standard (item 18 above), has the institution met that standard for the last 12 months?			NC#
21. Is there a security inspection/review of tool control and key control at least monthly, and are such inspections/ reviews documented?			NC#
G. Inmate Grievance System 1. Is there an inmate grievance system?			NC#
2. Has the inmate grievance system been certified or reviewed and approved by an outside agency such as the U.S. Department of Justice or the courts?			NC#
3. Does management stress the importance of treating all inmate grievances seriously?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Audit Checklist (continued)

Criterion	Status	Method	Comments
4. Does management regularly review the substance of inmate grievances?			NC#
5. Is there a monthly summary of all grievances, including subject, area of institution, and numbers upheld and denied?			NC#
V. Institutional Emergency Plans			
A. Does the department require institutional emergency plans to be written in a standardized format?			NC#
B. Does the department have a formal approval procedure for institutional emergency plans?			NC#
C. Does the approval procedure for institutional emergency plans include a requirement that a manager from the department's central or regional office review and approve each institutional plan?			NC#
D. Does the institution have a single, comprehensive emergency plan (versus individual plans for various emergencies)?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
E. Did the institution's emergency plan go through a formal approval procedure, and is the plan signed and dated?			NC#
F. Has the institution's emergency plan been formally reviewed during the preceding 12 months?			NC#
G. Does the plan include a distribution list showing locations and/or individuals who have copies of the plan?			NC#
H. Is each copy of the plan identified by a unique number or letter, and is there an inventory system for the copies?			NC#
I. Does the emergency plan include a procedure for documenting changes and updates to the plan?			NC#
J. Checklists 1. Does the plan include an initial response (command post) checklist?			NC#
2. Does the plan include procedures for specific types of emergencies?			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 instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
3. Does the plan include job-specific checklists to be used during emergencies (emergency post orders)?			NC#
4. Does the plan include a deactivation checklist?			NC#
K. Is the institution emergency plan tailored to that specific institution?			NC#
VI. Risk Assessment			
A. Does the institution's emergency plan require an annual risk assessment?			NC#
B. Are executive staff and emergency specialists required to review the annual risk assessment?			NC#
C. Is the section on risk assessment specific to that institution?			NC#
D. Does the risk assessment include identification of those emergencies judged most likely to occur at that institution?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
E. Does the risk assessment identify institutional "hot spots"?			NC#
F. Does the risk assessment include evaluation of the security of control centers, armory, emergency generators, and perimeters?			NC#
G. Does the risk assessment include provisions for mitigating those risks that could be reasonably reduced?			NC#
H. Does the risk assessment include an evaluation of changes in the inmate population and how those changes affect risk and vulnerability?			NC#
VII. 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 (PIOs, negotiators, etc.) as well as for top managers?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
3. Are key emergency staff and top management staff contact phone numbers maintained separately from general staff recall phone lists?			NC#
4. Are general staff recall phone procedures organized by geographic proximity to the institution?			NC#
5. Are staff emergency notification lists (next of kin) updated annually?			NC#
6. Are staff emergency notification lists available to the commander in an emergency?			NC#
7. Are there special ID cards to expedite entry of outside emergency personnel?			NC#
8. Is there a system to minimize the number of calls the control center must make in an emergency (e.g., phone trees)?			NC#
9. Are there phone lines that can be restricted to only outgoing calls in the event of 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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Audit Checklist (continued)

Criterion	Status	Method	Comments
10. Does the institution have rapid-dial or auto-dial equipment to assist with emergency staff recalls?			NC#
B. Plot Plans			
1. Are plot plans/blueprints for every area of the institution available in the command post?			NC#
2. Do plot plans show location and type of all emergency utility cutoffs (electric, water, gas, oil, etc.)?			NC#
3. Do plot plans show all secondary fire access doors?			NC#
4. Do plot plans show the size or volume of all rooms and buildings in the institution (in case chemical agents must be used)?			NC#
5. Do plot plans show direction doors and windows open?			NC#
6. Do plot plans show emergency escape routes for various areas of the institution in case of a hostage incident or insurrection?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Audit Checklist (continued)

Criterion	Status	Method	Comments
7. Do plot plans show all fire extinguishers, standpipes, and fire hose locations?			NC#
8. Does the institution have current video of all areas showing entry, egress, windows, door operation, and floor layout?			NC#
9. Is there a mechanism to update emergency plot plans if routine or scheduled maintenance is done?			NC#
C. Can the institution disable all inmate pay phones and/or outside phones?			NC#
D. In an emergency, can staff disable inmate access to television?			NC#
E. Are all roofs painted with numbers or letters for helicopter identification?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
F. Are all buildings labeled with large letters or numbers on all 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 institution during an emergency?			NC#
J. Is there a plan for providing phone information on the status of individual inmates to family members during a lengthy emergency or evacuation?			NC#
K. Is there an inventory of staff foreign language skills (including sign language) available to the command post?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
L. Is there a group of staff trained in search and rescue for individuals in the institution?			NC#
M. Are there written procedures for command post security during an emergency?			NC#
N. Is there a plan for operating food service during a major emergency?			NC#
O. Is there an emergency plan for facilities maintenance engineering?			NC#
VIII. Staff Specialists			
A. Tactical Teams 1. Does the institution have a tactical team trained to respond to emergency situations?			NC#
2. If the institution does not have its own tactical team, have clear, detailed arrangements been made with an external tactical team?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
3. Are the tactical team structure and minimum size specified in writing?			NC#
4. Is the tactical team currently at or above minimum strength?			NC#
5. Does the tactical team have an identified leader and assistant leader?			NC#
6. Are the minimum training standards for the tactical teams specified in writing?			NC#
7. Is the tactical team currently in compliance with its minimum training standards?			NC#
8. Is there a medical person (nurse, med tech, etc.) attached to the tactical team?			NC#
9. Is there a video operator attached to the tactical team?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
10. Are equipment standards specified for the tactical team?			NC#
11. Does the tactical team's equipment currently meet those standards?			NC#
12. Does the tactical team train with command-level staff and negotiators?			NC#
13. Does the tactical team practice with a wide variety of scenarios?			NC#
14. Are tactical team members available by pager?			NC#
15. Does the tactical team include snipers?			NC#
16. Are snipers trained to work with spotters?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
17. Are team members' leave and vacation schedules coordinated to ensure team availability?			NC#
B. Disturbance Control 1. Does the institution have a disturbance control team?			NC#
2. If the institution does not have its own disturbance control team, have clear, detailed arrangements been made with an external disturbance control team?			NC#
3. Are the disturbance control team structure and minimum size specified in writing?			NC#
4. Is the disturbance control team currently at or above minimum strength?			NC#
5. Does the disturbance control team have an identified leader and assistant leader?			NC#
6. Are the minimum training standards for the disturbance control team specified in writing?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Audit Checklist (continued)

Criterion	Status	Method	Comments
7. Is the disturbance control team currently in compliance with its minimum training standards?			NC#
8. Is there a medical person (nurse, med tech, etc.) attached to the disturbance control team?			NC#
9. Is there a video operator attached to the disturbance control team?			NC#
10. Are minimum equipment standards specified for the disturbance control team?			NC#
11. Does the disturbance control team's equipment currently meet those standards?			NC#
12. Are all team members current with baton training?			NC#
13. Are all team members current with chemical agent training?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
14. Have all team members had training in restraint and transport techniques?			NC#
15. Are all team members current with CPR and first aid training?			NC#
C. Hostage Negotiators 1. Does the institution have its own trained negotiators?			NC#
2. If not, does the institution have detailed arrangements with external negotiators who would be used in an emergency?			NC#
3. If the institution relies on external negotiators, do the arrangements guarantee the availability of the negotiators to the institution on a 24-hour basis and with an acceptable response time?			NC#
4. Is there a written standard for the minimum number of negotiators available to the institution?			NC#
5. Does the number of currently available negotiators meet this standard?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
6. Is there an identified chief negotiator and assistant chief negotiator?			NC#
7. Are there minimum standards for initial and refresher training for negotiators?			NC#
8. Do all of the institution's negotiators currently meet these training standards?			NC#
9. Is the working structure of the negotiating team specified in writing?			NC#
10. Do the negotiators have a portable audiotape recorder, throw phone, and preprinted negotiation log forms?			NC#
11. Is negotiator availability guaranteed by coordinating leave and vacation schedules?			NC#
12. Do the negotiators train with the command-level staff and with the tactical team?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
D. Public Information Officer (PIO)			
1. Does the institution have an identified PIO?			NC#
2. Is there at least one alternate or assistant PIO?			NC#
3. Are there minimum training standards specified for the PIO?			NC#
4. Does the PIO meet these training standards?			NC#
5. Is there a written overview or description of the institution available for distribution to the media in an emergency?			NC#
6. Is there a procedure for logging and returning media phone calls in an emergency?			NC#
7. Are there written procedures for identifying and escorting media personnel in an 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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
8. Do procedures exist to establish an 800 information line during an extended emergency?			NC#
9. 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#
IX. Training			
A. Do new security staff receive at least 8 hours of training on the emergency plan and emergency procedures?			NC#
B. Does this training include hostage situations, riots, disasters, and other emergencies?			NC#
C. Do new civilian (nonsecurity) staff receive at least 4 hours of training on the institution's emergency plan and on emergency preparedness?			NC#
D. Have all institution staff at the level of shift commander and above received at least 20 hours of formal training on emergency preparedness?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
E. Have all institution staff at the level of shift commander and above participated in emergency preparedness exercises/ drills?			NC#
F. Have all institution staff received at least 4 hours of training on emergency situations during the last 2 years?			NC#
G. Has the institution conducted emergency exercises or simulations during the last year that involved external (mutual aid) agencies?			NC#
X. External Agency Agreements			
A. Does the institution have written agreements for assistance during an institutional emergency with the following external agencies			
1. State police?			NC#
2. Local police?			NC#
3. Local sheriff?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
4. Nearby correctional institutions (including county jails, federal prisons, U.S. Citizenship and Immigration Services)?			NC#
5. National Guard?			NC#
6. State/federal emergency management agency?			NC#
7. Local fire department?			NC#
8. Nearest hazardous materials (HAZMAT) team?			NC#
9. Local phone company?			NC#
10. Utility company(ies)?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
11. Local hospitals?			NC#
12. Ambulance services?			NC#
B. Does each written external agency agreement include the following 1. Emergency contact names and 24-hour phone numbers?			NC#
2. Services the agency can provide?			NC#
3. Equipment they can provide?			NC#
4. Restrictions on assistance?			NC#
5. Reporting (staging) locations?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
6. Command relationships?			NC#
7. Provision for annual review of agreement?			NC#
8. Provision for involvement of the external agency in emergency simulations and drills at the institution?			NC#
9. Provision for the institution to provide assistance in the event of a community disaster?			NC#
C. Does the institution have interagency agreements with other institutions within the department?			NC#
D. Are there written agreements with external agencies?			NC#
E. Are there specific ordinances, regulations, statutes, or verbal agreements covering interagency operations in emergencies?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
F. Within the last 12 months, has the institution held meetings with all external agencies to review and update emergency plans and procedures?			NC#
XI. Emergency Equipment			
A. Is there a comprehensive inventory of emergency equipment?			NC#
1. Is such an inventory available to the command post?			NC#
2. Is the emergency equipment inventory current within the last 12 months?			NC#
3. Does the inventory include the location of each item?			NC#
4. Is emergency equipment stored in an area accessible to staff?			NC#
5. Is emergency equipment secured to prevent access by inmates?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
6. Is there an emergency equipment testing program to ensure that all equipment is serviceable and ready for use when needed?			NC#
B. Is there a comprehensive motor vehicle inventory for the institution?			NC#
1. Is such an inventory readily available to the command post?			NC#
2. Is the vehicle inventory updated for accuracy at least quarterly?			NC#
3. Are the vehicles accessible after business hours?			NC#
4. Is vehicle fuel available after business hours?			NC#
C. Armory 1. Are there written policies and procedures for the armory?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
2. Does policy or departmental regulation specify all approved types of weaponry, chemical agents, ammunition, and other defensive equipment?			NC#
3. Does policy or departmental regulation specify minimum quantities of each such weaponry, chemical agents, 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#

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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Audit Checklist (continued)

Criterion	Status	Method	Comments
9. Are discrepancies in the armory inventory investigated and reconciled?			NC#
10. Is the armory inventory reviewed by management?			NC#
11. Is the armory inspected by a management-level staff person at least quarterly?			NC#
12. Are ammunition and firearms inventoried?			NC#
13. Is there a written procedure for checking out weapons and other armory equipment?			NC#
14. 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#
15. Chemical Agents a. Are there sufficient chemical agents to control a large riot at the institution?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
b. Are the pyrotechnic, blast, barrier, and aerosol formats available in both projectile and throwing grenade types?			NC#
c. Are all chemical agents clearly dated?			NC#
d. Are all chemical agents (except those for training use) within manufacturers' shelf life?			NC#
e. Are those chemical agents designated for training use clearly labeled as such to differentiate them from the general inventory of chemical agents?			NC#
f. Has the department specified a minimum number or percentage of security staff who must be currently qualified in the use of chemical agents, and is the institution in compliance with that requirement?			NC#
g. Is there a policy requiring immediate medical screening/ treatment for offenders and staff who have been exposed to chemical agents?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
h. Are chemical agents stored in a secure location?			NC#
i. Do duty staff have immediate 24-hour access to stored chemical agents?			NC#
16. Firearms a. Considering the size and nature of the institution, is there an adequate supply of firearms?			NC#
b. Are the types of firearms and ammunition appropriate for the nature of the institution and for the location and function of armed posts at the institution?			NC#
c. Are all firearms cleaned, inspected, tested, and sighted on a regular schedule?			NC#
d. Has the department specified a minimum number or percentage of security staff who must be currently qualified in the use of firearms, and is the institution in compliance with that requirement?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
e. Do duty staff have immediate 24-hour access to stored firearms?			NC#
D. Does the institution's emergency equipment include the following: 1. An adequate supply of flexcuffs (four times the entire inmate population)?			NC#
2. An adequate supply of steel restraints?			NC#
3. A supply of binoculars?			NC#
4. A supply of flashlights and batteries?			NC#
5. Distraction devices (flash-bang grenades)?			NC#
6. Bomb blanket?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
7. Long-handled corner (90-degree) mirror?			NC#
8. Loud hailers?			NC#
9. High-visibility clothing (fluorescent vests, etc.)?			NC#
10. Portable smoke ejectors?			NC#
11. Portable emergency generator?			NC#
12. Portable lighting?			NC#
13. High-speed cutting torch?			NC#
14. Bolt cutters?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
15. Radio with a tactical channel?			NC#
16. An adequate supply of riot shields?			NC#
17. An adequate supply of helmets with face shields?			NC#
18. An adequate supply of riot batons?			NC#
19. An adequate supply of potable water (48–72 hours)?			NC#
20. Fire axes?			NC#
21. An adequate supply of gas masks?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
22. Stun shield(s) or taser(s)?			NC#
E. Emergency Keys 1. Are there emergency key rings for all buildings and areas of the institution?			NC#
2. Is there a set of emergency keys outside the perimeter of the institution?			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 key rings soldered or welded closed to prevent unauthorized removal of keys?			NC#
6. Do emergency key rings include a metal ring disk ("chit") stamped with the name of area the ring accesses and the number of keys on that ring?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
7. Have all emergency keys and locks been tested in the last 12 months?			NC#
F. Emergency Generators 1. Is there an emergency generator?			NC#
2. Is the emergency generator adequate to run critical areas of the institution and critical equipment safely for 24 hours?			NC#
3. Are the critical areas and equipment powered by the emergency generator documented and annually tested 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#

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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
7. Are the emergency generators full-load tested for 10 minutes or more at least quarterly to determine that they are in proper working order, and are such tests documented?			NC#
8. Do all emergency generators have sufficient fuel to run for a minimum of 72 hours continuously?			NC#
9. If the emergency generators must be started manually in the event of a main power outage, are there staff on duty on a 24-hour basis who are trained to start and operate those generators?			NC#
10. Is the diesel fuel for the emergency generators checked for mold on a regular basis?			NC#
XII. Locations			
Are the following locations specified in the institutional emergency plans:			
A. Command post?			NC#
B. Alternate command post?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
C. Command post location outside 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#

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 instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
J. Mass casualty/triage area?			NC#
K. Disturbance control team dressing/ assembly area?			NC#
L. Tactical team dressing/assembly area?			NC#
M. Morgue?			NC#
N. Heliport?			NC#
O. Staff break areas?			NC#
XIII. Procedures			
A. Does the institution have a general procedure for responding to major emergencies?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
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 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 counts?			NC#
G. Are there written procedures for emergency lockdown?			NC#
H. Is there a standard procedure for sending staff to investigate a report of a developing emergency (a cover group)?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
I. Are there procedures that specify accounting for staff, visitors, volunteers, etc., in the event of an emergency?			NC#
J. At the onset of a major emergency, could the institution quickly account for all staff within the institution and determine the identities of staff not accounted for?			NC#
K. At the onset of a major emergency, could the institution quickly account for all visitors within the institution and determine the identities of any visitors not accounted for?			NC#
L. Are emergency traffic-control procedures specified?			NC#
M. Does procedure call for cutting off inmate telephones at the onset of a major emergency?			NC#
N. Is there a procedure for briefing on-duty and returning staff about the nature of an emergency?			NC#
O. Does procedure call for informing the inmate population of emergency conditions?			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 instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
P. Is there a procedure for limiting the initial staff response to a reported emergency to avoid set-up or distraction (as opposed to a procedure whereby all available staff respond as quickly as possible to the location of the reported emergency).			NC#
Q. Does the institution have a system of first responders?			NC#
R. Does the institution have a system of second responders?			NC#
XIV. Evacuation *Note: The Natural Disaster/HAZMAT/Fire self-audit checklist also includes questions pertaining to offsite evacuation plans and fire prevention and response.* A. Is there an evacuation plan for all areas of the institution?			NC#
B. Does every area of the institution have a secondary evacuation route?			NC#
C. Are evacuation routes posted in all areas of the institution?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Audit Checklist (continued)

Criterion	Status	Method	Comments
D. Are there battery-powered or emergency generator-powered emergency exit lights in all living and program areas of the institution?			NC#
E. Self-Contained Breathing Apparatus (SCBA) Units 1. Are SCBAs available in or adjacent to all living areas of the institution?			NC#
2. Are SCBAs stored or hung on walls 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 medically cleared to wear and use SCBAs?			NC#
6. Have all staff been trained in the use of SCBAs?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
7. Does the SCBA training for all staff include donning the SCBA, achieving a seal, and then breathing for some period of time?			NC#
8. Are staff trained to use SCBAs in pairs?			NC#
9. Have all staff in the institution 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#
2. Are inmates given orientation on fire evacuation procedures?			NC#
3. Are fire drills unannounced?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
4. Are all fire drills a. Monitored?			NC#
b. Timed for clearing the area in which the drill was held?			NC#
c. Timed for clearing a count of inmates evacuated?			NC#
d. Evaluated in writing by monitors?			NC#
5. Are fire drills conducted on all shifts?			NC#
6. Are there minimum standards for how often fire drills must be conducted in each area of the institution?			NC#
7. Have all areas of the institution met this standard within the last 12 months?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
8. Are fire drill reports, evaluations, and plans for improvement reviewed and approved by management?			NC#
9. Are fire drill reports and evaluation records kept in one central location?			NC#
10. Has the local or state fire marshal inspected the facility within the past year for compliance with state/local fire codes and regulations?			NC#
11. Has the local or state fire marshal approved the number, type, and location of fire extinguishers throughout the institution?			NC#
12. Are all fire extinguishers inspected, charged, and tagged at least quarterly?			NC#
13. Are all fire hoses and standpipes inspected, tested, and tagged at least annually?			NC#
14. Does the institution know the actual response time for the local fire department?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
15. Has fire-fighting equipment been brought into institutional areas to make sure the equipment can be connected and effectively used in each area?			NC#
16. Does the institution have its own fire brigade (trained inmates or staff)?			NC#
17. Has the institution considered training a fire brigade that would serve as a first-response force until the fire department arrived?			NC#
G. Are manual unlocking devices and/or backup keys available onsite for unlocking every living area of the institution 24 hours a day?			NC#
H. Is there an offsite evacuation plan?			NC#
I. If yes, does the offsite evacuation plan include the following: 1. Potential destinations?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
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#
7. Arrangements for meal service at the new location?			NC#
8. Arrangements for inmate identification and count at the new location?			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 instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
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#
J. Are there defend-in-place ("safe harbor") procedures, equipment, and supplies to protect the inmate population in emergencies when evacuation is not necessary, feasible, or possible?			NC#
K. Have areas been designated as defend-in-place within the facility, based on the types of potential hazards identified?			NC#
L. Is facility staff trained on the predesignated defend-in-place areas and the preparation needed, if any, to activate them?			NC#
XV. Organizational Structure			
A. Is an emergency organizational structure defined in detail?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
B. Are responsibilities specified for managing the unaffected portions of the institution during an emergency?			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#
F. Is the responsibility for emergency equipment detailed and assigned?			NC#
G. Is the responsibility for liaison with external agencies assigned?			NC#
H. Is the intelligence function described and responsibility for it 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).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
I. Is the responsibility for the tactical function defined and assigned?			NC#
J. Is the responsibility for coordinating emergency staff services (ESS) assigned?			NC#
K. Are there written guidelines (emergency post orders) available for each specialized emergency assignment?			NC#
L. Is there an emergency checklist available for each specialized emergency assignment?			NC#
XVI. Extended Emergencies			
A. Is there a written plan for staffing in an extended emergency (beyond 12 hours)?			NC#
B. Is responsibility for assignments and scheduling in an extended emergency assigned?			NC#
C. In an extended emergency, is the length of shift specified by assignment?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
D. Does the plan for extended emergencies include provision for staggered relief of key positions including the emergency response commander?			NC#
E. Does the plan for extended emergencies include arrangements for onsite bivouac of key staff?			NC#
F. Does the plan for extended emergencies include arrangements for bivouac of staff on emergency call-back duty?			NC#
G. Are relief procedures specified for key staff during an extended emergency?			NC#
XVII. Aftermath			
A. Are damage assessment procedures outlined and responsibilities assigned in the emergency plan?			NC#
B. Are report writing and debriefing procedures detailed in the emergency plan?			NC#
C. Is there a review and approval procedure for all reports?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
D. Is there a procedure for collecting audiotapes, videotapes, photos, and/or logs?			NC#
E. Is there a chain-of-custody procedure for all reports, logs, photos, etc.?			NC#
F. Is there a procedure for gathering staff-generated inmate disciplinary reports?			NC#
G. Is there a procedure for gathering external agency reports?			NC#
H. Is a short-term step-down procedure required before key staff are relieved of duty?			NC#
I. Are crime scene preservation procedures specified?			NC#
J. Are criminal evidence collection and preservation procedures detailed?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
K. Is immediate liaison with criminal prosecution authorities required?			NC#
L. Is civil liability review mandated?			NC#
M. Does the plan include procedures for managing released hostages?			NC#
N. Are medical and psychological screenings required for key and/or traumatized staff?			NC#
O. Is a critical incident review mandated?			NC#
P. Are critical incident review procedures specified?			NC#
Q. Are critical incident reviews shared with all institutions in the department?			NC#
R. Is a review of insurance issues mandated?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Audit Checklist (continued)

Criterion	Status	Method	Comments
S. Does the emergency plan specify developing a media relations plan as part of the aftermath activities?			NC#
T. Do procedures specify the identification, segregation, and interviews of inmate suspects and witnesses?			NC#
U. Do procedures specify releasing information to all staff?			NC#
V. Do procedures specify releasing information about emergency status to inmate populations?			NC#
W. Do procedures require developing a plan for communications with the local community?			NC#
X. Do procedures require a plan for regularly briefing central office and other branches of government?			NC#
Y. Is there a procedure for establishing emergency purchasing authority in the wake of a major crisis or 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).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
Z. Does the emergency plan include procedures to prevent staff retaliation?			NC#
AA. Does the emergency plan include procedures to deactivate the command post?			NC#
XVIII. Emergency Staff Services (ESS)			
A. Is there a general plan for ESS?			NC#
B. Are responsibilities for ESS during emergencies assigned?			NC#
C. Are ESS resources for specialized help (e.g., trauma counseling) identified?			NC#
D. Does the family support plan include child care provisions?			NC#
E. Does the family support plan include transportation provisions?			NC#
F. Does the family support plan include emergency financial assistance?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
G. Does the plan include liaison assigned to each family of hostage/injured staff?			NC#
H. 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#
I. Does the plan include provision for individual and group trauma counseling within 48 hours of the incident?			NC#
J. Does the plan include procedures for rehabilitating traumatized staff?			NC#
K. Are there arrangements for secure motel/hotel housing for staff families during the incident?			NC#
L. Is administrative leave mandatory for hostage/traumatized staff?			NC#
M. Does the plan include death notification procedures?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Audit Checklist (continued)

Criterion	Status	Method	Comments
XIX. Medical Services			
A. Is there a comprehensive medical plan for an institutional emergency?			NC#
B. Does the plan include mass casualties/ triage?			NC#
C. Are staff trained in blood-borne pathogen precautions?			NC#
D. Are supplies for safely handling blood or other body fluids provided or readily available?			NC#
E. Does the plan include evacuation procedures for nonambulatory or critically ill inmates?			NC#
F. Is a location other than the infirmary identified for mass casualties/triage?			NC#
G. Does the institution have an emergency-equipped medical crash cart?			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 instruction 13.

AUDITOR: _____ DATE: _____

Emergency Preparedness Audit Checklist (continued)

Criterion	Status	Method	Comments
H. Are there adequate numbers of gurneys?			NC#
I. Are backup medical resources for emergencies identified in the community?			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 instruction 13.

AUDITOR: _____ DATE: _____

SUMMARY OF NONCOMPLIANCE ITEMS
Emergency Preparedness Self-Audit Checklist

AUDITOR: _____ PAGE _____ OF _____

DATE: _____

NC #	Item Description	Reason for Noncompliance	Assigned To	Due Date	Apprvd By	Apprval Date
Status:						
Method:						
Status:						
Method:						
Status:						
Method:						
Status:						
Method:						
Status:						
Method:						

Review of all items on this page completed: Yes_____ No_____

NAME: _____

SIGNATURE: _____ DATE: _____

Natural Disaster/HAZMAT/Fire Self-Audit Checklist: Outline

Natural Disaster/HAZMAT/Fire Self-Audit Checklist

INSTITUTION(S): _____ DEPARTMENT: _____

TEAM LEADER: _____

AUDIT TEAM: _____

Criterion	Status	Method	Comments
I. General Considerations			
A. Does the institution have policies in place specific to natural disaster planning, response, and recovery operations?			NC#
B. Does the institution conduct routine training in natural disaster response, including drills and exercises?			NC#
C. Does the institution conduct an annual vulnerability analysis (risk assessments) for natural disasters?			NC#
D. Does the institution mitigate the threat of natural disasters, where possible, based on the vulnerability analysis?			NC#
E. Are natural disaster shelter areas identified that will maximize protection for inmates, staff, and visitors?			NC#
F. Does the institution have current mutual aid agreements with outside agencies to coordinate response activities during 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).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Natural Disaster/HAZMAT/Fire Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
G. Does the institution have emergency response plans and checklists specific to natural disaster response?			NC#
H. Do the specific emergency response plans and checklists include a "defend-in-place" strategy for situations where evacuation may not be practical or possible?			NC#
I. Has the institution identified supplies and equipment that may be needed in a natural disaster (water, tents, portable toilets, portable lighting, blankets, etc.)?			NC#
J. Does the institution have agreements to obtain critical equipment and supplies that are not available onsite or that may become inoperable during a natural disaster?			NC#
K. Does the institution have evacuation and relocation plans, alternative sites selected, and arrangements and agreements for natural disasters?			NC#
L. Does the institution have and conduct routine tests of early warning systems for natural disasters?			NC#
M. Does the institution have a plan to operate the institution with reduced staffing levels should a natural disaster make that necessary?			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 instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
N. Does the institution have an emergency staff services (ESS) program available to respond to staff and staff family needs in the event of a natural disaster?			NC#
O. Does the institution have a public information strategy prepared in the event of a natural disaster?			NC#
P. Has the institution planned for "desert island operations" (operating for an extended period without contact or assistance from outside) in the event of a natural disaster?			NC#
1. Is the institution prepared to maintain security and essential services, in the event of loss of power or other utilities, for as long as 72 hours?			NC#
2. Does the institution have a 3-day supply of potable water onsite or an alternate water supply system?			NC#
3. Does the institution have a 3-day supply of food that would not need cooking?			NC#
4. Does the institution have a 3-day supply of medications for inmates onsite?			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 instruction 13.

AUDITOR: _____ DATE: _____

Natural Disaster/HAZMAT/Fire Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
5. Have staff been encouraged to maintain a 3-day supply of their medications and an extra pair of eyeglasses on site?			NC#
Q. Are staff trained in initial response procedures specific to natural disasters?			NC#
R. Do staff and inmates participate in severe weather drills?			NC#
S. Do the emergency response plans and checklists for natural disasters include notification of and coordination with the department emergency operation center?			NC#
T. Does the institution have current copies of the county emergency management agency's emergency operating plan, and are those copies kept with or part of the institution's emergency plan?			NC#
U. Are staff encouraged to maintain a family emergency preparedness kit at home?			NC#
V. Are staff encouraged to identify family relocation areas?			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 instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
W. Are staff encouraged to identify an out-of-area relative or friend for family phone contacts and to relay messages?			NC#
II. Vulnerability Analysis			
A. Has the institution's vulnerability analysis been distributed to both county and state emergency management agencies?			NC#
B. Does the vulnerability analysis include conditions affecting the institution (understaffing, overcrowding, etc.)?			NC#
C. Does the vulnerability analysis cover all natural disasters for which the institution is at risk and include an assessment of the degree of risk for each disaster?			NC#
D. Does the vulnerability analysis include a historical review of natural disasters that have affected the institution?			NC#
E. Does the vulnerability analysis include an assessment of which people, property, facility functions, etc., are at particular risk with regard to specific types of disasters?			NC#
F. Have the vulnerability analysis and institution emergency response plans for natural disasters been reviewed by the county and state emergency management agencies?			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 instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
G. Have other emergency services external agencies reviewed the institution's vulnerability analysis and emergency response plans?			NC#
III. Offsite Evacuation Plan			
A. Do the institution's offsite evacuation plans account for expected civilian evacuation routes?			NC#
B. Do the institution's offsite evacuation plans include procedures for maintaining security of the facility after evacuation?			NC#
C. Do the institution's offsite evacuation plans include procedures for reoccupying the facility after the natural disaster has concluded?			NC#
D. If yes, do these procedures include the following: 1. Testing of security systems?			NC#
2. Testing of all life lines (telephone, electricity, water, etc.)?			NC#
3. Gradual phase-in of the inmate population?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
4. Evaluation of medical and food service facilities?			NC#
E. Do the institution's offsite evacuation plans include provisions for moving crucial inmate records with the inmate population?			NC#
F. Do the institution's offsite evacuation plans include provisions for securing or backing up noncrucial inmate records that will not be moved during the evacuation?			NC#
G. Does the institution have different offsite evacuation plans for different types of natural disasters (e.g., are the plans for a flood different from those for an earthquake)?			NC#
IV. Recovery Operations			
A. Does the institution have a detailed and thorough plan for conducting a damage assessment after a natural disaster?			NC#
B. Does the institution have a plan for conducting search and rescue operations after a natural disaster?			NC#
C. Does the institution have a plan for management and treatment of mass casualties resulting from a natural disaster?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
D. Has the institution identified resources (internal and external) necessary for cleanup and immediate repair to barriers and security systems damaged in a natural disaster?			NC#
E. Does the institution have written procedures for working with insurance carriers and/or the state government's risk management agency in the aftermath of a natural disaster?			NC#
F. Does policy specify that the institution will apply to the Federal Emergency Management Agency (FEMA) for assistance in the aftermath of a natural disaster, and does policy designate responsibility for submitting that application?			NC#
V. Tornado			
A. Are there specific tornado procedures in the institution's emergency plans?			NC#
B. Does the institution's vulnerability analysis include an evaluation of each building's ability to withstand a tornado?			NC#
C. Have tornado shelter areas been identified within the institution?			NC#
D. Do the institution's response plans distinguish between tornado watch and tornado warning, and are staff trained on this distinction?			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 instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
E. Does the institution have mandatory procedures that are enacted in response to a tornado watch or warning for the area?			NC#
F. Are there procedures for evacuating towers or other vulnerable staff posts in the event of a tornado watch or warning?			NC#
G. Are there procedures for bringing in outside inmate work crews and/or moving inmate groups at risk to safety in response to a tornado watch or warning?			NC#
H. Does the institution 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#
I. Do staff practice tornado drills at least once per year?			NC#
J. Do inmates receive orientation on tornado response and participate in tornado drills at least once per year?			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 instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
K. Do the institution's emergency plans include safety precautions for staff or inmates who may be in offices, classrooms, or other areas at risk from flying glass during a tornado?			NC#
L. Does the institution have a National Oceanic and Atmospheric Administration (NOAA) radio with battery backup and warning alarm?			NC#
M. Are there tie-downs for trailers and portable buildings, anchoring them to concrete foundations?			NC#
N. Do tornado response plans include provisions for sheltering/evacuating visitors?			NC#
O. Do tornado response plans include procedures for evaluating damage to the security perimeter and making short-term repairs as needed?			NC#
VI. Earthquake			
A. Does the institution have a specific response plan for earthquakes?			NC#
B. Has the institution evaluated its earthquake risk based on proximity to fault lines and seismic history of the area?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Natural Disaster/HAZMAT/Fire Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
C. Has the institution evaluated the structural ability of each building to withstand earthquakes of various severities?			NC#
D. Has the institution evaluated the vulnerability of the following to earthquakes: 1. Emergency power generators and fuel storage?			NC#
2. Water supply and primary power supply?			NC#
3. Natural gas lines and/or propane storage?			NC#
4. Communication systems, perimeter security, armory, infirmary and emergency medical services, etc.?			NC#
E. Are the institution's earthquake plans based on the ability to be self-sufficient onsite for as long as 72 hours?			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 instruction 13.

AUDITOR: _____ DATE: _____

Natural Disaster/HAZMAT/Fire Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
F. Are the institution's maintenance plans, diagrams, and architectural records available onsite?			NC#
G. Are bookcases, appliances, and high, heavy objects tied down or anchored against walls to mitigate risk in the event of an earthquake?			NC#
H. Have hanging objects been identified and secured or removed?			NC#
I. Has the institution completed a structural engineering review of earthquake-vulnerable buildings to design potential retrofitting with foundation ties, sheer wall, foundation beams, etc.?			NC#
J. Have staff received specific training on response to earthquakes?			NC#
K. Have inmates received specific training on response to earthquakes?			NC#
L. Does the institution have contingent contracts with structural engineers or any other special provision for evaluating structural integrity of buildings in the aftermath of an earthquake?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
VII. Flood			
A. Has the institution identified and posted county emergency management agency phone numbers in control rooms and other appropriate locations?			NC#
B. Has the institution conducted a thorough risk assessment of vulnerable areas and equipment in the event of rising water?			NC#
C. Does the institution have detailed plans for a complete offsite evacuation in the event of a flood?			NC#
D. Have those offsite evaluation plans been reviewed carefully within the past 12 months?			NC#
E. Has the institution practiced or drilled with a flood-related offsite evacuation scenario within the past 24 months, at the level of table-top exercise or above?			NC#
F. Does the institution have a plan for moving expensive or crucial equipment in the event of rising water?			NC#
G. Is the institution's offsite evacuation plan for flood developed in stages, so it could be enacted in response to predetermined flood stages or severity of warning?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
H. Does the institution have access to small boats or rafts that could be used for search and rescue operations with rising flood waters at the facility?			NC#
I. Do the institution's flood plans 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 those flood stages?			NC#
J. Do the institution's response plans distinguish between flood watch and flood warning and are staff trained on this distinction?			NC#
VIII. Chemical Spill/HAZMAT Incident			
A. Has the institution analyzed the surrounding area for potential hazardous material situations such as chemical factories, fertilizer manufacturing, and chemical storage or transportation routes?			NC#
B. If such an analysis of the area has been done, does it include prevailing wind and weather patterns?			NC#
C. Does the institution have staff who have been trained in HAZMAT first responder procedures?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Natural Disaster/HAZMAT/Fire Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
D. Does the institution have interagency agreements or arrangements with a nearby HAZMAT team that is fully trained and equipped?			NC#
E. Has the external HAZMAT team toured the institution to familiarize themselves with structural and operational issues?			NC#
F. Has the external HAZMAT team participated in an emergency drill, exercise, or simulation at the institution within the last 3 years?			NC#
G. Do the institution's HAZMAT response plans include contact information for a laboratory that could quickly identify an unknown substance that is potentially hazardous?			NC#
H. Do the response plans include defend-in-place provisions?			NC#
I. Has the institution conducted table-top exercises involving HAZMAT situations and defend-in-place strategies within the last 24 months?			NC#
J. Has the institution conducted a functional exercise or full-scale simulation involving a defend-in-place strategy with a HAZMAT incident within the last 24 months?			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 instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
K. Has the institution set aside any supplies and/or equipment specifically for a defend-in-place response to a HAZMAT incident?			NC#
L. Has the institution's storage and/or disposal of chemicals and/or hazardous materials been reviewed by any external agency within the last 24 months?			NC#
IX. Hurricane			
A. Does the institution's risk assessment include an evaluation of the likelihood of hurricane?			NC#
B. Has the institution conducted an analysis of all buildings to determine their ability to withstand hurricane-force winds?			NC#
C. Does the institution have supplies and plans for reinforcing/protecting vulnerable areas such as windows?			NC#
D. Do hurricane response plans include provisions for moving out of buildings that would be structurally unsound during a hurricane or that cannot be adequately protected?			NC#
E. Is there a plan for managing the inmate population while waiting to see if a hurricane actually will hit the institution?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
F. Has the institution retrofitted buildings with tie-downs or other structural improvements, where possible and practical, to increase protection against hurricanes?			NC#
G. Does the institution inspect the yard and other outside areas annually, prior to the start of hurricane season, for objects and materials that could become airborne and dangerous with extremely high winds, and remove or secure such items?			NC#
H. Have staff received any training specifically on preparing for and responding to a hurricane within the last 24 months?			NC#
I. Have inmates received orientation specifically on hurricane response within the last 24 months?			NC#
J. Do the institution's hurricane plans include an assessment of potential for localized flooding?			NC#
K. Do the institution's hurricane plans include an assessment of the vulnerability of various utilities?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
L. Does the institution have a NOAA radio with a battery backup and warning alarm?			NC#
M. Are staff trained on the distinction between hurricane watch and hurricane warning?			NC#
N. Does the institution have portable water pumps?			NC#
X. Severe Winter Storm			
A. Do the institution's emergency response plans include severe winter storms?			NC#
B. If the institution were to lose heat during extended below-freezing weather, does the facility have a backup system or backup plan?			NC#
C. Does the institution have its own snow-clearing equipment, and is it heavy enough to operate in an extreme winter storm?			NC#
D. Does the institution have specialized clothing for staff who would need to operate snow-clearing equipment or do other outside work under extreme winter blizzard conditions?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
E. Does the institution have an adequate supply of heavy jackets, blankets, etc., for the inmate population during an extreme winter storm?			NC#
F. Has the institution evaluated which utilities would be most vulnerable to failure during an extreme winter storm?			NC#
G. Is the institution's primary water supply at risk in an extreme winter storm?			NC#
H. Is the institution dependent on perimeter electronics that would be likely to fail in an extreme winter storm?			NC#
I. Is there a specific and detailed plan for managing the inmate population during an extended period of extreme winter weather?			NC#
J. Is there a plan for transporting staff to and from the institution in small groups or in pairs, for their own safety, during extreme winter weather?			NC#
K. Does the institution's response plan include provisions to switch to 12-hour shifts?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
L. Has the institution analyzed the compound for areas and equipment that would be at risk during long-term subfreezing conditions or from the weight of large amounts of ice?			NC#
M. Does the institution keep an adequate supply of sand and salt for walkways and essential vehicle access areas?			NC#
N. Does the institution maintain a supply of chains for use on its vehicles during extreme winter weather?			NC#
XI. Fire Prevention and Response			
A. Fire Loading			
1. Does the institution have written standards for the amount of inmate property permissible in cells or dormitories?			NC#
2. Are these written standards consistent with minimizing fire loading in living areas?			NC#
3. Are inmate cells and other living areas inspected at least once per month for compliance with this standard?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
4. Is the standard strictly adhered to?			NC#
5. Are all other areas of the institution inspected at least once per month to determine if there is excess fire loading?			NC#
6. If excess fire loading is discovered, is there a procedure that mandates reporting the situation to management?			NC#
7. Does the institution maintain written records of inspections for fire loading and of corrective efforts when excessive fire loading is discovered?			NC#
8. Is there a mandatory review for flammability and toxic smoke during fire, for all supplies and materials ordered for the institution?			NC#
B. Ignition Control 1. Are inmates permitted to keep matches or lighters in their cells or dormitories?			NC#
2. Do inmates have open access to matches or lighters in day rooms or other common areas?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
3. Are electric outlets and accessible wiring in inmate living areas and common areas inspected at least monthly for tampering or maintenance problems?			NC#
4. Are housing areas and common areas accessible to inmates inspected at least monthly to review proximity of flammable items to heat sources such as electric lights?			NC#
C. Fire Safety Review 1. Does the institution have a staff member in charge of fire safety?			NC#
2. Does the institution's fire safety officer report directly to a person at management level?			NC#
3. Are all areas of the institution inspected at least monthly to determine if fire doors are operable and fire exits and evacuation routes are kept clear?			NC#
4. Are written records required for these reviews?			NC#
5. When a problem is encountered during a fire inspection and is not immediately corrected, is there a policy or procedure that mandates bringing the problem to management attention immediately?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
6. Does the institution, on at least an annual basis, review all living units and other occupied areas to ensure that there are at least two exits in the case of fire?			NC#
7. Has the local or state fire marshal inspected the institution within the past year for compliance with state/ local fire codes and regulations?			NC#
8. Has the local fire department inspected the institution within the past year to discover potential fire problems and to become familiar with the physical plant?			NC#
D. Fire Drills and Fire Evacuation 1. Is there an evacuation plan for all areas of the institution?			NC#
2. Does every area of the institution have a secondary evacuation route?			NC#
3. Are evacuation routes posted in all areas of the institution?			NC#
4. Are there battery-powered or emergency generator-powered emergency exit lights in all living and program areas of the institution?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Natural Disaster/HAZMAT/Fire Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
5. Are staff trained in fire evacuation procedures for areas currently assigned?			NC#
6. Are inmates given orientation on fire evacuation procedures?			NC#
7. Are fire drills unannounced?			NC#
8. Are all fire drills a. Monitored?			NC#
b. Timed for clearing the area in which the drill was held?			NC#
c. Timed for clearing a count of inmates evacuated?			NC#
d. Evaluated in writing by monitors?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
9. Are fire drills conducted on all shifts?			NC#
10. Are there minimum standards for how often fire drills must be conducted in each area of the institution?			NC#
11. Have all areas of the institution met this standard within the last 12 months?			NC#
12. Are fire drill reports, evaluations, and plans for improvement reviewed and approved by management?			NC#
13. Are fire drill reports and evaluation records kept in one central location?			NC#
E. Fire Equipment 1. Has the local or state fire marshal approved the number, type, and location of fire extinguishers throughout the institution?			NC#
2. Are all fire extinguishers inspected, charged, and tagged 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 instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
3. Are all fire hoses and standpipes inspected, tested, and tagged at least quarterly?			NC#
4. Self-Contained Breathing Apparatus (SCBA) Units a. Are SCBAs available in or adjacent to all living areas of the institution?			NC#
b. Are SCBAs stored or hung on walls in pairs?			NC#
c. Are SCBAs examined annually for functionality?			NC#
d. Are all SCBAs inspected, charge-checked, and tagged at least quarterly?			NC#
e. Have all staff been medically cleared to wear and use SCBAs?			NC#
f. Have all staff been trained in the use of SCBAs?			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 instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
g. Does the SCBA training for all staff include donning the SCBA, achieving a seal, and then breathing for some period of time?			NC#
h. Are staff trained to use SCBAs in pairs?			NC#
i. Have all staff in the institution had refresher training on SCBA use within the past 24 months?			NC#
5. Are fire doors or fire door locks color coded for easy match to fire keys?			NC#
6. Are fire door locks and emergency keys notched for identification in dark or smoke-filled conditions?			NC#
7. Are manual unlocking devices and/or backup keys available onsite for unlocking every living area of the institution 24 hours a day?			NC#
8. Does the institution have two or more sets of turn-out gear?			NC#

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Evaluation Methodology: OB – Observed; **DR** – Document Review; **SI** – Staff Interview; **II** – Inmate Interview; **OT** – Other (specify).
NC# Boxes: See instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
F. Fire Response			
1. Does the institution know the actual response time for the local fire department?			NC#
2. Does the institution have its own fire brigade (trained inmates or staff)?			NC#
3. Has the institution considered training a fire brigade that would serve as a first-response force until the fire department arrived?			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 instruction 13.

AUDITOR: _____ DATE: _____

SUMMARY OF NONCOMPLIANCE ITEMS
Natural Disaster/HAZMAT/Fire Self-Audit Checklist

AUDITOR: _____ PAGE _____ OF _____

DATE: _____

NC #	Item Description	Reason for Noncompliance	Assigned To	Due Date	Apprvd By	Apprval Date
Status:						
Method:						
Status:						
Method:						
Status:						
Method:						
Status:						
Method:						
Status:						
Method:						

Review of all items on this page completed: Yes_____ No_____

NAME: _____

SIGNATURE: _____ DATE: _____

Counterterrorism Self-Audit Checklist: Outline

Counterterrorism Self-Audit Checklist

INSTITUTION(S): _____ DEPARTMENT: _____

TEAM LEADER: _____

AUDIT TEAM: _____

Criterion	Status	Method	Comments
I. Consideration of Terrorist Strategies			
A. Have the department and institution planned for the possibility that prisons might be targeted for a terrorist attack either because of the density of people in an isolated location or because the facility is a symbol of government control and stability?			NC#
B. Have the department and institution planned for and analyzed the potential for terrorists to target an institution for mass escape, either to create panic or to demonstrate the vulnerability of government controls?			NC#
C. Have the department and institution planned for and analyzed the potential for terrorist groups to recruit "soldiers" from the inmate population?			NC#
D. Have the department and institution planned for and analyzed the potential for an inmate strategic threat group (STG) to affiliate with a terrorist organization or to plan terrorist activity on its own?			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 instruction 13.

AUDITOR: _____ DATE: _____

Counterterrorism Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
II. Emergency System			
A. Is there policy in place that requires the department and institution to conduct an annual risk assessment?			NC#
B. Does the risk assessment specifically evaluate the risk of a terrorism emergency?			NC#
C. Has the institution completed a risk assessment in the last 12 months?			NC#
D. Does policy require that action plans be developed to mitigate deficiencies identified in the risk assessment?			NC#
E. Are those action plans monitored throughout the year to determine progress and completion?			NC#
F. Emergency Policies *1. Command* a. Does policy specify who is in command in a terrorism event?			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 instruction 13.

AUDITOR: _____ DATE: _____

Counterterrorism Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
b. 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#
c. Does policy specify where the command post will be situated?			NC#
d. Does policy specify who will be allowed in the command post?			NC#
2. Does policy require mutual aid agreements and/or letters of understanding with outside agencies regarding counterterrorism policies and procedures?			NC#
3. Notification a. Does policy specify which agencies to notify during a terrorism event?			NC#
b. Does policy specify which services/functions each external agency is expected to provide?			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 instruction 13.

AUDITOR: _____ DATE: _____

Counterterrorism Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
c. Do the notifications include local law enforcement?			NC#
d. Do the notifications include the state police?			NC#
e. Do the notifications include the state emergency management agency?			NC#
f. Do the notifications include the FBI?			NC#
g. Are telephone numbers of external agencies kept current (verified annually or more frequently)?			NC#
h. Does policy specify that emergency manuals contain contact information (business- and after-hour telephone numbers, as well as cell phone and pager numbers) for all mutual aid agencies?			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 instruction 13.

AUDITOR: _____ DATE: _____

Counterterrorism Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
4. Public Information a. Does policy specify who is to speak for the department/ institution during a terrorism event?			NC#
b. Does policy specify how information will be shared with outside agencies?			NC#
c. Does policy specify "one channel out" (a single source controlled by the commander) for communicating information to the media?			NC#
d. Does policy require mutual aid agreements and/or letters of understanding with outside agencies regarding management of public information?			NC#
e. Does policy specify where a joint public information center will be located?			NC#
5. Training a. Does policy require counterterrorism emergency exercises at least annually for the department?			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 instruction 13.

AUDITOR: _____ DATE: _____

Counterterrorism Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
b. Does department policy require counterterrorism emergency exercises at least annually for each institution?			NC#
c. Does policy require a functional and/or full-scale counterterrorism exercise at least every 3 years for the department?			NC#
d. Does policy require a functional and/or full-scale counterterrorism exercise at least every 3 years for the institution?			NC#
e. Does policy require that outside agencies (FBI, Department of Homeland Security, state police, state emergency management agency, and local health, law enforcement, and fire departments, at a minimum) be invited to participate in counterterrorism functional or full-scale exercises?			NC#
f. Does policy require evaluation of counterterrorism exercises, written identification of areas that need improvement, and monitoring of those areas?			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 instruction 13.

AUDITOR: _____ DATE: _____

Counterterrorism Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
g. Are all staff trained in awareness of potential terrorist threats?			NC#
h. Are all staff trained in early detection and intervention strategies to prevent terrorist events?			NC#
i. Are all staff trained in specific action steps expected if a terrorist event takes place?			NC#
j. Are first responders trained specifically in precautions to take if a terrorist event is suspected?			NC#
k. Are mailroom and warehouse staff trained in how to identify a suspicious package or substance and what to do in response?			NC#
l. Are specialized staff trained in decontamination procedures?			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 instruction 13.

AUDITOR: _____ DATE: _____

Counterterrorism Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
m. Are institution staff trained in basic fire suppression (in the event that local fire agencies are not available to respond because of a community terrorism incident)?			NC#
III. Emergency Plans			
A. Does the institution have specific emergency plans for responding to a physical assault from outside the facility?			NC#
B. Does the institution have emergency plans for responding to a biological attack on the facility?			NC#
C. Does the institution have emergency plans for responding to a biological attack in the community?			NC#
D. Does the institution have emergency plans for responding to a chemical attack on the facility?			NC#
E. Does the institution have emergency plans for responding to a chemical attack in the community?			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 instruction 13.

AUDITOR: _____ DATE: _____

Counterterrorism Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
F. Does the institution have emergency plans for responding to a suspicious package or substance received by an individual staff member or the mailroom?			NC#
G. Does the institution's emergency plan specify how to isolate and treat staff who may have been contaminated?			NC#
H. Do institution emergency plans specify how to preserve crime scenes and protect evidence?			NC#
I. Does the institution have emergency plans that describe steps to take in a mass casualty emergency?			NC#
J. Does the institution have emergency plans that specify how daily operations will be carried out during a utility failure?			NC#
K. Do the department's central office and the institution have plans for responding to a cyber attack?			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 instruction 13.

AUDITOR: _____ DATE: _____

Counterterrorism Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
L. Does the institution have emergency plans for responding to bomb threats?			NC#
M. Does the institution have emergency plans that specify how to respond if a bomb is found or is detonated?			NC#
N. Do institution emergency plans specify where inmates and staff are to be evacuated if necessary in a terrorist attack?			NC#
O. Do institution emergency plans specify what will be done regarding staff families in the event of a terrorist attack in the community?			NC#
P. Do institution emergency plans specify how to respond to an aircraft impact or vehicle impact/explosion?			NC#
Q. Do the central office and the institution have a plan for operating with reduced staffing levels if a terrorist attack in the community prevents staff from reporting to work?			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 instruction 13.

AUDITOR: _____ DATE: _____

Counterterrorism Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
IV. Mitigation			
A. Do post orders specifically require that officers monitor the exterior of the institution to detect unusual activities?			NC#
B. Are specially selected and specially trained counterterrorism staff assigned to armed posts?			NC#
C. Are food and water storage areas secured and protected from outside tampering?			NC#
D. Have arrangements been made for critical equipment and supplies (potable water, portable toilets, packaged meals, etc.) in the event of a terrorism incident?			NC#
E. Are deliveries closely inspected and screened before they enter the institution?			NC#
F. Are vendors and contractors required to submit to background checks before they enter the institution?			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 instruction 13.

AUDITOR: _____ DATE: _____

Counterterrorism Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
G. Are blueprints/site plans signed for by the contractors and returned to the institution after projects are completed?			NC#
H. Are emergency generators and regular power and water supplies outside the perimeter secured from public access?			NC#
I. In an emergency, can the power plant emergency generators and water supply be operated without inmate labor?			NC#
J. Are the front entrances and vehicle sally ports monitored by video cameras?			NC#
K. Has the institution analyzed its vulnerability to car bombs or vehicle intrusion and erected vehicle barriers to mitigate high-risk threats?			NC#
L. Does the institution have onsite explosive detection equipment?			NC#
M. Does the institution have onsite x-ray equipment?			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 instruction 13.

AUDITOR: _____ DATE: _____

Counterterrorism Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
N. If the institution does not have x-ray or explosive detection equipment, does it have written agreements with outside agencies to obtain that equipment if needed?			NC#
O. Are National Crime Information Center (NCIC) checks conducted on all new staff?			NC#
P. Is staff parking separated from visitor parking?			NC#
Q. Can the staff parking area be readily secured under emergency conditions?			NC#
R. Are procedures for high-risk inmate escort/travel orders reviewed annually?			NC#
S. Are visitor vehicle license plates checked at random periodically for outstanding arrest warrants?			NC#
T. Do the site plans show the institution "as built" rather than "as designed"?			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 instruction 13.

AUDITOR: _____ DATE: _____

Counterterrorism Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
U. Does the institution have video or photographs of each building, with indications of square footage, distances, utilities, entry/egress points, keys, phones, etc.?			NC#
V. Do staff check visitor areas (including lockers) before and after each visitation period?			NC#
W. Does the institution update its staff emergency notification/information sheets at least annually and keep staff photos current?			NC#
X. Are staff encouraged to maintain a personal emergency preparedness checklist in their home?			NC#
Y. In the event of an emergency, are utility shut-off locations available to responding police, fire, and utility company staff?			NC#
Z. In the event of an emergency, do authorized personnel have 24-hour access to building plans?			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 instruction 13.

AUDITOR: _____ DATE: _____

Counterterrorism Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
AA. In the event of an emergency, are special ID cards available to expedite entry of outside emergency personnel?			NC#
BB. In the event of a heightened terrorism alert, are there plans for increased perimeter security patrols?			NC#
CC. In the event of a heightened terrorist alert, are there plans to provide special armament and equipment to perimeter patrol staff and traffic checkpoint staff?			NC#
DD. Does equipment for these staff include rifle, shotgun, sidearm, aerosol chemical agent, flashlight, lantern, florescent vest/ jacket, protective vest, and handcuff/ flexcuffs?			NC#
EE. Are driver photographs, driver license numbers, and truck license plate numbers for regular delivery vehicles available to institution staff at extended traffic checkpoints?			NC#
FF. Is an area identified for offloading deliveries and supplies outside the institution's secure perimeter, and is there a plan to use this area if necessary.			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 instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
GG. Does the institution's inventory of state vehicles include license plate numbers, and is it updated at least annually?			NC#
V. Security Threat Groups (STGs)			
A. Is there a formalized plan to identify and monitor STGs?			NC#
B. Are all staff trained to recognize STGs through language used, signs, and tattoos?			NC#
C. Are possible threats by STGs regularly identified and monitored?			NC#
D. Do staff monitor STG recruitment activities?			NC#
E. Are staff aware of significant holidays observed by STGs and do they monitor activities of STG members during those times?			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 instruction 13.

AUDITOR: _____ DATE: _____

Counterterrorism Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
F. Are STG members denied access to certain jobs and/or areas of the institution?			NC#
G. Is the mailroom staff trained to monitor written materials for STG activity?			NC#
H. Is incoming mail for STG members monitored more frequently or more closely than mail for general population inmates?			NC#
I. Is there a reporting protocol established with the FBI and state police regarding STGs and members?			NC#
J. Are STG member phone calls monitored more frequently than phone calls for the general population?			NC#
VI. Inmate Visitation			
A. Are inmate visitors checked for outstanding arrest warrants?			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 instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
B. Are inmate visitors checked against a database of former inmates?			NC#
C. Are visitors of STG members (and/or other high-risk inmates) subjected to a higher level of screening/security checks than other inmate visitors?			NC#
D. Are inmate visitations randomly monitored for conversation content?			NC#
E. Are visitations of high-risk inmates monitored more frequently or more closely for conversation content than visitations of general population inmates?			NC#
VII. Inmate Telephone Calls			
A. Are phone calls restricted to an approved list of individuals for each inmate?			NC#
B. Are individuals on inmate phone lists screened for warrants?			NC#
C. Are individuals on inmate phone lists screened against a database of former inmates?			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 instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
D. Are individuals on high-risk inmate phone lists subjected to a higher level of security screening than individuals on general population inmate phone lists?			NC#
E. Is there a standard for the percentage of an inmate's phone conversations that are monitored?			NC#
F. Are high-risk inmate phone conversations monitored more frequently than phone conversations of general population inmates?			NC#
G. Are all inmate phone conversations electronically recorded to provide a perpetual database of at least 10 days' duration?			NC#
VIII. Inmate Mail			
A. Is mail to inmates monitored for coded information or terrorist information/ activity?			NC#
B. Are publications identified that are aligned or associated with terrorist groups or activities?			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 instruction 13.

AUDITOR: _____ DATE: _____

Counterterrorism Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
C. Is mail for high-risk inmates subjected to a higher level of screening than mail for general population inmates?			NC#
D. Is there a protocol for reporting adverse or potentially dangerous terrorist information obtained from inmate mail?			NC#
IX. Specialized Equipment			
A. Does the institution conduct annual equipment assessments specifically to determine needs and accessibility with regard to terrorism incidents?			NC#
B. Is emergency equipment tested on a monthly/quarterly/annual basis, with documentation of those checks?			NC#
C. Do staff have immediate access to personal protective equipment in the event of hazardous material contamination?			NC#
D. Have staff been trained in the use of this equipment?			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 instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
E. Does the institution have bomb detection equipment or bomb-sniffing dogs available?			NC#
F. In the case of an explosion, is search and rescue equipment readily available to the institution?			NC#
G. Does the institution have equipment and/or systems that provide communication among all key external emergency organizations?			NC#
H. Does the institution have an adequate supply of radios that share a frequency with local and state law enforcement and the local fire department?			NC#
X. Response to a Terrorism Incident in the Community			
A. Does the institution have a plan for supplying the community with food and other provisions?			NC#
B. Does the institution have a plan for loaning out staff in response to a community terrorism incident?			NC#
1. Does the institution have a plan to supply medical staff/equipment to the community?			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 instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
2. Does the institution have a plan to send specialized teams such as CERT to assist in a community terrorist incident?			NC#
C. Does the institution have a plan to make inmates available to the community to assist with cleanup?			NC#
D. Does the institution have a plan to make transportation available to the community if needed?			NC#
E. Do the institution's emergency preparedness specialists train with the local and state emergency management agencies at least annually?			NC#
XI. Institutional Intelligence Function			
A. Does the institution have an identified intelligence operation?			NC#
B. Does department-level policy or procedure specify coordination of institution intelligence operations?			NC#
C. Have staff assigned to the intelligence function received training in identifying terrorist activity and in responding to terrorist threats and incidents?			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 instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
XII. Response to Notification of Terrorist Threats			
A. Does the institution have different levels of alert (or readiness) defined in policy?			NC#
B. Does the institution have different levels of alert (or readiness) specified in its emergency plans?			NC#
C. In responding to notification of a credible and serious terrorist threat, does the institution have emergency policies that specify the following: 1. Security for employee parking?			NC#
2. Methods to increase screening of delivery vehicles?			NC#
3. Methods to increase security of mail and package delivery and storage?			NC#
4. Provisions for increasing security of vehicles on grounds?			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 instruction 13.

AUDITOR: _____ DATE: _____

Counterterrorism Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
5. Procedures for identifying/locating abandoned packages, suitcases, etc.?			NC#
6. Procedures for verifying staff and visitor identification?			NC#
7. A plan to reduce points of access to the institution?			NC#
8. A plan to increase inspections of all internal and external physical premises?			NC#
9. A plan to arm (or increase the arming of) the perimeter?			NC#
10. Provisions for erecting temporary vehicle barriers?			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 instruction 13.

AUDITOR: _____ DATE: _____

Counterterrorism Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
11. Procedures for informing management staff families about receipt of suspicious packages/mail?			NC#
12. Provisions for increasing liaison with local, state, and/or federal law enforcement?			NC#
13. Plans to move vehicles, crates, large trash receptacles, and other things that could conceal explosives or weapons away from buildings and critical areas?			NC#
14. Provisions for increasing external security patrols?			NC#
15. Plans to place emergency specialists on standby?			NC#
16. Plans to suspend inmate programs, outside work crews, onsite construction, etc.?			NC#
17. Plans to notify contractors, vendors, and/or visitors of restricted or cancelled access?			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 instruction 13.

AUDITOR: _____ DATE: _____

Counterterrorism Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
18. A plan to move into hard lockdown?			NC#
19. A plan to establish a traffic control point (or to move it farther from the institution)?			NC#
20. A plan to increase computer security?			NC#
21. A plan to increase random security spot checks of vehicles, visitors, packages, staff, etc.?			NC#
22. A plan to notify staff and staff families of higher alert levels to reduce rumors and family anxiety?			NC#
23. A plan to add security for and decrease access to critical resource areas?			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 instruction 13.

AUDITOR: _____ DATE: _____

Criterion	Status	Method	Comments
24. A plan to discontinue all inmate transfers in/out and to transport inmates to community hospitals and courts only in emergency situations?			NC#
D. Is there a protocol established for reporting relevant terrorist information to the state police and FBI?			NC#
XIII. Response to Cyber Attack			
A. Have the institution and the department's central office analyzed vulnerabilities to cyber attack?			NC#
B. Have the institution and the central office identified crucial records and crucial databases?			NC#
C. Have the institution and the central office designated "hot sites" (locations with an operating computer system that can accept and maintain software and/or database information from a disabled site) distant from their own locations?			NC#
D. Are all crucial databases and records within the department backed up offsite?			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 instruction 13.

AUDITOR: _____ DATE: _____

Counterterrorism Self-Audit Checklist (continued)

Criterion	Status	Method	Comments
E. Are there detailed plans for data recovery?			NC#
F. Are there detailed plans for operating with primary servers, databases, and programs disabled?			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 instruction 13.

AUDITOR: _____ DATE: _____

SUMMARY OF NONCOMPLIANCE ITEMS
Counterterrorism Self-Audit Checklist

AUDITOR: _____ PAGE _____ OF _____

DATE: _____

NC #	Item Description	Reason for Noncompliance	Assigned To	Due Date	Apprvd By	Apprval Date
Status:						
Method:						
Status:						
Method:						
Status:						
Method:						
Status:						
Method:						
Status:						
Method:						

Review of all items on this page completed: Yes_____ No_____

NAME: _____

SIGNATURE: _____ DATE: _____

Section 4

Report on the National Survey of Emergency Readiness in Prisons

In This Section

Report on the National Survey of Emergency Readiness in Prisons

Discussions of emergency preparation and response in prisons typically address what is done, what is in place, what is commonly accepted, and what is missing, with no recourse to systematic evidence or a body of data. Rather, such discussions typically reflect the experience of individuals who may be familiar with departments of corrections (DOCs) in a few states and sometimes are based simply on unexamined assumptions and biases. Believing that data on the current state of emergency preparedness and practices in prisons nationwide would benefit the field, the project team decided to develop a comprehensive survey for state DOCs with questions ranging from prevention and policy to equipment and personnel.

Method

Once the survey was developed, the project team recognized several barriers that might keep DOCs from completing it:

- The survey asked for a substantial amount of information and would require several hours of staff time to complete.
- Some departments have an individual in charge of emergency preparedness departmentwide; others do not. Moreover, the titles of these positions vary from state to state, and the positions may be located in the department's central office, at a specific institution, or at a training academy. Thus, there was no ready answer to the question "To whom should this survey be sent?"
- The survey asked for information about several areas that many departments regard as sensitive and/or confidential (e.g., tactical team training).

To overcome these barriers, the project team implemented a two-step strategy. First, a letter describing the overall project, the purpose of the guide, and the survey was sent to the commissioner (or director or secretary) of each department. The letter invited the department to participate in the survey and asked the commissioner to identify either the person in charge of emergency preparedness or the person who would be designated to complete the survey. The project team would then work directly with that individual rather than continue to work through the commissioner's office. The letter also emphasized that the project was being conducted under the aegis of NIC. This fact served to assuage department concerns regarding confidentiality, even in states where the commissioner was unfamiliar with both the organization conducting the project, LETRA, Inc., and with individual members of the project team.

Once a commissioner agreed to participate in the survey and identified a contact person within his or her department, the project team corresponded with the contact person and sent the survey itself. If the contact person did not return the completed survey in approximately 6 weeks, the project team followed up with a reminder letter. If several more weeks passed with no response, a member of the project team telephoned the

department contact person to encourage completion of the survey.

Survey Limitations

Accuracy

Like most surveys, this instrument was designed for self-report—that is, the information the responding departments provided could not, for the most part, be verified. The survey instructions did ask the departments to return backup information such as copies of emergency policies and emergency response plans along with the completed survey, and these documents confirmed most of the responses of most of the departments. However, the project team was not always in a position to know whether a department's state of emergency readiness was as good as the department claimed. Similarly, if a department answered a question inaccurately because the person filling out the survey misunderstood the question, the project team had no way to identify the error.

Completeness

Some departments that filled out and returned the survey did not answer every question. Most of these departments provided no explanation for responses left blank. Possibly, the unanswered questions seemed inapplicable to the person filling out the survey or too time consuming or difficult to answer.

Timeliness

These survey results were obtained in 2002–2003 and reflect the national status of emergency readiness in state DOCs at that time. The results will be less representative as time passes and departments change.

Results

Participating Departments

Of the 51 departments asked to complete the survey (the 50 state DOCs and the Federal Bureau of Prisons), 41 initially agreed and 34 actually returned completed surveys—that is, 7 departments whose commissioners agreed to participate did not return completed surveys, despite additional correspondence and phone calls encouraging them to do so. Several of these departments continued to state their commitment to participate but simply did not find time to actually complete the survey. A few departments did not communicate with the project staff in any way after the commissioner's initial commitment to participate. Of the remaining 10 of the 51 departments, 1 declined to participate and 9 never responded to the initial letter or to followup letters.

Overall, 34 of the 51 departments—exactly two-thirds—completed the survey, providing a large sample. Given the amount of information the survey asked for and the confidential nature of some of the information, the response rate actually exceeded the project team's most optimistic initial estimates. The sample includes four of the five largest DOCs in the country as well as an excellent cross section of medium-sized and small departments. All geographic regions of the country are also represented.

Characteristics of Sample

Of the 34 departments, 3 have full peace officer powers for their security staff, 12 have partial peace officer powers, and 19 have no peace officer powers. Seven of the participating departments are combined jail and prison systems. Only 3 of the responding departments include juvenile institutions, while 29 do not. Some form of probation and parole is provided by 25 departments, 19 of which have probation and parole staff within the department.

Interpretation of Survey Results

Although 34 state departments of corrections returned completed survey forms, the number of responses to a specific question may be fewer than 34. There are two reasons for the variance in the number of responses. First, as noted above, some departments did not answer every survey question. The second reason is that some survey responses were difficult to interpret. If the project team was not reasonably certain about the meaning of a response to an item, the response was excluded from the data and analysis presented in this report. The number of respondents *(N)* is noted in tables when appropriate.

Emergency System

The terms "emergency plan" and "emergency system" should not be confused. "Emergency plan" most often designates the planned response to an emergency at a particular institution, whereas "emergency system" usually designates a department's comprehensive preparations for emergencies. Emergency systems may include philosophy and goals in emergency situations, emergency policies, organizational structure, plans for addressing aftermath issues, staff training on emergency topics, prevention strategies, and risk assessment, in addition to individual institutional emergency plans that focus on response procedures, emergency equipment, and emergency teams.

Twenty-eight of 33 departments (85 percent) reported having a departmental emergency system in place at each institution in the state (table 1). Although the other five departments did not have departmental emergency systems, it was evident from their answers to other questions in the survey that they do have some emergency plans, policies, and procedures at their institutions. For these five departments, emergency planning is entirely an institutional function. With no departmental framework, requirements, or template, emergency preparation and response may vary widely from prison to prison, and issues such as mutual aid may be more problematic.

Table 1. Most departments do have some type of emergency system

Characteristic of Emergency System	Departments	
	Yes	No
Departmental system	28	5
System developed internally	14	12

Of the 14 departments that reported developing their own emergency system (table 1), 7 stated that the system either was modeled on that of another state or that they had used materials from another state. Several of these departments cited the Oregon DOC's emergency system as their model or as one of the primary sources for the development of their system. Three departments reported basing their system on some variation of the Incident Command System (ICS) originally developed for fire departments. One of these departments cited a local fire department as its source, and the other two mentioned the Federal Emergency Management Agency (FEMA). The majority of state DOCs whose emergency systems were used as models by other states use the LETRA system themselves.

Ten of the twelve departments that did not develop their own emergency system reported using LETRA's *Emergency Preparedness for*

Correctional Institutions.[1] Several other state DOCs reported using as a model a state that uses the LETRA emergency system without citing LETRA directly. No other proprietary systems were mentioned.

Emergency Plans

Emergency plans differ dramatically from department to department, in form as well as content. Although emergency plans are institution specific in most correctional agencies, they are departmentwide in a few. For most DOCs, the term "emergency plan" is synonymous with each institution's emergency manual (or manuals). However, there are departments in which emergency plan refers to a section of the departmental policies and procedures. Many prisons have emergency plans that are several hundred pages in length, but it is also possible to find prison emergency plans that are fewer than 10 pages. It is tempting to assume that all prisons have an emergency plan, whether large or small, good or bad. Although that is true for the vast majority, some prisons have no emergency plan at all. For example, the inquiry after the 1993 insurrection at the Montana State Prison (see Section 6, Case Studies, "Riot at Max: Montana State Prison") discovered that the warden had been working on a draft emergency plan at the time of the riot, but that no plan was or had been in place.

The survey data reflect two fundamentally different approaches to emergency planning (table 2). For many years, the traditional way to develop an emergency plan was to create a separate, independent plan for each type of emergency considered. When compiled, the separate plans became the overall institutional emergency plan.

Table 2. Most departments have separate plans for different types of emergencies

Type of Emergency Plan(s) in Use	Departments (*N* = 34)
Generic plan for all emergencies	10*
Separate plans for different kinds of emergencies	30
Both generic and separate plans	6†

* All 10 departments use the LETRA emergency system.
† It was not possible to determine from these departments' responses whether they have generic plans combined with specific emergency additions or traditional separate plans accompanied by some departmental provisions that are more general.

More recently, some departments have changed to a single, comprehensive plan (sometimes called an "all-risk" plan) that is the basis for responding to any emergency or large-scale crisis in the prison. This generic plan is supplemented by appendixes or emergency-specific additions that specify how the plan will be augmented or modified for a particular type of emergency. The rationale for using a generic plan is as follows:

- Most of the steps that must be taken in response to any major crisis are the same (emergency lockdown, command notifications, staff callbacks, use of mutual aid agencies, etc.).
- It is easier to train staff in one generic plan than six or eight different plans.
- Different plans may actually provide conflicting directions when an emergency situation involves more than one type of crisis.

Nearly half of the departments reporting have changed to the generic plan approach, either solely or in combination with some form of individual plan.

The responses regarding the specific types of emergencies addressed in emergency plans were somewhat surprising (table 3). It was predictable that most DOCs would have emergency plans

[1] The comprehensive emergency system developed by LETRA, Inc., for correctional institutions is described in *Emergency Preparedness for Correctional Institutions,* 3d edition (Campbell, CA: 2004).

that specifically considered fire, hostage incidents, riot, and mass escape. However, less than one-third of the responding departments had engaged in any specific planning for terrorism or terrorist threats, even some 2 years after the attacks of September 11, 2001 (9/11). Similarly, less than half the departments reported any specific plans for responding to an outside assault on the prison, although such situations have occurred several times around the country, typically as an attempt to break specific inmates out of the prison.

Table 3. Departments varied greatly in the number of specific types of emergencies addressed in their emergency plans

Type of Emergency Addressed in Plan	Departments (*N* = 34)
Fire	31
Hostage incidents	30
Severe weather	28
Riot	28
Mass escape	28
Hurricane	12
Outside assault	12
Terrorism or terrorist threats	11

The format of an emergency plan is an important consideration, one that goes far beyond questions of style. The advantages to using the same emergency plan format at all institutions in a DOC are obvious when an institution is in the midst of a large-scale crisis and needs staff or other resources from other institutions in the department. Additionally, the uniform format will enable central office staff to review the emergency plans of the institution experiencing the crisis without research or analysis, thus saving precious time. A uniform emergency plan format also allows staff transferring from one institution to another within the state to understand the new institution's emergency plans quickly and easily. The data in table 4 indicate that 82 percent of the responding departments require a uniform emergency plan format at each institution.

Table 4. Most DOCs employ a consistent format for emergency plans

Format of Emergency Plans	Departments (*N* = 33)
Uniformity of plans	
Same at each institution	27
Vary from prison to prison	6
Format of plans	
Checklist and narrative	26
Predominantly checklist	7
Entirely narrative	2
Computerized emergency system	
In use and available to each institution	5
Not used	28

Recognition has also increased over the past 25 years that checklist-driven emergency plans are more practical and user friendly than plans that use a narrative format. Thirty-one of the 33 departments responding to this question (94 percent) use emergency plans that are either predominantly checklist based or that combine checklists and narrative (table 4). Only two departments reported using emergency plans that are entirely narrative in format.

As expected, only a relatively small percentage of departments (15 percent) reported using emergency systems that are computerized to any substantial degree (table 4). No department reported an emergency system that is exclusively computerized. In private industry, computerized approaches to disaster planning are quite common, and many companies now base their disaster planning efforts around a proprietary software program. An important distinction is that for many private industries, the emphasis is on disaster planning and disaster recovery, whereas for correctional institutions, the greatest

emphasis must be on responding to the emergency in real time. Nevertheless, it seems probable that future directions in prison emergency planning will rely increasingly on software and automated systems for some aspects of emergency planning and response.

Large-scale crisis situations also frequently require highly specialized functions. The majority of the responding departments reported having written plans for some specialized functions within their overall emergency response procedures (table 5). As might be expected, the number of departments varied with the type of specialized function.

Table 5. Most emergency plans include procedures for specialized functions

Specialized Function Represented in Emergency Plans	Departments
Inmate death	29
Emergency count	26
Emergency lockdown	23
Posttraumatic support for staff	23
Mass casualties	16
Officer-involved shooting	11

The results in table 5 are very encouraging. They reflect a sharp increase in the degree of sophistication of DOC emergency plans across the United States.[2] Two-thirds of the responding DOCs indicated that their emergency plans included specific procedures for posttraumatic incident support for staff, and two-thirds also have specific procedures for emergency counts. Almost half the departments reported procedural consideration for mass casualty situations. These results reflect a degree of sophistication not found as recently as 10 years ago.

[2] This observation is based on the project director's personal review of emergency readiness in more than half of the state DOCs during the past 20 years.

Emergency Teams

The responses on the use of emergency teams are surprising (table 6). Of 32 departments responding to the question, 31 (97 percent) said they maintain one or more emergency teams, suggesting that the use of emergency teams has become close to universal in state prison systems. This finding is another indicator of the sharply increasing sophistication of the corrections field in the area of emergency readiness. Just over two-thirds of the responding departments also said they rely on external teams at some of their institutions. That is, a DOC may have its own CERT teams and hostage negotiation teams at its major institutions but rely on local or state law enforcement emergency teams to provide these functions at its smaller and more isolated prisons—typically those that are lower security institutions. Such a strategy is practical and efficient but requires a great deal of planning, coordination, and training to be effective.[3]

Table 6. Most departments have their own emergency teams

	Departments	
Use of Emergency Teams	Yes	No
Department has one or more teams (CERT, SORT, hostage negotiators, etc.)	31	1
Department relies on external teams at some of its institutions	21	9

Departments were asked to describe the types of emergency teams they maintained. These data are not precise because some departments use the same name for different types of teams, whereas other departments use very different names for teams with essentially the same function. In particular, some departments maintain marksman/observer teams (snipers), but because

[3] The topic of emergency teams is also discussed in the chapter by that name in Section 5: Resource Materials.

these teams are attached to or part of the tactical team, the departments may not have identified them separately. Thus, it is likely that marksman teams are underrepresented in these data.

Similarly, almost all departments had some form of tactical and/or disturbance control team (table 7). The survey distinguished between these two types of teams as follows:

- **Tactical team:** Team members train with firearms. The team's function includes missions such as hostage rescue. It is a lethal force team, although it is also trained and equipped to use sublethal force.
- **Disturbance control team:** Team members typically train with batons and shields and with chemical agents and practice formations but do not train with firearms. The team's identified missions do not include hostage rescue and dynamic entry with firearms. It is a sublethal force team.

Table 7. Most DOCs have tactical teams and hostage negotiation teams

	Departments (*N* = 33)	
Type of Emergency Team	Number	Percent
Tactical	32	97
Disturbance control	18	55
Hostage negotiation	26	79
Posttrauma or peer counseling	6	18
Marksman ("sniper")	5	15
K–9	4	12

If a department responded by describing a CERT or SORT team and its description did not clarify whether the team should be classified as a tactical or disturbance control team, the department was arbitrarily counted as having a tactical team. As a result, these data may overestimate the number of tactical teams and underestimate the number of disturbance control teams.

In most cases, the tactical teams were statewide or regional and the disturbance control teams were institution based; however, there were exceptions.

The responding departments used a wide variety of names for both hostage negotiation and posttrauma teams. The responses also identified several other teams unique to a particular department, such as public information teams and mounted horse teams.

Table 7 demonstrates state DOCs' almost complete acceptance of tactical and disturbance control teams as essential to emergency preparedness. Only one department responded that it had neither a tactical nor a disturbance control team. It may well be that this department has decided to use law enforcement tactical teams when the need arises. On the other hand, one department did not answer this survey question, and there is almost certainly a sampling bias in these survey results. That is, DOCs that have emphasized emergency preparedness were more likely to respond to this survey than departments that have ignored or given short shrift to emergency readiness. Thus, it is reasonable to surmise that some of the 17 DOCs that did not participate in this survey have not developed or maintained emergency teams and may have made no alternate arrangements (e.g., with law enforcement agencies within their state).

Seventy-nine percent of the departments have their own hostage negotiation teams. These data reflect more than simply an increase in sophistication about hostage incidents in the field of corrections. They indicate a change in philosophy. In the 1970s and 1980s, many DOCs did not have hostage negotiation teams. In some cases, the absence of a hostage negotiation team was a result of a lack of knowledge or lack of specialized expertise but, in many cases, it was because the department leadership had taken the stance that "we don't negotiate" (sometimes

expressed as "If they take hostages, we are going to assault—period!"). The history of hostage incidents in American prisons and jails has demonstrated that most hostage situations can be resolved successfully through negotiation—although some cannot—and that when negotiation can be used successfully, doing so is decidedly a much safer alternative for the hostages. The change in the general approach to dealing with hostage incidents demonstrated by the survey data reflect a broad awareness of this history.

Only six departments (18 percent) reported maintaining posttrauma or peer counseling teams. It is tempting to interpret this relatively small percentage as a negative reflection on the field. However, that conclusion is not warranted because a relatively large number of departments indicated elsewhere in the survey that they depend on external resources (e.g., contract mental health professionals) rather than on departmental teams for these services. These data do suggest that relatively few departments use both specialized private psychological service providers for posttrauma care and peer support groups for additional capacity to screen, debrief, and work with potentially traumatized staff. Such a combined approach may deserve more attention than it appears to have received.

Emergency Training

The findings on emergency preparedness training for new recruits are discouraging. The survey results show the length of the average recruit academy to be almost 5 1/2 weeks, with only 6 hours devoted to emergency preparedness (table 8). Emergency preparedness is both an unusually broad topic and one in which "the devil is in the details." For recruit training on emergency preparedness to be effective, newly hired staff must come away from the academy training program with a clear understanding of the specific procedures required in various types of crisis situations. How that goal can be accomplished in 6 hours or less is difficult to understand.

Table 8. The average recruit academy is more than 5 weeks' duration

Criteria	Hours*
Average length of recruit academy	213†
Average time spent on general emergency preparedness in recruit academy	6‡

* Thirty departments responded to this question.

† The responses ranged from a low of 36 hours to a high of 720 hours.

‡ Most departments identified a few emergency subjects, such as fire, riot, and hostage situations, to which they give a small number of hours of additional specialized emphasis. Each of these topics averages 2 hours' coverage within the recruit academy curriculums. No other emergency subject area was identified by as many as five departments.

The commitment represented by a 5 1/2-week training program for new recruits must be acknowledged, however, as a direct manifestation of a profound change that has taken place in corrections. State corrections has gone from being a largely nonprofessional endeavor as recently as three to four decades ago to being a professional field with rigorous standards for personnel and training. In some departments, older staff still talk about reporting for their first day of work and receiving a set of keys and a warning to "be careful while you're figuring it out," with no training whatsoever. Although those days were 25 to 35 years ago in most departments, the use of lengthy and comprehensive recruit academy training programs has only evolved much more recently.

The responses on inservice training on emergency preparedness reflected three distinct approaches:

- A substantial initial inservice training program, typically between 8 and 16 hours,

followed up with annual refresher training, ranging from 4 to 8 hours.

- Annual inservice training ranging from 2 to 4 hours, with no substantial initial block of training on either an inservice or preservice basis.
- Little or no inservice training (1 hour or less).

Of the 30 departments responding to the question about inservice training, 8 (just over one-quarter) were in the last category. One hour or less per year of emergency preparedness training is obviously inadequate for prison staff. This lack of commitment to ongoing emergency training can itself create unacceptable risks.

In contrast to the results on inservice training for general staff, the data for mid- and upper-level managers are quite positive. The majority of the responding departments provide additional training on emergency preparedness to staff at middle management level and above—a finding that reflects awareness that prison staff at these levels serve as shift commanders. In almost all prisons, it is the shift commander who is in charge of the institution during evenings and weekends and who may suddenly be in command if an unexpected crisis occurs. It follows that these staff members need far more depth of preparation for responding to emergency situations than the front-line staff member or first-line supervisor. For these reasons, it is encouraging to find that 23 of the 30 responding departments (77 percent) provide managers at mid-level and above with at least 2 hours of emergency training annually beyond that provided for general staff (table 9).

Given the high percentage of DOCs that provide additional refresher training on emergency preparedness for mid- and upper-level managers, the responses regarding additional initial emergency training for these managers are somewhat surprising. Only 12 of 30 departments (40 percent) provide more initial emergency training for their mid- and upper-level managers than for their general staff (table 9). Some departments clearly indicated not only that they provided additional training for management staff on emergency and crisis issues, but that the training was specifically tailored to the responsibilities of higher ranking staff. In many cases, however, the departments' descriptions of their training programs and curriculums were too idiosyncratic or lacking in sufficient detail to allow the project team to draw further conclusions.

Table 9. Most departments provide additional training on emergency preparedness at the middle management level and above

Hours of Additional Emergency Preparedness Training	Departments (*N* = 30)
Initial training	
8–16	7
1–4	5
None	18
Refresher training (hours/year)	
More than 10	2
6–10	5
2–4	16
1 or less	7

Emergency Drills and Simulations

All departments responding to the survey indicated they conduct fire drills of some sort, but two departments did not indicate how frequently (table 10). The majority of the departments conduct some actual timed evacuation drills and some simulations (staff walkthroughs) (tables 11 and 12). The following patterns were the two most commonly cited:

- Conducting all fire drills as actual evacuation drills, except for those in restricted or segregation housing units, which are handled with staff walkthroughs.

- Conducting actual evacuation drills on one shift per quarter per housing area and staff walkthroughs on the other two shifts in each housing area each quarter.

Table 10. All departments require fire drills

Frequency of Fire Drills	Departments (*N* = 34)
Once a month on each shift in each housing area (36 drills per year per area)	1
Once per quarter on each shift in each housing area (12 drills per year per area)	13
Once per quarter per housing area (4 drills per year per area)	18
Frequency not reported	2

Table 11. Most departments time and evaluate evacuation fire drills

Requirements for Fire Drills	Departments Yes	No
Timed evacuation and written critique of drill's strengths and weaknesses	32	2
Monitors or evaluators must be present	28	4
Observation/assessment by community fire officials in all or some drills	7	27

Table 12. Most departments require some program of emergency drills and exercises

Type of Emergency Exercise or Simulation	Departments (*N* = 34) Yes*	No
Tabletop exercises	23 (12)	11
Functional exercises	29 (20)	5
Full-scale simulations	21 (16)	13

* The number of departments that require the given type of exercise by policy is given in parentheses.

One fire drill issue deserves special mention, as it remains controversial: Should fire drills in a prison's highest security areas (e.g., administrative segregation) and areas most difficult to move (e.g., an infirmary) be conducted as actual, timed evacuation drills or as staff walkthrough simulations? Some prison administrators would never consider actual evacuation drills for such areas because they believe the risks are too high. Others feel just as vehemently that without conducting actual evacuations, procedures exist only on paper and there is no way to discover problems or adequately prepare staff for the eventuality of a real evacuation. Administrators that subscribe to the latter rationale typically deploy extra staff and use extra planning when conducting evacuation drills in high-profile areas. The survey did ask specifically about areas excluded from evacuation drills, but the question proved not to be well-enough defined, and the answers were not consistent enough to be interpreted numerically.

Excluding fire drills, at least some other type of emergency exercise or simulation is required by policy in 23 departments (table 12). These include tabletop exercises, functional exercises (defined by the survey instrument as involving role playing in real time without the participation of external agencies), and full-scale simulations (major exercises in real time using actual areas of the facility and actual emergency equipment and involving the participation of external agencies). Most of the departments conduct functional exercises and full-scale simulations annually at each institution, although a small number indicated that they conduct them quarterly. The data in table 12 also indicate that some of the departments regularly conducting emergency exercises and drills do not require that activity by policy.

Table 13 shows the general requirements for emergency drills and simulations reported by the 29 departments in the survey that conduct them. When asked whether they conduct emergency exercises on each shift, 16 departments said "yes," 13 said "no," and 5 did not answer the question. This result reveals a longstanding bias. Emergency drills and emergency plans

tend to be written on the assumption that crises and disasters will strike on the day shift between Monday and Friday, and prison administrators often operate under the same assumptions. History says these events tend to happen during the evening and on weekends.

Table 13. Emergency exercises are typically planned, evaluated, and critiqued

General Requirements for Emergency Drills and Simulations	Departments (*N* = 29) Yes	No
Monitors or evaluators must be present	26	3
Written plan for exercises required with objectives stated	25	4
Written critique of strengths and weaknesses discovered during the exercise required	27	2
Controllers employed to monitor safety of exercise and stop it if conditions become unsafe or a real emergency develops	28	1

Emergency System Audits

Twenty departments reported using a written emergency system audit form or protocol and 13 said they did not have or use such an instrument. The most common frequency of emergency system auditing was annually (13 departments), followed by biannually (6 departments).

Basic Security and Operational Information

Security audits, random urinalysis testing of inmates, and inmate grievance systems are well-accepted best practices, and the survey's documentation of their widespread use is encouraging (table 14). The results also show increasing acceptance of the crucial role the public information function plays, not only in prison crises, but in day-to-day correctional management. Of 34 departments responding, 20 (59 percent) have designated public information officers at each institution. All 20 of these departments also have a department-level public information officer.

Table 14. Almost all departments conduct security audits and urinalysis tests and operate an inmate grievance system

Security Procedure	Departments Yes	No
Regular security audits	32*	2
Combination of one or more of the following methods	26	—
Self-audit	16	—
Security managers from other institutions	13	—
Participation of staff from the central office	26	—
External security consultants	6	—
Random urinalysis testing of inmates for illegal drugs†	34	0
Random urinalysis testing of staff for illegal drugs	8	18
Formal inmate grievance system	34	0
Monthly summaries by area of institution, shift, and nature of grievance	30	4
Departmental public information officer	24	10
Public information officer at each institution	20	14

Note: —, not applicable.

* Most departments stated that they conduct audits annually.

† The percentage of the inmate population tested each month ranged from 2 to 40 percent, for an average of 10 percent.

The breakdown of information in table 14 on how security audits are conducted reveals that of 32 departments, only 6 (19 percent) rely primarily on external consultants, whereas 26 (81 percent) use some combination of their own staff and other departmental staff. The overall security audit data represent another important change in the field: As recently as 15 years ago, regular security auditing was not a common practice among state DOCs.

These results do raise a troubling question: How do DOCs define a security audit? Most corrections professionals with specific expertise in security auditing would assume that a security audit is a rigorous, detailed, comprehensive examination that covers a great number of an institution's security procedures and practices as well as its security equipment, logs, reports and other documentation, and more. As a practical matter, that kind of audit is far too demanding to be performed monthly. Thus, the DOCs reporting monthly security audits may be referring to security inspections or some other review that is far less thorough than what is generally understood by the term "security audit."

Emergency Policies and Specific Response Plans

The survey responses on emergency policies, procedures, and response plans held few surprises. Most departments indicated specific policies, procedures, and response plans for many of the predictable aspects of a crisis or emergency situation (table 15). Only 12 of 30 departments responding (40 percent) reported the use of any kind of risk assessment process—a somewhat surprising result, because risk assessment should be the starting point for emergency planning at any institution. Without performing a risk assessment, it is impossible to prioritize resources, planning, and training time to match the relative probabilities of specific types of emergencies at the facility.

Table 15. Most departments have specific policies, procedures, and response plans for the predictable aspects of a crisis or emergency situation

	Departments	
Specific Emergency Policies, Procedures, and Response Plans	**Yes**	**No**
Written policy/procedure for emergency counts	29	4
Written policy/procedure for emergency lockdowns	20	14
Crucial emergency locations identified at each institution (e.g., media area)	31	3
Specific response plans		
Offsite evacuation	25	9
Defending in place*	18	16
Natural disasters	27	5
Specific policies/procedures		
Prevention of major emergencies	23	11
Natural disasters	18	15
Terrorist threats or response to terrorism	11	23
Command post checklists used	30	4
Risk assessment processes	12	18
Emergency assessment form used to evaluate a developing emergency	15	19
Assessment form used to gauge readiness for natural disasters	10	24
Policy requiring institutional emergency plans to be reviewed or approved outside the institution	23†	11

* Maintaining a defensive position within the facility rather than evacuating.

† Twenty-two of these departments require the review and approval process to occur annually.

Table 15 shows a puzzling discrepancy in the data on planning for natural disasters. Of 32 departments responding, 27 (84 percent) said they have specific response plans for natural disasters. A response plan for natural disasters would certainly include some specific procedures, yet only 18 of 33 responding departments (55 percent) replied that they have specific policies or procedures for natural disasters. Possibly some departments that stated they had natural disaster response plans did not then respond that they had specific policies and procedures for natural disasters because they believed the previous response had already answered the question—that is, the apparent discrepancy may be an artifact of the sequence of questions. The low percentage of departments reporting specific policies and procedures for dealing with natural disasters was, however, a major factor in the decision to include in this guide a freestanding self-audit checklist for natural disasters, fires, and HAZMAT situations.

Twenty-five of 34 departments (74 percent) indicated that they had specific response plans for offsite evacuation. It is worth noting that offsite evacuation is a very easy concept but a very complex and challenging reality.

Finally, LETRA's emergency preparedness system began 25 years ago to advance the concept that checklist-driven emergency plans are more user friendly during a crisis. The data in table 15 showing that 30 of 34 departments (88 percent) use a command post checklist suggest that acceptance of that principle is now almost universal.

Any thoughtful analysis of prison emergency situations will conclude that some of the well-accepted standard policies and procedures used to direct day-to-day operations will not work well in emergencies or large-scale crises. For example, an institution's policies and procedures typically assign responsibilities for certain functions by rank or specific position within the institution. In an emergency, however, specific individuals or any staff of a specific rank may be off duty, on annual leave, or otherwise unavailable. Nevertheless, the function in question must be managed immediately or the overall response to the emergency situation may fail. In such circumstances, emergency plans must include emergency post orders or a similar mechanism that allows an available staff member to be assigned to an emergency responsibility for which that staff member may have minimal training and preparation. The data in table 16 suggest that most DOCs now recognize the distinction between day-to-day policy and procedure and emergency policy and procedure.

The survey responses demonstrated a high level of emphasis on postemergency procedures (table 17). Predictably, a reporting process for documenting emergencies was the deactivation procedure mentioned most often, cited by 32 of the 34 participating agencies (94 percent). Many departments also reported plans for emergency deactivation and policies or plans for returning to normal operations ("stepdown" plans) (76 percent and 79 percent of responding departments, respectively). The least frequently cited postemergency policy or procedure was a method for using "lessons learned," reported by only 17 of 30 of responding departments (57 percent).

The somewhat lower frequency of use of lessons learned compared with other deactivation and postemergency procedures probably reflects a hesitancy to analyze and document weaknesses and failures that occurred during a crisis. Although some of this hesitancy may be ascribed to defensiveness on the part of the department or individuals leaders, much of it is likely rooted in fear of litigation. A department may recognize that it is professionally important to disseminate a thoughtful critique of its performance in an emergency situation but may be less sanguine about creating a roadmap for potential plaintiffs.

Thoughtful administrators recognize that almost nothing escapes the discovery process in civil litigation and that it is far more important to learn from mistakes than to hoard information that could avert a future emergency.

All 34 departments participating in the survey reported using some form of employee assistance program (EAP), whether state government, department, or institution based (table 18). Twenty-one departments—a significant 62 percent—also provide some type of specialized crisis intervention help for traumatized or injured staff or staff families, and 14 departments (41 percent) provide peer counseling or peer support group assistance for injured or traumatized staff. These data demonstrate a marked shift from the traditional stance of "You have to get back in the saddle," and "If you aren't tough enough to deal with this, maybe you aren't tough enough to work here." Most departments' posttrauma programs or services have been developed within the past 20 years, and this change in the field is another that is emblematic of a philosophical shift. (The apparent

Table 16. Many emergency policies and procedures differ substantially from day-to-day policies and procedures

	Departments	
Standard Policies and Procedures That Change During an Emergency	**Yes**	**No**
Designated command structure for emergencies that is different from the day-to-day organizational structure	31	3
Emergency post orders or similar vehicle used to specify command duties during an emergency	31*	3
Emergency policies that are separate and distinct from everyday policy	27	6
Public information policy for emergencies	11	23
Policy on change of command during an emergency	24	10
Policy plans for the treatment of hostages after release	26	8
Specific staff position for coordinating emergency readiness and response		
Department level	20	14
Institutional level	17†	7

* These are the same departments that responded "yes" to the previous question.

† All of these departments also have a departmental emergency preparedness coordinator.

Table 17. Most departments have detailed procedures for the aftermath of an emergency

	Departments	
Postemergency Policies and Procedures	**Yes**	**No**
Emergency deactivation plan	25	8
Policy or plan for "stepping down" from emergency conditions to normal operations	26	7
Standardized reporting process for documenting emergencies	32	2
Policy mandating a postemergency strategic response that includes identifying and addressing the factors that caused the emergency	20	14
Standard method for finding and disseminating lessons learned from emergency situations	17	13

Table 18. All departments offer an employee assistance program, and the majority provide additional specialized posttrauma care

Postemergency Staff Support Services	Departments (*N* = 34)
Employee assistance program (EAP)*	34
State government program	22
Department program	15
Institution program	9
Services in addition to EAP	
Peer counseling	14
Specialized crisis intervention services	21

* Some departments have more than one form of EAP.

discrepancy between these findings and the data reported earlier indicating that only six departments maintain peer support or peer counseling teams may be a gap between policy and reality. That is, some departments may have policy and plans specifying that peer support will be provided in the aftermath of a traumatic situation but may never have organized a team to provide such support or may have initially formed a team and then allowed it to lapse. The authors have had experience with that state of affairs, not only with peer counseling teams but also with hostage negotiation teams.)

Reliance on outside agencies is not a new concept. It is probably as old as prisons themselves. Prisons have always relied heavily on local fire departments to respond to major fires and on state and local police to help respond to large inmate riots and prison disturbances, or even to take over in responding to these events. A riot or a hostage situation has always meant that ambulances and support from local hospitals might be essential. Thirty or forty years ago, that kind of help would have been unplanned—that is, details of the assistance would have been worked out on the spot, in the heat of the crisis. The data in table 19 show this is another area that has seen major change.

Table 19. State DOCs rely in part on external agencies for emergency assistance

	Departments	
External Agency Agreements	Yes	No
Emergency plans include interagency agreements	24	9
With state police	22	—
With local police	20	—
With local fire departments	19	—
Written interagency agreement to provide services to community in event of disasters	11	21
Inmates trained to provide community assistance in event of disasters	15	18
Working relationships with other agencies		
State emergency management agency	29	3
County emergency organization	16	16
National Guard	19	13

Note: —, not applicable.

Today, reliance on external agencies for assistance during a crisis is most often an integral part of a prison's emergency planning and is written into the institution's emergency manuals. In this survey, 24 of the 33 departments responding to this question (73 percent) indicated that written interagency agreements are included in the institution's emergency plans. Responses to two other questions reported in table 19 also reflect major changes that have occurred over the past 10 to 20 years in American prisons: 15 of 33 departments (45 percent) stated that they have trained inmates to provide some form of community assistance in the event of certain types of community disasters, and 11 of 32 departments (34 percent) have written agreements describing that kind of community assistance. Using inmates to help with community disasters is not a new or recent idea, but planning for that eventuality is an outgrowth of the recent emphasis on developing comprehensive, detailed, and realistic emergency policies and plans.

Thirty-two departments responded to a series of questions about working relationships with other agencies. Of the responding departments, 29 (91 percent) reported having a working relationship with their state emergency management agency, and 16 (50 percent) reported a working relationship with their county emergency organization. Many of these relationships have been forged since 9/11 and the advent of the Department of Homeland Security. Since FEMA was organized at the national level, some state emergency management agencies have had access to extraordinary emergency resources. However, until the 1990s—and until the events of September 11, 2001, in some cases—state DOCs had no working relationship with their state emergency agencies and had no awareness of the kinds of resources available to them through those agencies. The survey results show that this is no longer the case and that the National Incident Management System is being well incorporated into prison emergency planning.

The response pattern was quite different when departments were asked about terrorism and terrorist threats (table 20). The data on specific counterterrorism measures are quite consistent with the survey data on training on terrorism and terrorist activity. Notably, only 10 of 34 departments responding (29 percent) reported any specific policy, response plan, or procedure designed to respond to terrorist threats or a terrorist incident. These data are not encouraging when compared with the level of counterterrorism planning in fire departments and law enforcement. At the time of this survey, in the aftermath of September 11, almost every medium-sized or large local or state law enforcement agency and fire department would have answered this question in the affirmative.

Table 20. Specific counterterrorism measures remain infrequent among state DOCs

	Departments (*N* = 34)	
Counterterrorism Measure	**Yes**	**No**
Regular participation in interagency meetings on terrorism	24	10
Specific policy or response plans/ procedures for terrorist threats or terrorism	10	24
Equipment acquired specifically for threat of terrorism	3	31
Policies/procedures for integrating FBI into department's response to terrorist activity	3	31

The first item in table 20 is more positive. Of 34 departments responding, 24 (71 percent) were regularly participating in interagency meetings on counterterrorism at the time of the survey. Continued participation of state DOCs in interagency counterterrorism meetings and task forces should lead departments to incorporate counterterrorism concerns, policies, and procedures more frequently into their emergency planning.

Summary

Fifteen years ago, it is doubtful that one-third of the state DOCs had any kind of serious system of emergency preparedness and response. The survey results suggest that today this figure is above 70 percent and perhaps closer to 85 percent. Corrections has come a long way in emergency preparedness if it has indeed reached the point where having a few old, unrealistic emergency plans on the shelf in the warden's office is no longer acceptable and where a true system of preparation and response designed for correctional institutions is the norm. That is not to say every department in the country takes emergency readiness seriously. Some 15 percent of the departments responding in this survey

acknowledged having no departmentwide emergency system, although they did have some degree of planning at the institutional level, and it is reasonable to assume this percentage would rise if the DOCs of all 50 states were examined.

Fifteen to twenty years ago, almost all DOCs used separate and distinct plans for different kinds of emergencies, and emergency plans at different institutions in the same department typically bore no relation to each other. The survey results show that both of those factors are now changing. The majority of the responding DOCs reported that they specify a departmentwide format for emergency plans, an approach that has several advantages. The results also show the beginning of a clear trend away from developing separate plans for separate emergencies and toward the use of a single generic or comprehensive emergency plan with appendixes containing emergency-specific information, as first pioneered some 25 years ago in LETRA's proprietary approach to comprehensive emergency systems designed specifically for correctional institutions.

Another encouraging sign is the prevalence of well-defined emergency teams, which were the exception rather than the rule as recently as 10 years ago. The survey data show that highly specialized tactical teams (CERT or SORT), institution-based disturbance control teams, and teams of hostage negotiators are now the norm for state DOCs. There is also a clear trend toward peer counseling and posttrauma services designed to deal with staff needs after an incident. The creation of these emergency response teams and services represents a significant investment in and commitment to emergency preparedness on the part of the state DOCs.

The data on training may help separate the departments that are most serious about emergency readiness from those that are less so. Many departments have plans, policies, and even well-thought-out emergency teams but do not provide their rank-and-file staff with a reasonable level of training in the emergency system. However, many agencies do provide staff at the rank of shift commander and above with specialized training in emergency preparedness. This is important because it makes little sense to invest heavily in developing and training sophisticated emergency teams but to do little or no work with the shift commanders and higher ranking staff who will be in command of the situations in which those specialized teams are to be used.

The same pattern is seen with regard to drills and exercises. Although all the DOCs that responded to this survey conduct fire drills and most reported the right things about evaluators, monitors, written assessments, and the like, some departments appear to have no substantial program of emergency drills and exercises. On the other hand, a surprising number of departments are committed to an ongoing program of tabletop exercises, functional exercises, and full-scale simulations and have specified standards for these exercises in policy. This, too, is a major change in the field.

Planning tools such as specific response plans, emergency post orders, deactivation and step-down procedures, risk assessment tools, and prevention plans are now commonplace. The number and variety of specific planning tools and response mechanisms consensually accepted by the responding DOCs indicate that the corrections field is moving toward a common understanding of emergency preparation and response in prisons.

The one surprisingly negative note in the survey results was the relatively low percentage of departments that had developed specific preparations or response plans with regard to terrorism. It is not clear whether most state DOCs have simply been slow to respond in the wake

of the September 11 attacks or whether they believe terrorism is not a prison issue. The participation of most of the responding state DOCs in law enforcement-led task forces on terrorism is, therefore, an encouraging finding. Their involvement in these task forces may well lead to more specific and focused preparation for dealing with terrorist threats and responding to terrorism.

Overall, the survey found a healthy level of emergency preparedness in the nation's prisons. Undoubtedly, some departments may have responded to some items rather liberally, attempting to put forward the most positive face possible. However, even when the possibility of some positive bias is taken into account, the nationwide improvement in prison emergency preparedness over the past 8 to 10 years is unquestionable. At the same time, there remains room for, and substantial need for, improvement in this national picture. The various discussions in the "Results" section have raised specific problems and omissions, but the two most general weaknesses reflected in these survey data are the failure of many departments to engage in a systematic program of emergency drills, exercises, and simulations and the lack of adequate initial and refresher emergency preparedness training for front-line, supervisory, and management staff. A similar survey conducted 10 years from now would hope to find these deficits corrected and new areas of strength apparent.

Section 5

Resource Materials

In This Section

Leadership Issues During Crises

This paper is intended as a "think piece" about leadership during crises and major emergencies. Although the paper focuses on prison and jail crises, 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 the entire larger organization.

Status of Leadership Development

Fortunately, in the wake of large-scale inmate insurrections (e.g., Attica, Santa Fe, Lucasville, Camp Hill), most state prison systems and 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 prison or jail 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

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leadership. The leader who has planned for 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.

Despite being surrounded and scrutinized by staff during an emergency, the leader is in a sense alone.

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 disparage 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. However, over time, 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 the like 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 (and a coffee cup welded to one hand) 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. 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 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.

. . . the history and the culture of the organization will exert a strong influence on behaviors during the crisis.

Because second guessing, Monday morning quarterbacking, 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

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
- Analytic thinking

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 of crisis situations, and these dynamics change as the crisis unfolds. To some 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.

If planning, preparation, and training have been good, much of the initial response is almost reflexive.

Interpreting Available Information

During a prison 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 at the same time functioning as the only strategist in the situation and as a data analyst.

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 even though conditions do not warrant such an 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 just 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.

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—

Fiction vs. Real Life

Television and movies often portray extremely dramatic, high-risk initiatives as the only way to successfully resolve emergencies. The wise manager 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.

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."

"[E]ndless patience is active management."

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 didn't 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 both 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 won't 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 group to formulate and evaluate strategy alternatives (a "strategic planning group"). Any of these alternatives 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. ("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?")

Tactics vs. 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 prison disturbance, one strategy might be "let's contain it and then let it dissipate on its own"; another might be "we need 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.

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 step-down 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.

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. Like so much else in this paper, however, driving the agenda is easier said than done. It involves myriad tasks, including the following:

. . . in the aftermath of a major crisis . . . "drive your own agenda or someone else will drive theirs."

- Developing a thoughtful, detailed step-down 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.

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 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 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.

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 department and from 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 paper 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 Prison Emergencies

An emergency in a prison is a serious matter. Even a relatively brief prison 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 prisons are very high.
- Inmates typically are locked into their cells or living units or onto the prison 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 prison must be weighed against security interests and the prison'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 prison 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 paper first discusses the level of commitment to prevention in corrections and then addresses the question of whether prison emergencies can indeed be prevented. The bulk of the paper focuses on specific measures designed to prevent emergencies and on day-to-day operational issues that play a role in prevention.

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 prisons. That is not the case. Certainly the rhetoric is there. Almost every prison administrator and high-level correctional executive 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 prison practices.

First, one of the most important ways to prevent prison emergencies is to be well prepared to respond to emergency situations and to situations that have the potential to escalate into emergencies. Today, most prisons and most state departments of corrections (DOCs) do engage in serious, broad-scale efforts to maintain a high level of preparation for emergency situations. In that context, they are also engaging in important preventive activity.

Second, many prison practices have the effect of lowering the probability of a riot, a hostage situation, or some other major crisis involving inmate violence. However, prisons engage in most of these practices because the practices represent good day-to-day operations and are recognized as effective ways to run prisons—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 prisons have excellent inmate grievance systems, emphasize positive staff/inmate relationships, 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 prison management but that focus narrowly and clearly on prevention are largely lacking.

Good emergency preparedness can result in both prevention and mitigation.

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

Can Prison Emergencies Be Prevented?

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

Some prison emergencies obviously cannot be prevented. We cannot prevent an earthquake, a tornado, or a tsunami. Most natural disasters 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 prisons 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 many prisons are not at risk from forest fires, a smaller number of prisons 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 correctional agencies.) 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, prisons may be able to prevent a toxic material spill within the compound but they cannot prevent a similar event outside prison property.

"Potentially" preventable is an important distinction. No emergency is completely preventable. Even the best run prison may have a hostage incident or a riot. A devastating fire can happen even if a prison minimizes combustible loading and ignition possibilities and conducts frequent, serious fire drills. Nevertheless, common sense dictates that even though many kinds of prison 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, a prison 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 prison has minimized combustibles that would fuel the fire, and the prison's fire alarm system, fire-fighting response, and evacuation drills are all excellent, then the prison 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 prison to contend with the emergency.

The importance of preparedness in preventing prison emergencies cannot be overstated. Preparedness may seem to be primarily concerned 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 prison 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 prison 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 more successful resolution.

Specific Measures Designed To Prevent Prison Emergencies

Measures designed specifically to prevent prison emergencies include training staff to recognize 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, nevertheless plays a critical role.

Traditional Warning Signs

This is the one prevention initiative that almost all prisons 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 prison. The list of traditional warning signs may vary somewhat, but almost all DOCs 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 prison 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 prisons, 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 the yard.
- 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 get 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 in the yard.
- Decrease in inmate visiting.
- Decrease in staff/inmate interaction.
- Inmates actually warning well-liked staff not to come to work.

Agency-Initiated Crises

A number of now-infamous prison crises resulted from some change or other action by the prison administration. 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 DOC to conduct skin tests for tuberculosis on the entire inmate population throughout the department. Other states can point to prison riots that began with a decision to introduce a no-smoking policy, to restrict visits or packages, to change food service providers, etc.

Unfortunately, too many prison crises have been initiated by decisions at the institution 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 prison 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 case in point is the decision to change a prison to a no-smoking ("tobacco-free") environment. Such decisions are a relatively recent phenomenon but may already be the classic example of an agency-initiated crisis. Some prisons have decided to make the change, announced the decision and the effective date, done nothing else, and then had a serious inmate disturbance. Other prisons have made the same decision but then developed plans for minimizing the impact on inmates and communicated frequently with inmates about the change. (Many prisons in this latter group have used phased-in approaches and offered smoking cessation classes and/or cessation patches and gum, etc.) Very few prisons 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 the best but rather whether the prison 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 that a prison 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 prison 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 prison investigator or to the staff member who works with law enforcement agencies and with other institutions. These definitions are not mutually exclusive.

Intelligence as it pertains to prevention of prison 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 prisons 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 prison has assigned a staff member the specific responsibility of looking for such patterns.

Some prisons would answer "yes" but then go on to explain that recognizing dangerous patterns is the responsibility of the warden (or the deputy warden), 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 warden 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 prison'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. Prison staff, especially management, need to pay particularly close attention to any developing problems or incidents in these areas.

The "Turkey a 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 largest riot in Hawaii prison history occurred on that holiday, when many prison officials had the day off, no one remembered to plan appropriate food, and the old Oahu prison attempted to serve turkey a la king for dinner. In Hawaii, it is still referred to as the "turkey a la king riot."

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 prison 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 prevent a crisis should begin immediately.

This approach has great potential for preventing prison crises. Experienced prison 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. 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

Institutional Climate Scales

A number of state DOCs 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 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 prison officials to stop and 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 prison 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 prison operations rather than making a broad judgment about the overall climate in the prison.
- Involving the perceptions of at least several staff members from different levels and locations within the institution.

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

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 prisons. It may not be a specific initiative at all. Nevertheless, the quality of leadership in a prison 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 prison into a major crisis. When a prison 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 Prevention of Emergencies

In addition to measures designed specifically for the purpose of preventing emergencies, many elements of day-to-day prison 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 prison crises such as riots, disturbances, and other incidents involving inmate violence, including both planned and unplanned events. 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, could 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," and the opportunity was a security lapse.

It is tempting to assume that most prisons, particularly higher security institutions, are very good with basic security procedures and practices. That is a myth. While many prisons have well-designed security procedures and follow

those procedures consistently and in detail, many prisons 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 prisons will reveal problems such as poor or non-existent key control and/or tool control, munitions stored in areas where inmates could gain access, sally port doors operating on override rather than interlock, and 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 not only must staff consistently follow security procedures, those procedures must be well designed and effective in the first place. Poor implementation is far more common than bad procedures, but bad procedures do exist. Furthermore, despite an emerging national consensus as to what constitutes good security practices (a byproduct of the proliferation of security audit processes), specific areas of disagreement remain. In addition, many prisons 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, departments and institutions 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 prison management—are the foundation of emergency prevention. Two

Common Myths About Prison Security

Myth: Maximum-security facilities have the best security practices. Fact: If "good security" means procedures appropriate to the security level of the institution, then it is not difficult to find examples of very good and very bad security at all kinds of institutions—minimum, medium, and maximum security.

Myth: Security is the responsibility of the prison's uniformed (custody) staff. Fact: In a correctional institution, security is 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 inmate 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.

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

As noted previously, 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 will 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. Yesterday's fight is today's stabbing. Yesterday's two-inmate confrontation is today's gang war. Finally, 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.

Two problems—misclassified inmates and mismatches between inmates and institutions—can lead directly to crisis situations.

Despite these clear connections, some correctional administrators hesitate to commit substantial resources to developing early intervention skills and practices because the payback—i.e., bad things that do not happen—is not visible. In a twist on the "if a tree falls in the forest and no one hears it . . ." riddle, the question in a prison becomes "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?" Hesitant 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 prison is also referred to as its "atmosphere" or "climate." (Institutional "culture" is quite different. Culture 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 prison 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 prison, before they have walked 50 yards. 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 prison and a relaxed prison.

A prison's tone also has to do with the way the facility is run. In a prison 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 prison operated as openly as possible for its security level, where staff-inmate interactions are low key, informal, and generally positive.

Unlike a prison'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 prison'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 prison that is clean, quiet, and run within the boundaries of constitutional requirements than in a prison that is dirty, noisy, and run without regard to the constitutional rights of inmates. It is the overall tone of the prison 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 paper, staff professionalism does not exist in a vacuum. It both 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 prison emergencies.

In most prisons, 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 prison 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 parole board hearings, track their release dates, and arrange for family visits, among many other tasks. At a high-security prison, 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 obvious benefits) and is also a major factor in staff safety.

Conclusion

As noted at the beginning of this paper, some prison emergencies cannot be prevented. However, serious prevention efforts can stop some crisis situations from occurring and will mitigate other incidents so they never develop into full-scale crises. A surprisingly wide range of initiatives have excellent potential to prevent prison emergencies, and many of these initiatives have been underutilized in prison management. In addition, many aspects of a prison'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 prison management. The old adage bears repeating: "The best way to deal with prison emergencies is not to have them in the first place."

Emergency Teams

Emergency teams are critical to emergency preparedness in any department of corrections (DOC). The three types of teams discussed in this paper—tactical, hostage negotiation, and crisis intervention—deal with life-and-death matters. They have saved lives in the past and there is no doubt that they will continue to save lives in the future. 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.* Conversely, 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 prison administrators, "emergency teams, can't live with them, can't live without them").

Clearly, the subject of emergency teams is important. This paper is directed to institutional CEOs and departmental administrators and focuses on strategic, organizational, and management issues associated with emergency teams—with particular attention to 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 paper does not attempt to synthesize training or procedural materials for the various types of emergency teams, nor is this paper intended as a "how to" manual.

Background

Terminology

Most state DOCs and most medium-sized and large local jails 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.

[Emergency teams] have saved lives in the past and there is no doubt that they will continue to save lives in the future.

The most common of the three general types of emergency teams is a **tactical team.** This paper uses "tactical team" as a generic name for various units—disturbance control, SORT (Special Operations and Response Team), CERT (Correctional Emergency Response Team), SWAT (Special Weapons and Tactics), 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.** These teams may also be called "SitCon," "crisis negotiation," "crisis intervention," or various other, less frequently used names.

The third type of emergency team is most commonly known as a **crisis intervention team,** although some departments use that term to refer 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 paper 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 team, or the like. This paper 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 paper 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. It uses "CERT/SORT team" 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 paper 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, but their function is not within the scope of this discussion.

General Management Issues

Coordination

Prisons 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 department-level person will be assigned responsibility for coordinating all three types of teams throughout the prison system. This person needs the authority to ensure that teams are properly trained, follow departmental policy, and maintain a positive team culture.

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.

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:

The goal is to attract the very best . . . those who are concerned about saving lives and who understand what it may take to respond to an emergency in a controlled manner.

- 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).

In order to select the right type of employee for membership on an emergency team, psychological evaluations may be conducted. A psychological evaluation may not be helpful if a thorough evaluation and background investigation of the employee are conducted. The question is whether a "psych" evaluation adds value to the selection process. If an employee has a clean

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).

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. A complete list of problems prisons have encountered with tactical teams would be much longer and would include some truly bizarre incidents. In some cases, members of tactical teams have gone to prison for their activities.

. . . of the three types of emergency teams, tactical teams present the greatest risk for management.

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 much 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) warden or 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.

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.

Team Culture

A clear understanding of mission and philosophy—shared by the team members and leader, institutional managers, and departmental 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. 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 was 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.

Leadership

Prison managers tend to think that the tactical team leader should be one of the 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 in order 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 only be worn for training or when on assignment as part of the tactical team; the rest of the time, the team members should wear the same uniform as other officers.

Similarly, it is usually 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 their basement ready-room telling apocryphal stories, talking trash about other staff, and ordering in pizza.

A mark of a good tactical team is support for accountability as a team and as individuals.

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 bad behavior.

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 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 a "special forces" philosophy about the team, 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 convince team members that every inmate in the institution is plotting their assassination. Rather, tactical team training should be practical and varied. It should emphasize skill building, discretionary decision-making, and professionalism. Exercises and simulations should reflect the range of crises,

emergencies, and disasters that the prison 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. Instead, initial training must first 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 relatively 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, or overtime for training in an agency in which overtime is rare, or comp time, or some more creative solutions. If the incentives are too great, they will be resented by the rest of the workforce and develop unrealistic expectations among team members. 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.

Tactical team members need a relatively high level of competence with a relatively broad range of skills.

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, these 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 paper does not endorse any particular team size or structure, although it is recommended that each tactical team include a medical person and a video camera person.

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

Backup Planning: The Key to Handling Simultaneous Emergencies

The department should have policies and procedures in place to govern how tactical teams from different institutions and regions 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. 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.

vary with the size of the department and the size and geographic location of its institutions. The key question is 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 at each of the respective institutions?" (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 institution based, regional, or statewide. 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 regional or statewide CERT/SORT teams.

Weapons Assault and Marksman ("Sniper") Capacity

A prison system cannot avoid the possibility that it will need to use a weapons assault team. Similarly, it cannot deny the chance that a marksman ("sniper") may be needed. Situations that need to be handled by a hostage rescue team using firearms are, fortunately, very rare in American prisons. Situations that require the use of marksmen are far more rare. Still, either is possible. The correctional department 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.

Traditionally, a two-person marksman/observer ("sniper") team is assigned to the hostage rescue team. Because of the architectural design of prisons, 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. States should ensure that policies and procedures are crystal clear about authorizing a shot

Why Marksman Capacity Is Necessary

If a DOC 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 DOC 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 DOC would find it difficult to explain (or live with) this outcome.

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 in this paper, 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," "communications officer," "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, Texas, 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 reflects that person's judgments, values, and subjective perceptions.

The hostage negotiation team must report directly to the situation commander.

The Stockholm Syndrome

The phenomenon in which hostages begin to identify with their captors—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 over-identifying with the hostage takers and beginning to blur its allegiances. That is an important reason for the commander to assess negotiations firsthand.

Training

A department or an institution often 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, and the prison may 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, the crisis intervention function is fulfilled primarily by consultants or local mental health professionals rather than by a staff team.

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 be seen by the 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 paper, some recommendations are in order.

After a large-scale prison 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 and a responsibility to determine whether some staff need professional assistance and to provide related information to the staff members involved. However, it is the right of individual staff members 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 EAP's confidentiality, or they may want to deal with professionals who have experience in a correctional environment. Uniformed staff also are unlikely 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 families of staff members.
- 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 paper, prison 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 paper 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.

Prisons and Counterterrorism

Since the attacks on the World Trade Center and the Pentagon on September 11, 2001, terrorism has been at the forefront of U.S. priorities and the American psyche. A new Cabinet-level department of the federal government, Homeland Security (DHS), was created specifically to combat terrorism. President Bush declared a "war on terrorism," and that phrase has become a regular part of our national vocabulary.

A complete list of all the activities we have engaged in on a national level to prevent or combat terrorism would be very lengthy. The domestic components of the war on terrorism have focused heavily on airport security and on police, fire, and health departments—that is, on our first responders. Billions of dollars have already flowed to these agencies and services for equipment, training, developing new capacities, and augmenting existing capabilities.

For fire departments—which include paramedic units—and firefighters, the reason for the resources and focus is quite clear: they will be crucial first responders in the event of almost any type of terrorist attack. Whether the situation is a bombing or other kind of explosion (like the one at the World Trade Center), an attack that results in massive fire, or an incident involving chemical agents, biological agents, or other hazardous materials, firefighters and paramedics are likely to constitute much of the initial reaction and first line of defense in the wake of a terrorist attack.

Law enforcement's role in domestic counterterrorism is also clear, if somewhat broader. Like firefighters, the police are first responders. It is difficult to envision any kind of large-scale terrorist incident in this country in which local law enforcement would not play a central role in attempting to apprehend perpetrators, engaging in crowd and traffic control, establishing crime scene and evidence preservation, providing security for firefighters and medical personnel, and more. In addition to its role as first responders, law enforcement also constitutes the largest intelligence network in the country—a separate but crucial part of a comprehensive domestic counterterrorism strategy.

The field of corrections has not yet been fully considered in the counterterrorism discussion . . . .

There are other agencies and services that have clearly identified roles in counterterrorist preparation and/or response. Hospitals and ambulance services constitute another important group of first responders in the event of a terrorist attack. Few Americans can remain unaware of the changes that have been made in airports and airport security. It is incontrovertible that the nation has embarked on an extensive counterterrorism effort directly involving more than a million people, billions of dollars, and a broad range of activities.

The field of corrections, however, has not yet been fully considered in the counterterrorism

Defining Terrorism

Many intelligence agencies and political entities have attempted to define terrorism. However, no one definition has been adopted or officially recognized. This paper uses the FBI's definition of terrorism: "the unlawful use of force against persons or property to intimidate or coerce a government, the civilian population or any segment thereof, in the furtherance of political or social objectives." This definition includes three elements: (1) Terrorist activities are illegal and involve the use of force. (2) The actions are intended to intimidate or coerce. (3) The actions are committed in support of political or social objectives. Also, these activities may be carried out by one or several individuals.

discussion, although many correctional agencies participate to some degree with local or state law enforcement intelligence networks and are peripherally involved in other counterterrorist efforts. A strong argument can certainly be made for the contributions American corrections can make toward increasing national security with regard to terrorism, but much of that work remains to be done. By and large, corrections is not yet a major component of our domestic counterterrorism plans or strategy.

This paper examines the role of prisons in a national counterterrorism strategy and presents recommendations for how prisons should prepare for and respond to terrorist threats and incidents. Much of this discussion will also be relevant to city and county jails; however, the potential roles of other branches of corrections in the war on terrorism are not considered here in any detail.

Role of Prisons in a National Counterterrorism Strategy

Prisons constitute a potential target for terrorist attack in at least three important ways. First, prisons are densely populated and difficult to defend against external assault. The cells, gates, fences, and other security barriers that keep prisoners inside also make it difficult for both prisoners and staff to evacuate quickly. An attack on a prison could kill a large number of victims.

Second, unlike many other high-density potential terrorist targets, prisons are symbols of government authority. As such, they represent an attractive target for terrorists seeking to create a scenario in which the government appears unable to protect its citizens, even within its own domains of power.

Finally, in attacking a prison, terrorists have the potential to effect a mass outbreak of hundreds of high-security prisoners who would represent a grave danger to surrounding communities. The predictable widespread panic that would result might be a more important objective to terrorists than a high death count. Terrorists might well regard the death and destruction at the prison itself as beneficial byproducts to the central goal of mass escapes, community terror, and chaos.

Unfortunately, the experience of foreign countries in which terrorist activity has been relatively frequent substantiates these arguments. In reality, prisons have been targets for terrorists, as have jails and police stations. For example, for many years, police in England have been high-priority targets of the Irish Republican Army (IRA). Basque separatists have attacked Spanish police stations. As this is written, Iraqi police are the frequent targets of insurgents.

As described above, prisons may be a likely target of terrorist attack, and they also have additional potential to contribute to national counterterrorism efforts. In addition to their attractiveness as terrorist targets, there are at

Role of Other Branches of Corrections in Counterterrorism

The other major branches of corrections have differing relationships to potential terrorist activities and threats that affect their need for counterterrorism preparedness and role in counterterrorism response. For example, the risk of probation and parole agencies being targeted for terrorist attack is extremely low. On the other hand, those same agencies are potentially invaluable in the area of intelligence because of their detailed knowledge of a wide range of criminal offenders in the community and their active monitoring of the activities of many of those offenders.

Jails, like prisons, are potential terrorist targets—densely populated structures that are difficult both to defend and to evacuate. In addition to being potential targets of terrorist activity, jails may be involved with terrorists in other ways. Many of the criminal offenders monitored by probation and parole officers in the community are also occasionally arrested by law enforcement and then spend time in county jails, whether for short stays or en route to state prison. Jails also receive individuals who may be wanted for very serious offenses but have been arrested on quite minor charges. For these reasons, jails are in a position to make crucial contributions to counterterrorist intelligence efforts.

least three other important reasons to make prisons an integral part of our domestic counterterrorism effort:

- Terrorists may exist within the prison population and could be identified.
- The prison population offers terrorists a promising pool from which to recruit new members, allies, or mercenaries.
- The prison population is a potential source of intelligence about terrorist groups.

These issues, which are explored in the following sections, are either unique to prisons or more evident within prisons than any other area of government.

Potential To Identify Terrorists Within Prison Populations

Many if not most prisoners are apolitical. That is, the average criminal offender may be a violent and dangerous high-security inmate with a long record or a low-security inmate doing time for a nonviolent crime, but the odds are high in both cases that the inmate is uninvolved—and probably uninterested—in national or international politics. In fact, "politics" within a prison population usually refers to personality dynamics among small groups of inmates and sometimes to prison gangs or prison racial groupings. However, a small percentage of the prison population within the United States is intensely involved in larger political issues. This group of politically aware and active inmates tends to be heavily weighted toward the extreme right and extreme left of the political continuum—the compass points that produce terrorists.

Committed terrorists may be housed among our prison population and may not be easy to identify. Active terrorists may be sentenced for some crime unrelated to terrorism and go unrecognized in prison. Such individuals may be skillful

at maintaining their identities as "regular" prisoners. Prisoners who become committed terrorists while in prison, on the other hand, are much more likely to be less skilled and experienced at hiding their true philosophies and objectives and would typically be individuals who were well known for their extremist views. In any case, the potential for prisons to identify active and/or committed terrorists within their own inmate populations should not be ignored.

Potential for Terrorists To Recruit Members and Allies

Prisons offer terrorists perhaps the single most fertile ground in this country for recruiting new members, allies, or mercenaries. Among the hundreds of thousands of people locked up in our prisons are many smart, tough, disciplined individuals who blame our society, our laws, and our government for their ruined lives and for the fact that they are in the midst of serving long sentences. Many of them are angry and alienated enough to be easily turned from violence for criminal purposes to violence for political or even religious purposes. For terrorists, recruiting these people is a great advantage: They do not have to be taught to be violent. In many cases, their criminal records prove they are capable of being extremely violent and that they are psychologically able to cope with committing violence at the level of terrorism.

The question for correctional administrators and for policymakers outside the area of corrections is: How well prepared are our prisons and prison staff to recognize terrorist recruiting activities? Unfortunately, the current answer is not at all.

It would be folly to ignore the potential for terrorist groups to look to our prison populations as breeding grounds for recruits and/or allies, particularly given the history of the late 1960s and early 1970s, when the Symbionese Liberation Army (SLA) and other groups with similar philosophies and characteristics were incubated entirely within our prison system. There is no obvious reason why history could not repeat itself.

The question of mercenaries deserves additional mention. Finding "hired help" would be much easier for terrorists than attempting to recruit new members and allies. If a group were planning an attack or some other terrorist activity that required larger numbers of people to carry out than the terrorist group itself had, where would that group look for "soldiers"? Whereas only a very small percentage of the prison population might be approached on political grounds to become members of a terrorist group, a very large percentage could be approached with money to do almost anything.

Prisons are an all too obvious source if the need is simply for people who will do bad things for a great deal of money rather than people who are philosophically, religiously, or politically committed in any way. The question for correctional administrators and for policymakers outside the area of corrections is: How well prepared are our prisons and prison staff to recognize terrorist recruiting activities? Unfortunately, the current answer is not at all.

Potential To Gather Intelligence About Terrorists

For the reasons discussed above, potential intelligence about terrorists is more available in prisons than many other places. Terrorist groups and terrorist incidents can originate wholly within a prison or department of corrections (DOC). Under certain conditions—the influence of leaders who are more political than religious, events in the outside world (e.g., the United States at war with a particular country or in a particular region of the world), or perceived discrimination against the group itself—religious, ethnic, and racially affiliated groups have the potential to become terrorist organizations or to spawn such

organizations. In general, knowledge of these groups and their leaders may be crucial.

It is also true that an organized group of terrorists operating within the United States must do a number of things outside the law. The group may be laundering money, obtaining weapons illegally, purchasing false identification, operating under false identities, or engaging in a host of other activities that are not central to its violent objectives but that are required to allow the group to operate in secrecy or to proceed with its plans. These various illegal activities provide potential avenues for identification of terrorist groups. When a terrorist group operating in this country needs to purchase unregistered or untraceable weapons, obtain false identification, or gain access to stolen motor vehicles, it is most likely to look to the "common criminal" in our cities and on our streets to arrange the necessary illegal business transactions.

Government attempts to locate and identify terrorist groups through interdicting these low-level criminal transactions have traditionally focused on intelligence efforts ranging from local law enforcement to state antiterrorism networks to national organizations such as the FBI. Consideration of the prison population has been left out of the equation. Because the prison population is largely transient and because the criminals who sell guns, license plates, false identification, and so forth tend to cycle from street crime to prison and back, the prison population is a repository for a large amount of information about the kinds of illegal activities taking place in the community and the individuals who are involved. Admittedly, a great deal of rumor and false information circulates among the prison population, but there is also valid information. Monitoring this source of intelligence about illegal activities that could support terrorist groups should be an integral part of our counterterrorism strategy.

Counterterrorism Preparedness and Response in Prisons

The remainder of this paper considers how prisons should prepare for and respond to terrorist threats and incidents. In short, what constitutes counterterrorism at a prison?

The starting point for any prison assessing its capacity to prevent and respond to a terrorist attack must be its system of emergency preparedness. The news for U.S. prisons is good in this regard. Unlike 20 or 30 years ago, most prisons now have well-defined emergency preparedness systems supported by substantial resources, detailed plans, specialized equipment, and extensive staff training. This emergency readiness is the foundation upon which prison counterterrorism efforts must be built. There is no practical alternative. The relatively small number of U.S. prisons that have little or no emergency readiness will not be able to seriously consider how they would respond to a sophisticated terrorist attack until they sort out policy issues concerning command during major emergencies, train negotiators (or set up agreements to use external negotiators), prepare for dealing with the media during a large-scale crisis, and address all of the other components of a detailed and realistic emergency plan discussed in section 1 of this guide and enumerated in the Emergency Preparedness Self-Audit Checklist in section 3.

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However, counterterrorism at a prison involves considerably more than basic emergency preparedness. After a prison has established its general emergency preparedness plan, trained its staff in all of the plan's components, and embarked on a program of drills, exercises, and

refresher training, it must give further attention to the following areas critical to preparing for and responding to terrorist threats and activity:

- Intelligence operations.
- Staff training.
- Target hardening.
- Alert systems.
- Medical services.
- Procedures for responding to alarms.
- Interagency agreements.
- Aftermath.

These topics are addressed in the sections that follow.

Intelligence Operations

The core of most counterterrorism prevention efforts in prisons will be the prison's intelligence operations. Existing intelligence operations in prisons vary widely. Some prisons have extremely sophisticated intelligence functions, whereas others have no intelligence capabilities whatsoever. Not surprisingly, prisons with sophisticated intelligence operations in place will be able to incorporate counterterrorism functions much more easily than those with less well-developed abilities to gather and analyze critical information.

One of the first priorities for a prison seeking to develop intelligence on terrorism is to explore and understand local and statewide intelligence

Security Threat Group Operations

Many prisons have a **security threat group (STG) coordinator.** This person may operate relatively independently, but in large prisons, he or she may also have subordinate staff. STGs are often defined as neither more nor less than gangs and may be street gangs or prison gangs. The STG coordinator's job includes reviewing new admissions to identify both gang members and inmates who are not gang members but may be affiliated with particular gangs. The coordinator may accomplish this through interviews, identification of tattoos, information obtained from other inmates, the new inmate's record, and information from local and state law enforcement agencies. Typically, once gang members or affiliates are identified, they are entered into the STG database and then tracked and monitored throughout their stay in the prison.

A good STG operation will have safeguards against practices such as overloading a housing unit with too many members of one particular gang, allowing relatives of members of one gang to cross-visit at the prison, and permitting the identified gang member to make collect phone calls to known gang members on the outside. Phone conversations of gang members may be monitored or recorded and archived. The prison will monitor and attempt to stop gang efforts to recruit within the inmate population and to control housing assignments, recreation, commissary goods, or other potential sources of power. The elements of a well-developed STG operation—early identification, suspect databases, tracking and monitoring procedures, and the capacity to monitor mail, phone, and visitation—are equally applicable to prison counterterrorism intelligence operations.

networks involving law enforcement, the military, staff from county and state emergency management agencies, federal enforcement agencies, and other such organizations. The prison should work to become a full partner in such terrorism task forces.[1]

Preventing terrorist activity is a prison's responsibility, but it is also an external issue. Prisons and correctional agencies may have little control over preventing terrorist activity when the threat is external. For example, if a terrorist group is targeting a prison for an attack, but no inmates or other individuals associated with the prison are involved in the planning or with the group in any other way, the success or failure of the terrorists' plans may rest solely with national law enforcement resources, particularly the FBI. The targeted prison might not know about the plot until members of the terrorist group are apprehended or, if law enforcement intelligence efforts are unsuccessful, until an attack actually takes place. However, if the plot to attack a prison also involves inmate collaborators or plans to free high-profile "political" prisoners, or if members of the terrorist group have infiltrated either the inmate population or the prison workforce, then the prison and prison staff might have the opportunity to foil the terrorists' plans through effective intelligence operations.

Staff Training

The biggest difference between prison gangs and terrorist organizations may be summed up as "sophistication." While some of the larger, longer established prison gangs are reasonably sophisticated, with constitutions, bylaws, and well-defined organizational cultures, even these gangs are a far cry from the sophistication of most terrorist groups. Most correctional staff, like most law enforcement officers, have little experience with groups of offenders who are smart, well funded, highly trained, and disciplined. Prison staff are accustomed to inmate groups that plan poorly, follow through badly, and have trouble keeping secrets for more than 30 minutes. Few staff in prisons have any concept of the level of planning, training, resources, secrecy, and commitment to cause that is required for an event like the September 11 attacks. It follows that staff training on terrorism is one of the most important and earliest steps in building counterterrorism capabilities into an existing prison emergency preparedness system.

The lack of awareness of an appropriate frame of reference and of specific knowledge about terrorism on the part of prison staff is not limited to intelligence operations or other prevention efforts. The need for staff training specific to terrorism is equally relevant to planning and preparation and also applies to building response capabilities for possible terrorist acts at or in prisons.

Target Hardening

Once a prison has declared alert status or activated an alert system in response to a terrorist threat, specific activities and procedures fall into several categories, the first of which is usually referred to as "target hardening." Target hardening includes a wide range of steps that most prisons can initiate to increase security against outside assault. As noted above, almost all prison security is designed from the inside out, and many high-security institutions that are extremely well designed to prevent escape have almost no security systems that are effective against external threats. Examples of target hardening include the following measures:

- Establish vehicle- or traffic-control checkpoints at some distance from the main gates.

[1] Understandably, small minimum-security prisons may give counterterrorist intelligence efforts much lower priority than large medium- or high-security facilities.

- Change procedures or erect barriers at vehicle sally ports.
- Tighten or restrict inmate mail or visitation procedures.
- Institute background checks and positive identification requirements for delivery truck drivers and/or inmate visitors.
- Increase external vehicle patrols and arm those staff.
- Increase night lighting for areas outside perimeter fences.

The list will vary substantially depending on the nature of the particular institution and the level of the perceived threat.

One of the greatest assets available to wardens seeking to identify opportunities for target hardening is the expertise of their tactical teams. Many wardens have never analyzed their facility's degree of vulnerability to external assault. It is a challenging exercise, and the results are often disturbing. Wardens who charge their CERT teams to assume the role of a group of soldiers of fortune hired to attack the prison to execute an escape will likely be alarmed at the vulnerabilities the team identifies. Many of the risks found will have been unrecognized, and some may be obvious and severe. The leader must recognize that the more alarming the information, the more valuable the exercise.

Alert Systems

As used in this paper, the term "alert system" refers to a method for placing a prison in higher stages or levels of readiness in response to heightened threat levels. In our post-September 11 world, almost everyone in the United States is familiar with the statement "We are now at threat-level orange," and people who served in the military during the cold war are unlikely to forget "We are now at DEFCON 3." However, a prison alert system should not be confused with the five threat levels of DHS's color-coded advisory system. The core concept of a prison alert system is the need for a rational, planned method for responding to a heightened threat of terrorist activity aimed at the prison or its surrounding community. All staff must be well trained in the alert system.

Most state DOCs do not have any sort of alert system; however, some states have exactly this kind of system built into their overall emergency preparedness plans. Notably, New York's DOC has a detailed, sophisticated, and well-designed alert system, and the group of states using LETRA's *Emergency Preparedness for Correctional Institutions* have an alert system that is an integral part of that approach.[2]

There is no single type of prison alert system that must be used. Because experience with alert systems in prisons is limited, it would be difficult to make a case for the number of stages of readiness a prison alert system should have. There is a good deal of room for creativity and varied approaches in designing a prison alert system. However, effective alert systems have at least one element in common: they are true systems with specific plans and measures in which staff have been trained. The importance of planning and training cannot be overemphasized. Prisons cannot expect to figure out how to respond once they are under serious threat. Without thorough planning, training, and practice, it is an unfortunate certainty that under threat and time pressure, the prison will make avoidable mistakes and forget obvious procedures.

The information leading a prison to activate its alert system may come from intelligence sources within the prison or from law enforcement or other external sources. Similarly, the

[2] The comprehensive emergency system developed by LETRA, Inc., for correctional institutions is described in *Emergency Preparedness for Correctional Institutions,* 3d edition (Campbell, CA: 2004).

target of the threat identified in the intelligence may be the prison itself, but it is also possible that the prison may have to respond to threats to a nearby city or the surrounding geographic area.

Responses to declaring alert status or raising the threat level, if the alert system has stages or levels, include but are not limited to the following:

- **Activating emergency command procedures.** The prison may need to ensure that one of its top managers is either onsite or available in relatively close proximity 24 hours a day.
- **Initiating target-hardening measures.** For example, if the intelligence points to the possible use of a truck bomb, concrete barriers might be erected in front of vehicle sally ports, and a traffic-control post might be established at some distance from the institution and staffed around the clock. If the intelligence points instead to a biological threat, processing of mail and packages might be moved to a location outside the institution's perimeter.
- **Marshalling additional resources, either through activation or standby status.** For example, intelligence staff may need to increase their operations, and the administration may need to cancel vacations for members of CERT teams, hostage negotiators, and other staff with critical jobs during emergencies. Hostage negotiation and CERT teams may need to be on phone standby.
- **Activating interagency agreements.** For example, intelligence-sharing activities may be intensified.
- **Developing an initial media strategy if the prison's response comes to media attention.** For example, if the intelligence information received is highly confidential, the prison will need some acceptable public explanation of security measures such as traffic controls, the reduction in inmate visiting, and increased staffing. The same explanation may need to be given to the staff and inmate population as well.
- **Modifying operations in ways that reduce exposure to the threat.** For example, if the threat is an attack involving a bomb or an explosion intended to kill people within the prison and allow mass escapes, then reduced programming and some degree of lockdown may mitigate the risk of mass escape.

Other Benefits of Alert Systems

An alert system, even if developed specifically as part of a counterterrorism plan, has the potential to serve the institution well in the more traditional kinds of prison crises and emergencies. Most prisons operate in two well-defined modes: normal day-to-day operations and the crisis mode that goes into effect in response to any major emergency. There is usually nothing in between. This situation is problematic in that, for most prisons, the time spent building up to or recovering from a major emergency is usually much longer than the time spent operating under emergency conditions. Yet emergency operations are carefully specified in detail, while the much more common situation of operating under very high tension and at very high risk is handled on a "catch-as-catch-can" basis, without serious planning or procedures. A well-thought-out alert system can fill this gap.

The range of options a prison must consider in response to a credible threat of terrorist attack is broad. This brief summary of some of the more obvious actions should illustrate that it is too late to build that response after the threat is received.

Medical Services

Whether a terrorist attack at a prison involves automatic weapons, a bombing or explosion, or the unleashing of chemical or biological agents, the potential for mass casualties is very high. Consequently, a medical services plan developed as part of the prison's overall emergency preparedness procedures may be insufficient to respond to a terrorist incident. Medical services plans for prison emergencies are usually given the same priority as emergency food services plans or emergency facilities and maintenance plans. The medical services plan developed for response to terrorist incidents must be far more detailed and must envision the possibility of very large numbers of dead and/or injured, including both inmates and staff.

If onduty staff at a prison found people sick or dying and suspected chemical or biological contaminants, would any of them know how to contact the nearest HAZMAT team?

The most obvious need will be for a large mass casualty center and an alternate location, should the primary location be unavailable or disabled because of the nature of the incident itself. Large-scale triage operations will have a similarly high priority. The prison should scrutinize its existing interagency agreements with community hospitals and ambulance services, as these agreements will likely need to be expanded.

Procedures for Responding to Alarms

Prisons should also examine their procedures for responding to alarms and reported emergencies. Those that already use some form of first responder system[3] will have an advantage in this regard. Any system that controls staff response to an alarm should offer some level of protection against a well-planned diversion designed to bring all available staff into one area of the prison so that they can be attacked or taken hostage or so that something else can happen at the other side of the prison compound. However, when focusing on counterterrorism capabilities, prisons should carefully examine even a well-defined first responder system, particularly with regard to the training of the first responders themselves. In most prisons, how many initially responding staff would recognize a potential anthrax situation and know they should stop further response and attempt to isolate and seal off the area? If onduty staff at a prison found people sick or dying and suspected chemical or biological contaminants, would any of them know how to contact the nearest HAZMAT team? Does the prison have protective clothing or other safety equipment available for first responders and other prison staff if a biological or chemical terrorist incident is suspected? If a potential bomb was discovered in the prison, would staff know not to move or handle it? Has the prison conducted drills or simulations for responding to a biological attack? A discovered bomb? Are there specific procedures that would help staff in these kinds of emergencies?

"Defend-in-place" strategies—remaining in the facility and coping with the crisis rather than evacuating—also deserve attention. Many potential terrorist scenarios could require a defend-in-place response. With the exception of institutions in areas at high risk for tornados, few prisons or jails place a premium on planning or practicing defend-in-place strategies. However,

[3] A first responder system is one in which specific staff are designated as initial responders to an alarm, fight, or other such incident and other staff are held in reserve as second responders. First responder systems include a variety of methods other than the old and traditional approach that calls for every available staff member in the prison to drop everything and run to the incident as soon as an alarm goes off.

if a terrorist attack is sudden and produces death and chaos, the nature of the attack may not be clear, nor may it be clear which direction represents safety and which represents increased danger. When the risks to community safety resulting from the unplanned movement of large numbers of inmates are added to the equation, a defend-in-place response may be the only viable alternative. This rationale suggests that defend-in-place strategies may need considerably more attention and practice than they have received to date in prisons.

Interagency Agreements

Interagency agreements with hospitals, ambulance services, fire departments, HAZMAT teams, and other agencies are indispensable to a prison's counterterrorism preparedness. For most prisons, however, the most crucial interagency agreements in many types of terrorist incidents will be those with law enforcement. If a prison has not yet found a need for detailed and comprehensive written interagency agreements with state and local law enforcement agencies, focusing on potential terrorist activity should provide the necessary motivation. Jurisdictional issues must be carefully considered and worked out in advance, rather than argued about in the midst of the response to a bombing. The use of prison staff outside the boundaries of the prison and the use of law enforcement officers inside the prison should be considered with regard to questions such as arrest powers, authority for use of force, reporting relationships, and extent of authority. After law enforcement, other very high-priority interagency agreements would include those with county and state emergency management agencies (many of which already include prisons in their planning) and the National Guard.

Interagency Agreements Necessary to Prison Counterterrorism Planning

- Local and state law enforcement agencies
- County and state emergency management agencies
- Hospitals
- Local utility companies
- Ambulance services
- Fire departments
- Other correctional facilities or agencies
- HAZMAT teams
- FBI Correctional Terrorism Initiative
- American Red Cross

Developing realistic and comprehensive interagency agreements is a substantial amount of work. However, the good news is the work is "front-end loaded." That is, once the agreements are fully developed, maintaining and updating those agreements are relatively easy. Both agencies should review the agreements annually for changes or necessary additions.

Aftermath

A prison's general emergency plan should include detailed policies, procedures, and resources for dealing with the aftermath of an incident. Most of these measures will be equally effective if the incident in question is a terrorist act rather than, say, an inmate hostage taking. There are several key differences, however:

- In a terrorist incident, most of the investigation and prosecution will be in the hands of national rather than state and local agencies.

- The prison will have much less control than it does after a "traditional" emergency. For example, even after the incident is over, a great deal of information will likely remain highly confidential and unavailable to the public and the media. This situation can create strong tensions between the media and the prison and between the prison and its own staff and inmates, even though the rules are not of the prison's making.
- Because the incident involves terrorism, its newsworthiness will likely be magnified to a degree that prison staff find almost unimaginable. The coverage of the event will be international and the scrutiny will likely continue for months rather than hours or days.
- The involvement of elected political figures is likely to be national as well as local and statewide.

These circumstances will strain the prison's resources and its emotional stability at a time when it is fighting to return to normal operations and can ill afford additional pressures, tensions, or other risk factors. A complete discussion of deactivation and aftermath procedures is beyond the scope of this paper. However, for a prison attempting to recover from a high-profile terrorist incident, the following areas and functions will be critical:

- A sophisticated long-term public information operation.

Drills and Exercises

Without drills or exercises, counterterrorism measures will be largely useless, as is true for other types of emergency planning. The counterterrorism procedures discussed in this paper are not "one-time fixes" that can be written or planned and then ignored as if they had already been accomplished. Although staff must receive refresher training, testing the procedures and other measures that are developed is even more important. Part of the reason for testing is to help staff become comfortable and familiar with the new procedures and measures. The other primary purpose is to see whether these procedures and measures can be put into practice under realistic conditions and, to the extent possible, whether they are effective in accomplishing their objectives. Accomplishing these goals requires neither more nor less than the kinds of exercises, drills, and simulations that should be second nature to emergency planners.

One warning must be added. It is easy to design a terrorism scenario or exercise that is overwhelming and frightening rather than challenging and realistic. Terrorism is inherently a dramatic and compelling topic for most people, especially correctional and law enforcement staff who are likely to find themselves on the front lines in the event of a terrorist attack. However, the point of exercises and drills is to test individual components of a counterterrorism system and build staff confidence through success. A practice scenario that begins with a tactical nuclear weapon exploding in the main dining hall of a large prison is unlikely to test anything worthwhile or to advance staff confidence.

- Ongoing emergency staff services (ESS).[4]
- Communication with staff and with the inmate population.
- Stepdown planning (returning prison operations to normal).
- Critical incident review (an analysis of the nature of the incident and what was done correctly and incorrectly).
- Assessment and repair of facility damage.

Conclusion

This paper has presented recommendations for how prisons can prepare to respond to terrorist threats and incidents. Almost every issue that has been discussed is also an element of a prison's general emergency planning, and an effective emergency preparedness system must be the foundation of any prison's counterterrorism measures. It makes little sense for prisons with almost nothing in the area of emergency preparedness and those with emergency plans and procedures that are outdated and/or ineffective to embark on a counterterrorism initiative that will be demanding of time, money, effort, and other resources. The end result would be a narrowly designed system that is only prepared to respond to terrorist activity, the probability of which at any specific prison is extremely small. For U.S. prisons that have neglected emergency planning, the threat of terrorism should serve as a wake-up call to begin developing comprehensive emergency preparedness systems that incorporate counterterrorist planning.

For U.S. prisons that have neglected emergency planning, the threat of terrorism should serve as a wake-up call to begin developing comprehensive emergency preparedness systems that incorporate counterterrorist planning.

American correctional institutions offer major opportunities for assisting with national security efforts that are underway, but much of that work remains to be done. Prisons, in particular, have the potential to function as an important and major component of the national counterterrorism effort. The implications of this conclusion point in two quite different directions. On the one hand, most U.S. prisons are not well prepared for the threat of terrorist activity. The responsibility for correcting that situation rests with prison administrators. On the other hand, our prisons, with a few minor exceptions, are not involved with or contributing to our national counterterrorism strategies. The potential to change this situation rests with high-ranking government officials and those who formulate policy and strategy at a national level.

[4] Emergency staff services should include, but not necessarily be limited to, psychological screening, posttrauma counseling for staff, assistance for staff families, and aid in filing for insurance and other benefits.

Section 6

Case Studies

In This Section

Fire in a New Institution: Taney County, Missouri

Taney County, Missouri, is located in a relatively isolated area of the Ozark Mountains. Forsyth, the county seat, is a town of approximately 1,200. The Taney County Jail in Forsyth was completed in 1982. It is designed to hold approximately 32 prisoners, primarily in double cells. The jail building also houses the County Sheriff's Dispatch Center and all of the offices of the Sheriff's Department.

The jail is constructed of steel and concrete and was equipped with numerous fire extinguishers but no self-contained breathing apparatus, fire hoses, or sprinkler system. Located behind the administrative areas and the dispatch room, the housing areas are entered through a sliding steel door that then gives access to three separate subhousing areas: the women's unit, the men's minimum unit, and a high-security men's unit. Each of these areas is accessed by another sliding, electrically operated steel door. The cells are of open-front construction, with sliding barred doors. All of the doors in the jail can be manually operated with a key in the absence of electric power, but there is no gang unlock and each cell door must be individually keyed open.

At approximately 3:45 a.m. on September 14, 1991, some of the minimum-custody prisoners in cells along the back wall of the jail became aware of a fire just outside the jail walls and visible through translucent windows in the housing area. They began yelling and woke the trusty inmates housed in the cells closest to the doors to the dispatch room, where the night staff member is usually stationed. At night, the Taney County Jail is staffed by one person, a dispatcher/jailer who runs the county dispatch center and also handles duties inside the jail. Inmates were unable to contact this staff member for a substantial period of time. By the time contact was made, smoke was coming into the jail from the roof.

A wooden shedlike structure had been constructed just outside the east wall of the jail building to house a large emergency generator for use in the event of a main power failure. The emergency generator was powered by propane, and a large propane tank was mounted outside the wooden shed approximately 1 to 2 feet from the shed's northern wall. By state code, the propane tank should have been at least 10 feet from any flammable structure. The shed housing the emergency generator also housed two large batteries and a battery charger, which was powered with electric lines run from inside the jail.

Although a number of issues surrounding this fire remain unclear or in dispute, a short circuit in the battery charger or its wires appears to have produced the fire that involved the wooden shed. The roof of the jail is constructed of prestressed concrete, but above that a wooden soffit, or eaves, and a false roof had been constructed in apparent violation of state codes.

The fire in the shed spread to the wooden structure above the concrete roof of the jail, and this wooden roofing apparently produced most of the smoke that entered the jail. At some point early in this series of events, the shed fire burned the wiring on both the emergency generator and the main power lines, and the jail lost all power.

When the dispatcher/jailer responded to the outer door of the jail housing areas, he had an immediate problem. If that door, the inner doors, and the cell doors were opened to evacuate the inmates, they would be in a corridor leading to an unsecured outside door to the jail and might escape. At some point after the power was lost, the dispatcher/jailer tried to manually key the main housing area door, but was unable to operate it.

Conditions within the cell areas became extremely bad. Thick smoke was reaching all of the cell areas. The built-in smoke ejector system did not work because it was dependent on power. Although timelines are not clear, reconstruction of events suggested that it may have been more than 30 minutes after the dispatcher/jailer was alerted before help arrived. Two or three jail staff, including the head jailer, and fire department assistance all arrived in close proximity to each other. After the head jailer tried unsuccessfully to operate the main housing area door manually, a firefighter wearing self-contained breathing apparatus was finally able to open the door. The doors of the units also had to be opened manually, and then cell doors had to be opened individually. The jail staff and firefighters were able to enter the women's area and the minimum-security men's area and open cell doors. The maximum-security unit door could not be operated manually and eventually was opened with an acetylene torch, causing even lengthier delays in reaching the cells there.

Three male inmates and one female inmate died of smoke inhalation. Another female inmate suffered very serious permanent lung damage and will require oxygen assistance for the rest of her life. The other 21 inmates housed in the jail suffered smoke-related injuries described as mild to medium. No serious injuries occurred to jail staff or firefighters.

The time at which the power and emergency power were lost has never been established with any degree of precision. There were allegations that the dispatcher/jailer had a window of opportunity after he had become aware of the fire, and before the power was lost, during which he could have operated all of the doors electrically and evacuated all of the inmates, and that he had failed to do so out of fear about escapes or simply because he did not know an evacuation procedure. It was also suggested that the power went out almost immediately after the fire was first noticed and well before the dispatcher/jailer was even notified.

The jail had not conducted fire drills or any sort of practice evacuations. State code required an annual fire safety inspection of the jail, with a written report of the results of the inspections. No such inspections had been conducted and the fire marshal did not have jurisdiction over the jail. The smoke detectors installed in the jail did not have battery backup and were ineffective.

No comprehensive analysis of what happened, and why, was attempted in the aftermath of the fire. With the exception of a short investigation report by the Division of Fire Safety of the State Department of Public Safety (consisting primarily of a description of what was found burned, partially burned, and intact), most of the available documentary information on the fire is found in deposition testimony resulting from a large number of lawsuits filed by surviving inmates and families of the deceased inmates.

The lengthiest of the civil cases was concluded in 1995. Taney County was insured, and the carrier settled relatively quickly at policy limits. Out-of-court settlements were also reached with the company that manufactured the security doors and the company that installed the propane tank that fed the emergency generator.

When the jail was repaired, the eaves and false roof were redesigned using nonflammable materials. The dispatcher/jailer who had been on duty had a severe posttraumatic stress reaction to the incident and eventually resigned from the Sheriff's Department.

Lessons Learned

1. No building is fireproof.
2. Even in a modern facility constructed of steel and concrete, many items are capable of producing life-threatening smoke, including mattresses, inmates' personal property, carpeting, wall paint, cleaning supplies, and insulation.
3. Unless procedures are tested with fire drills that include full-scale evacuation, some problems may not be identified until they occur during a real fire, perhaps with disastrous consequences.
4. Local fire departments should participate in simulated fire emergencies with local correctional institutions.
5. Every correctional institution should have self-contained breathing apparatuses and staff trained to use them properly. The primary purpose of this equipment is not fire suppression but search and rescue.
6. Fire exit signs and smoke and fire detectors should always have battery backup systems.
7. Inmate housing areas that are isolated from staff during some portions of the day must have a method or mechanism for alerting staff to an emergency.
8. Where possible, emergency generators should not be in the same location as the main power for the institution.
9. Every correctional institution should undergo a thorough fire inspection at least annually, conducted by someone not on the institution's staff.
10. A comprehensive critical incident review should be required after every serious emergency situation to ensure that problems encountered do not reoccur and to avoid other problems.

Lucasville Prison Riot: Ohio Department of Corrections

On April 11, 1993, Easter Sunday, the Southern Ohio Correctional Facility (SOCF) in Lucasville, Ohio, experienced the start of what has become the longest prison riot in the past four decades and the third most lethal disorder in recent penal history.[1] When the riot ended 11 days later, a correctional officer and nine inmates had been murdered. Nearly 2,000 law enforcement officers and National Guard troops were involved in responding to the riot over its 11-day course. In bringing the riot to a close, state negotiators accepted a 21-point list of grievances with the promise to review them for possible improvements to the besieged Lucasville prison.

At the time the riot began, SOCF held 1,822 inmates, 44 percent of whom were double celled because the prison was operating over capacity. As the state's only maximum-security prison, SOCF held the most violent and predatory inmates in a system with a total population of approximately 40,000.

In the months preceding the riot, the Ohio prison system had discovered a few active cases of tuberculosis (TB) among the prison population and decided to administer the tuberculin skin test to the entire prison population. All Ohio prisons but SOCF completed the TB testing without major problems. At SOCF, the Muslim inmates informed the warden that their religion prohibited skin testing and that they would not participate or comply. The warden met with an inmate leader and a Muslim imam and told them that they would have no choice and that it would be "my way or the highway." (The warden later candidly acknowledged that his approach was unnecessarily confrontational and a mistake.)

The SOCF command staff met on a Thursday and decided they would lock down the prison beginning the following Monday morning and do the skin testing by force if necessary. The next day, Friday, memos about the lockdown were drafted and requisitions for extra supplies were prepared, most of which were typed by inmate clerks. The inmate population knew that the lockdown would begin Monday morning, and they used Saturday to plan a disturbance that would start on Sunday.

On the afternoon of Sunday, April 11, 1993, two correctional officers and a recreation officer were in the L-block corridor as more than 100 inmates from L–6 returned from the recreation field. Another 180 inmates from L–2 and L–7 and 60 inmates released on passes were also preparing to enter L-corridor from the yard. An additional 100 or so inmates from K–6 were also on the recreation yard at this time. A total of 76 security posts, including towers and control centers, were scheduled during the second shift on any day at SOCF; 68 of these posts were staffed on Easter Sunday.

[1] Only the prison riots in Santa Fe, NM, and Attica, NY, caused more casualties.

At approximately 3 p.m., as L–6 inmates entered L-corridor from the yard, a group of them launched an assault on an officer, quickly overcoming him by shear force of numbers. As other inmates filed in from the yard, they joined the melee, assaulting other staff in the area. Inmates outnumbered staff so greatly that the staff's initial security and control objectives were soon replaced by the need to survive and to keep the uprising from spreading to other parts of the institution.

The riot was now under way. Within 15 minutes of the initial attack, the inmates gained control of L-corridor and the keys that opened all the doors to all of the blocks within L-corridor. They also took hostages and neutralized the remaining staff inside the block by capturing them or forcing them out of the area.

Chronology of Events

Day 1: Sunday, April 11, 1993

12 noon. Recreation period begins. Inmates from L–2, L–6, L–7, and K–6—approximately 400 inmates—are allowed to enter the yard. Approximately 60 additional inmates are also given passes for the yard.

2:50 p.m. An announcement to "close" the yard is broadcast over the public address (PA) system.

2:55 p.m. The PA announcement to clear the yard is repeated.

3 p.m. Inmates from L–6 (maximum security, level 4) begin to enter L-corridor.

3:03 p.m. Several inmates attack the corridor officer and gain possession of the keys that open the doors to all of the blocks on L-corridor.

The Southern Ohio Correctional Facility had been a troubled prison since it opened. Lucasville is located in the most isolated, rural, and poorest part of southern Ohio, a region that has more in common with the Appalachian area of Kentucky across the Ohio river than with the northern tier of industrialized cities in Ohio such as Cleveland, Akron, Toledo, and Canton. The mix of relatively unsophisticated rural white staff and streetwise, urban black inmates was problematic from the beginning. Race relations at the prison were bad, and the prison had experienced more than 20 homicides in its relatively short history before the Easter Sunday riot began. In most cases, the inmates serving the longest terms in the Ohio prison system were geographically the most distanced from their families, making visiting difficult and infrequent. Because of an antiquated phone switch, inmates had extremely limited access to pay phones. Moreover, although the prison held the most serious of the state's 40,000 inmates, it was run not like a maximum-security institution, but more like a relatively open medium-security prison. The new warden had changed some of that but had lost support among staff and in the local community by proving to be serious and professional on issues such as use of force.

When the shift commander (a lieutenant) and the only other lieutenant in the institution both responded to the fight in progress along with a sergeant and all three were engaged in hand-to-hand combat and injured, the control center and the institution were left with no one at the helm. A correctional officer might have "stepped up to the plate" to take charge and organize the response to the expanding emergency, but no one did. In the first 20 to 40 minutes of the disturbance—the traditional window that determines how much of an institution is lost and how many inmates become involved—SOCF was operating with no one in charge. When the shift commander finally did fight his way out of the cell blocks and get back to the control center, he was badly beaten, had broken bones, and was in no condition to exercise command authority. Other reports from the institution indicate that the first high-ranking administrator to get to the institution in response to callbacks ended up in a tower, divorced from the action, and exercised no direction or command.

3:04 p.m. Inmates attack four officers nearly simultaneously. One officer calls control center 1 and reports "a fight in L-corridor."

3:05 p.m. Control center 1 radios all units "We have a fight in L-corridor."

3:06 p.m. The shift commander responds to the call and is immediately attacked upon entering L-corridor. An additional lieutenant also responds and is attacked.

In leaving to respond to the call, the sergeant from J-block encounters inmates beating an officer with a side-handled baton (PR–24) and broom handle near L–6.

Control center 1 radios a report that two man-down alarms have gone off in L-block.

3:07 p.m. Both lieutenants and the sergeant fight their way through L-corridor.

Control center 1 receives a call that an officer needs help in L-block.

A recreation officer in K-block calls for stretchers after seeing injured officers crossing the yard from L-block to K-block.

3:08 p.m. Control center 1 calls the Ohio State Highway Patrol for assistance.

3:12 p.m. The two lieutenants and the sergeant succeed in fighting their way to the lower crash gate in L-corridor. They order control center 3 to close the crash gate.

3:15 p.m. A lieutenant radios control center 1, advising them that "the inmates have taken L-side." Inmates are heard chanting "We have the keys."

3:05–3:15 p.m. Efforts to call key staff on beepers are hampered because the staff member making the calls does not realize that a touch-tone line is required to activate beepers and is using a rotary phone line.

Some L-block officers run to the rear stairwell of L–5 as they have been trained to do. One officer is attacked in L–6 but manages to fight his way past the crash gate just before it is closed. Another officer is taken hostage when he enters L-corridor.

3:15–4:15 p.m. Tower guards are instructed to break the seals on their guns. Correctional

officers with shotguns take position at control center 3 to prevent L-block inmates from advancing further.

One officer calls for help from the L–5 rear stairwell where he and another officer have taken refuge. He makes contact with control center 1 on four occasions. No one is sent to rescue the officers.

The chaplain arrives at control center 1 and offers his assistance. The officer from the L–5 stairwell calls control center 1 a fifth time. A different person takes the call and immediately takes an armed team to attempt a rescue through the exterior L–5 door.

Using a weight-lifting bar taken from the gym, inmates break through the unreinforced concrete block of the L–5 rear stairwell, capturing the two officers just as the rescue team arrives at the exterior door—1 hour after the first call for help.

Inmates break through the rear L–2 stairwell wall, capturing another officer and an inmate. The inmate is savagely assaulted and murdered in front of the officer. (The inmate's body is dumped in the yard the following day. An autopsy reveals 163 stab wounds and major skull fractures.)

Another officer calls the control center from the rear L–4 stairwell seeking assistance for himself and a second officer. No one answers the phone. He tries to call for help a second time. Someone answers the phone, then hangs up. By now, inmates have smashed the window out of the stairwell door and are spraying the two officers with a fire extinguisher. The inmates manage to smash through the concrete block wall and take the officers hostage, beating them severely in the process.

Inmates erect a barricade against the lower crash gate in L-corridor to prevent or delay an assault from the control center 3 area.

Officers lock down K-block inmates wherever they are—in their cells, the shower, or the dayroom—to permit additional staff to

The housing units at SOCF are two stories high with solid ceilings between the two floors rather than open tiers. The front of each cell block opens onto a main housing corridor. At the rear of each housing block is a two-story stairwell with steel security doors on each of the two floors. Officers carry keys to those doors and are trained from the time they begin working at SOCF to retreat to the stairwell if they are in trouble on the housing block and cannot get to the main corridor. Once locked in the stairwell, the officer can use the phone there to call the control center, which, in theory, would then dispatch a group of staff to rescue the officer. The rescue staff would enter the stairwell via an additional security door from the yard to the first floor of the stairwell. Block officers do not carry keys to that door because doing so would breach the security envelope.

A number of officers used the stairwells exactly as they had been trained to do. However, although some officers called the control center many times over more than an hour, no staff were dispatched to rescue them. All of the officers in the stairwell were eventually beaten and/or taken hostage by inmates after the inmates broke through the unreinforced ceramic concrete block construction of the walls surrounding the stairwell security doors.

respond to the crisis and reduce the chances for spread of the riot.

Later, tactical response and disturbance control teams are deployed to K-block to place all prisoners back in their cells.

4 p.m. The prison duty officer, a unit manager, arrives at the institution. L-block inmates cross the yard and scale a fence, gaining access to the exterior of K-block. Inmates in the yard smash a window in K-block and obtain food and blankets from K-block inmates.

As inmates advance across the yard to K-block, armed officers in the towers and in K-block are instructed by the control center not to fire.

After the riot, serious controversy arose about whether the warden had been called and when. Control center staff said that they made several attempts to reach the warden by telephone at home and by pager. The warden testified that he had been available by phone and pager and that no one had tried to contact him until hours after the riot had begun. In the final analysis, the warden did not arrive at SOCF until approximately 4 hours after the riot had started.

4:15–5:15 p.m. The inmates have taken a total of 11 officers hostage. They assess hostage injuries, determine that one officer is seriously injured, and, fearing his death, make arrangements with prison staff to place him in the L–8 stairwell for rescue by an armed team. The rescue is carried out.

Inmates secure copies of the prison's negotiation and disturbance control manuals from a unit manager's office.

The SOCF negotiation team is assembled to negotiate with the inmates, who are now firmly in control of L-complex.

5 p.m. The SOCF disturbance control team is assembled (one member is a hostage).

5:15 p.m. The major makes calls to all L-block rear stairwells but receives no answer.

5:45 p.m. The SOCF tactical response team is assembled.

7:30 p.m. K-block officers use belly chains to secure doors in the M–1 gym because inmates now have M–2 keys, which also open M–1 doors.

9:16 p.m. Inmates release one correctional officer due to the seriousness of the injuries he sustained in the takeover. The officer is life flighted to Grant Hospital in Columbus, Ohio.

10:36 p.m. Inmates release another correctional officer who has serious head injuries, and the officer is transported to the hospital.

11:02 p.m. The bodies of five slain inmates are placed in the yard and retrieved a short time later by prison officials.

11:22 p.m. Another seriously injured correctional officer is released and taken to the hospital. The inmates have now released four of the hostages.

Day 2: Monday, April 12, 1993

1:45 a.m. The last of the inmates roaming in the yard are cleared and placed in K-block, which now has as many as 10 inmates to a cell.

10:15 a.m. A reporter from the Cleveland *Plain Dealer* is selected by lot to act as an intermediary in inmate negotiations. Prison officials cut off his telephone conversation with an inmate spokesperson when the inmates fail to confirm that all hostages are safe.

10:35 a.m. The body of another inmate is put out in the prison yard and retrieved.

Day 3: Tuesday, April 13, 1993

10 a.m. Prison staff discover the body of an inmate in a K-block cell. (Later accounts suggest that this inmate was murdered by other inmates because his nephew gave assistance to a correctional officer during the riot.)

4 p.m. A disturbance erupts in K–8, the closest K-block wing to L-complex, as inmates in L–1 shout encouragement to the K–8 inmates to join the riot. Prison staff discharge tear gas to quell the disturbance and begin to transport inmates from K-block to other institutions.

Day 4: Wednesday, April 14, 1993

3:50 a.m. A police helicopter crashes while patrolling the prison complex. Three persons suffer minor injuries.

9 a.m. Inmates hang a sheet from L-block windows displaying the message that they will kill a hostage if their demands are not met. Inmate demands include single cells, more educational opportunities, and additional visitation periods.

12 noon. The Governor of Ohio calls up the Ohio National Guard to provide perimeter security at SOCF.

5 p.m. Prison authorities provide food to the inmates in L-block in exchange for assurances that two hostages will be given prescription drugs they take for preexisting medical conditions.

Day 5: Thursday, April 15, 1993

12:20 p.m. Inmates throw the body of Correctional Officer Robert Vallandingham out of L-block. Officer Vallandingham's

Media representatives using telephoto lenses and binoculars could read the demands and threats that inmates had painted on sheets and hung out the prison windows. Prison officials were communicating intermittently with media representatives in a briefing area. When the media asked a deputy public information officer about the time ultimatums and the threat to kill a hostage, she responded that the inmates had been making such threats and ultimatums since the beginning of the disturbance and that there was no reason to think these were more serious than the earlier deadlines and threats. Her statements were broadcast and heard in the cell blocks, where inmates were monitoring media coverage on televisions and radios. Shortly thereafter, inmates took Officer Vallandingham, a young officer very popular with both inmates and staff, from his cell and executed him in cold blood. They then threw his body out to prison staff. Most staff and many other observers believe this execution was the direct result of the blatant mistake in dealing with the media. It should be emphasized that the deputy public information officer had no training in media relations during a crisis and that the department had neither policy nor procedure for such situations.

More than half the prison population at SOCF was locked down and was not involved in the insurrection. However, staff throughout the prison were extremely emotional and angry and treated the uninvolved inmates so badly that new rioting threatened to break out in uninvolved portions of the prison on at least two occasions. In response to a request from the State of Ohio, NIC sent a top administrator from another state to SOCF as an advisor. This consultant, who had considerable experience with prison crises and riots, ended up helping to manage the unaffected areas of the prison. In attempting to prevent retaliation against inmates who were not involved in the rioting, the consultant had an intense confrontation with one of the prison's top managers. Prison staff continued to maltreat the uninvolved inmates even after the riot ended on day 11. The prison remained on the verge of additional violence for several weeks, with the threat coming from inmates who had not been involved in the riot itself.

body is recovered and removed from the prison grounds.

8:20 p.m. In return for being allowed to make a live radio broadcast—their second of the day—inmates release a hostage.

Day 6: Friday, April 16, 1993

2:15 p.m. In return for a live television broadcast, inmates release another hostage. During the television broadcast, a Muslim inmate repeats the inmates' demand for elimination of forced racial integration of cells at SOCF.

Day 7: Saturday, April 17, 1993

10:40 a.m. In response to inmate demands, prison officials summon another television crew for a live broadcast, but negotiations fall through. Prison officials provide inmates with additional food and water, along with medicine for the hostages.

3:40 p.m. Bulldozers are moved to the prison perimeter, ostensibly to collapse any tunnels being dug by inmates.

Day 8: Sunday, April 18, 1993

Prison officials invite Cleveland lawyer Niki Z. Schwartz (no relation to one of the authors of this guide), who has previously represented inmates in lawsuits against the prison system, to SOCF to aid in negotiations with the inmates.

Prison authorities play an audiotape containing messages from the five remaining hostages for the hostage families.

Day 9: Monday, April 19, 1993

3:50 p.m. Inmates hang another sheet from L-block windows with a message saying, "State lying to you. We're willing to end this ordeal and want to meet face to face with our attorney."

Attorney Schwartz continues to consult with inmates through prison negotiators.

9 p.m. Throughout the night, in a scenario reminiscent of the Branch Davidian complex situation in Waco, Texas, prison authorities broadcast taped messages to the inmates in L-complex over loudspeakers, advising them of the warden's agreement to their demands.

Day 10: Tuesday, April 20, 1993

12 noon–3 p.m. Three inmates and Attorney Schwartz meet with members of the prison negotiating team at a table set up in the prison yard.

7:45 p.m. Attorney Schwartz advises reporters that an agreement is close at hand.

Day 11: Wednesday, April 21, 1993

2:50 p.m. Warden Tate and Attorney Schwartz announce that an agreement has been reached, ending the siege.

3:30–10:40 p.m. Inmates begin leaving L-complex through the M–2 gym door and are escorted to K-block for processing by members of the Ohio State Highway Patrol.

Two additional inmates are murdered in L-complex by other inmates.

10:40 p.m. As the last of the inmates clear L-block, the remaining hostages walk out to their freedom.

Lessons Learned

1. Emergency plans and procedures must be realistic, practical, and well known to staff. The emergency plans at SOCF met none of these criteria. They were out of date, contradictory in places, and generally inadequate for dealing with a major emergency. However, the quality of the emergency plans turned out to be irrelevant because staff had not been trained in them and did not know them. Inevitably, staff found themselves trying to invent emergency response procedures and strategies in the midst of the crisis.
2. Without effective leadership, other aspects of emergency preparation may not matter. In this riot, some staff were taken hostage and/or beaten simply because no one would take command and act decisively. Hours later, when the warden arrived and exerted strong leadership, the nature of the situation began to change in favor of staff, although it was too late to undo much of what had already occurred.
3. Professionalism must be established from day to day, long before a crisis occurs. Professionalism cannot be developed in the middle of an emergency. At SOCF, retaliation against inmates made a tragic situation worse and actually increased the risks involved in the emergency operation itself.
4. Leadership can be extraordinarily painful and emotional. Officer Vallandingham's body was waiting for the coroner in a corridor when an oncoming shift of officers arrived and entered the institution through the same corridor. That group of staff then happened to encounter the warden, who was away from his office. The officers pleaded with the warden to authorize an assault and to end the situation at any cost. The warden knew that this decision would be popular regardless of the outcome. He also knew that the remaining hostages were being held in three separate groups by three different inmate factions and that at least two of the groups of hostages were being moved periodically to keep their location unknown. Ordering an assault would have been tantamount to a death warrant for the remaining hostages, and the warden would not do it. Several days later, the remaining hostages were released without further physical harm. Neither the strength the warden's decision required nor the toll it took on him can be overestimated.
5. Although negotiations did lead to a nonviolent surrender and the release of the remaining hostages, the negotiation process and the negotiators themselves were highly

unpopular with staff. In fact, the negotiators had to be escorted out of the institution under armed guard because of the staff's reaction. Correctional staff need to understand the role and mission of negotiators long before an incident occurs.

6. If staff do not quickly recognize the severity of an emergency and immediately start to isolate and contain it, the emergency can escalate very quickly. Interviews of the rioters indicated, as has been true in some other major insurrections, that they did not expect the riot to be as "successful" as it was or to last as long as it did. The inmates never thought they could successfully take over the entire cell block.
7. Officers in the housing units were allowed to carry keys that opened several different doors in their housing units and some doors in other areas of the institution. This practice violated the security concept of the prison design and posed a serious security risk.
8. Under the policy at the time, the shift commander did not have the authority to order an armed assault. Such orders required the approval of a duty officer, who at the time was a unit manager. The duty officer was not at the institution when the riot started. Any thoughtful review would have revealed the existing policy to be deeply flawed.
9. Emergency preparedness training for all staff is important and necessary. At the time of the riot, preservice training for SOCF staff included 1 hour of critical incident training, in which staff were advised on methods of handling fight situations, medical emergencies, and disturbed inmates, and 1 hour of hostage situation training that consisted of advice on "how to be a good hostage." The tactical team received an initial 24 hours of training from senior staff, but after that, most training was conducted on their own time and there was no clear-cut policy on purchasing of equipment and clothing.
10. Use-of-force policies must be well thought out, written, and disseminated to all staff and should be given considerable emphasis during preservice training. Although tower officers in the early stages of the riot were instructed to break their gun seals, SOCF had no clear policy or direction regarding the use of tower weapons. One tower officer was reported to have stopped L-block inmates who were approaching K-block by threatening to shoot, but it was not clear that any of the tower officers knew whether or under what circumstances to shoot, other than in the case of a direct order or to prevent inmates from breaching the perimeter fence.
11. Contrary to popular correctional thinking, rival gangs worked together in this riot to manage negotiations, hostages, and L-block. For the 11 days of the crisis, the Sunni Muslims, Arian Brotherhood, and Black Gangster Disciples managed L-block in a way similar to the way in which the prison normally was managed. They divided into areas, had intermediaries, assigned guard duties, locked up their worst offenders, and even traded the hostages back and forth, based on which group would do the best job in guarding them. They operated an infirmary and did a reasonably fair job of suturing some inmate wounds.
12. Inmate work assignments must be reviewed with regard to access to confidential information. Inmate workers at SOCF had jobs that allowed them to read or hear sensitive information concerning prison operations and policies. Inmates worked in the captain's office, where they had access to staff records, and in unit offices, where they had access to telephones, sensitive information

regarding other inmates, and institutional documents like the disturbance control manual.

13. It is generally accepted that staff who treat inmates badly may be targeted in a riot. Officer Vallandingham, the officer killed during the siege, was not among those hated by the inmates. By all accounts, he was quite well liked. The Ohio State Highway Patrol could not identify any personal vendetta against Officer Vallandingham to justify his being targeted for death.
14. Media relations are a crucial, even life-and-death, part of emergency operations. Preparation for media relations during an emergency should be serious and extensive, and the procedures developed should be carefully distinguished from day-to-day media relations. During the SOCF incident, several problems arose with the media in addition to the tragic mistake that led to the murder of Officer Vallandingham. At the start of the riot, a helicopter from a TV station flew so close to the prison that negotiators could not make out the demands inmates were yelling over a bull horn. On another occasion, a helicopter from another TV station went aloft to televise a live shot of SWAT units crawling over cell block roofs preparing to take up positions should the order come for an assault.
15. The aftermath of an emergency can be the longest and most difficult part of responding to an emergency. Just the prosecution of the inmates involved in the Lucasville riot was overwhelming. Investigators gathered more than 4,000 pieces of evidence, 7,000 photos, more than 120 videos, and countless hours of audiotape and conducted more than 1,200 interviews. Eventually, the state successfully prosecuted 48 of the 50 cases presented in court.
16. Normality may not return for years. Investigations were still continuing 3 years after the riot.

Helicopter Intrusion/Escape: Colorado Department of Corrections

On Friday morning, August 18, 1989, at about 9:15 a.m., a helicopter entered the main compound of the Arkansas Valley Correctional Facility (AVCF) near Ordway, Colorado, and landed on the ballfield of the prison's main recreation yard. Within seconds, two inmates entered the helicopter and it rose, turned, and flew out of sight. At approximately 6 p.m. that day, the two escapees and their two female accomplices were located driving in a rental truck toward Holdredge, Nebraska. A shootout with police ensued, after which both inmates and both women were taken into custody in Holdredge.

The AVCF is a modern, medium-security state prison that opened in 1987. At the time of the escape, AVCF staff had become used to seeing helicopters from two television station news operations flying near the facility, and both of those helicopters were similar in appearance to the jet helicopter that made the intrusion on August 18.

The helicopter appeared to have circled the facility prior to crossing the perimeter and entering the compound. Officers on the perimeter reported the helicopter as it crossed the perimeter of the facility but not before that. At the time the helicopter entered the compound, there were 15 to 20 inmates on the main recreation yard and five staff members outside the buildings supervising inmates. When the helicopter landed on the ballfield, two inmates immediately entered the helicopter and two staff members ran toward it, getting quite close before it took off. The staff members who approached the helicopter were able to give descriptions of the male pilot and two female passengers.

The prison superintendent was in his office overlooking the recreation yard when the initial radio report indicated the helicopter entry to the facility. The superintendent gave immediate orders that if the helicopter lifted off, the perimeter officers were to stop or disable it with lethal force. He repeated this order two more times during the next minute, but no shots were fired. No armed posts at AVCF have sightlines or fields of fire to the ballfield. Given the helicopter's path of ascent and departure from the area, one of the two towers at best had a partially obstructed view. The position of the armed perimeter vehicle was also such that it was not able to fire at the helicopter, in part because of obstruction from the fence fabric. The other tower officer should have had a clear view of the helicopter once it rose over the ballfield and should have been able to fire several shots but did not. He was suspended pending investigation and subsequently discharged.

Staff estimates of the total time the helicopter took from initially crossing the perimeter of the facility to taking off from the ballfield and beginning to leave the institution ranged from 15 to 30 seconds. Estimates placed the helicopter's

speed when taking off from the ballfield and climbing at 40 to 50 miles per hour, accelerating to 90 to 100 miles per hour as it turned to leave the compound. Staff witnesses reported that it was also clear that the two inmates were waiting for the helicopter when it arrived, perhaps within 10 feet of the spot where it touched down. There were reports that the inmates wore distinctive bright clothing that could serve as a signal or beacon for the helicopter.

The facility called an emergency count within 5 minutes of the escape, at 9:20 a.m. The emergency count was completed at 9:32 a.m., and the identities of the two escapees were confirmed. Department headquarters and the Colorado State Patrol were both notified of the escape at approximately 9:30 a.m. The prison remained locked down (except for inmate kitchen help) until lunch hour. The incident was entered into the National Crime Information Center (NCIC) system and state warrants were issued quickly. "Wanted" fliers with pictures were also disseminated.

The facility duty officer left the facility to participate in the search, although the facility's procedures in the event of an escape call for the duty officer to remain at the prison and complete a specific checklist of responsibilities. Most of these responsibilities were handled by the shift commander. Both prison investigators also left the facility to participate in the search, hampering the development of intelligence about the escapees. For example, the escapees' cell was secured immediately after the emergency count, but the cell was not searched until the investigators returned.

The search itself quickly became problematic. AVCF procedures called for the use of structured search teams for any escape. In this instance, the structured search teams were not used, perhaps because of the unusual nature of the escape. Six vehicles and 14 staff left the institution on the search, and only half of those staff were designated search team members. The primary search commander and all three designated relief commanders joined this initial search. If the search had continued hours longer, no relief commander would have been available. Once the search vehicles were more than 30 miles north of Ordway, they lost all radio communication with the facility control center. Car-to-car communication was also difficult to impossible. Outside law enforcement agencies were able to provide some information to the institution about the status of the search vehicles, but the search commander had no information about vehicle positions or directions. Two search vehicles were participating without the knowledge of the search commander.

The AVCF armory officer was not in the facility at the time of the escape, so the shift commander assigned an alternate. It was subsequently discovered that several weapons had been taken from the armory without an armory officer present for proper weapons assignment and documentation.

Within 45 minutes of the escape, the facility discussed the situation with the Air National Guard commander, who immediately made helicopter training flights available to help with the search. The airborne surveillance from the Air National Guard and the Colorado State Patrol was extremely helpful with the search effort and with the coordination of communications.

At 9:46 that morning (31 minutes after the escape), a small local airport aviation company reported that a blue and white helicopter with two women and a male pilot aboard had landed at 8:40 a.m. and refueled. At 10:09 a.m., a county sheriff's office radioed that the helicopter was spotted on the ground some 35 miles north of the prison and that suspects had been seen running to a yellow rental truck. A press release was authorized at 10:24 a.m. At 10:40 a.m., the

helicopter and pilot were located near an abandoned farmhouse. A National Guard helicopter was dispatched and, 10 minutes later, the prison received information that the pilot had been tied up but was unharmed and that the two women and two inmates were armed. The prison determined that an older Volkswagen was registered to one of the inmates' wives, and at 11:40 a.m., the superintendent issued an all points bulletin for this car and its license plate. Prison officials speculated that the Volkswagen might be inside the rental van.

By midafternoon, the escape response at the prison was focusing on the planning of the escape and attempting to confirm the identities of the two women involved. At 2:30 p.m., the superintendent interviewed the two officers who had gotten within a few feet of the helicopter before it lifted off. One of them confirmed the identity of one of the female passengers as the wife of one of the two inmates. He recognized her from her visits to the prison.

As is often the case in such situations, there were a number of rumors, false starts, and misunderstandings. The sheriff of Arapahoe County, Colorado, had suggested at 10:30 a.m. that a female former deputy sheriff who had been fired from Arapahoe County for becoming involved with a jail inmate there might have been involved in the escape. The intelligence operation had been focusing on whether this former deputy sheriff might be the wife of one of the two inmates or might be involved in the escape using an alias. At 4:30 p.m. the sheriff's office advised the prison that the female ex-deputy sheriff and her attorney had appeared there to verify she was not involved in the escape.

When the police found the helicopter pilot, he was untied and claimed he had been able to cut the ropes using a pocket knife. The police initially were very skeptical. They reported to the prison that the pilot was likely a collaborator in the escape, and brought him to the jail as a suspect. It was not until mid- to late afternoon that it became clear that the pilot was an innocent victim.

By late afternoon, information about the chartering of the helicopter had become more clear. The helicopter had been chartered out of the Centennial Airport, but the two women who chartered it were actually picked up at the nearby La Junta Airport. They got on the helicopter carrying large bags and presumably took weapons from the bags once the helicopter was in flight. Because Centennial and La Junta are not commercial airports, no metal detectors or other commercial aviation security precautions are in place. It was also learned that the charter originally had been arranged for 2 days earlier but had been canceled by the helicopter company because of bad weather. The charter company operator remembered that one of the women had become irate when the earlier charter was canceled and that both were upset when the Friday morning charter was running 10 to 15 minutes late.

At 6:15 p.m., one of the department administrators was advised that the evening television news had just reported a shootout in Holdredge, Nebraska. Calls to the Holdredge Police Department were initially frustrating, as the Colorado Department of Corrections (DOC) was advised that the Nebraska State Patrol was handling all information about the incident. The Colorado DOC was unable to get an immediate status report. By 7:30 that evening, the DOC had detailed information from the Nebraska State Patrol and had verified that both inmates and their female accomplices were in police custody.

The day after the escape, the prison confirmed information that one of the two women involved had been a criminal justice student at a Colorado college and had done volunteer work at another

Colorado prison the year before as part of an internship. As an assistant to a case manager, she conducted tutoring and case management testing of inmates behind closed doors. She was terminated by that prison in November 1988, and in March 1989 she appeared at AVCF with papers indicating she had married an inmate (one of the two escapees) "by proxy." The other female accomplice was the wife of the second inmate.

Lessons Learned

1. Most of the problems encountered had to do with failures to follow the prison's established plans, policies, and procedures for escapes, rather than with inadequacies in the procedures themselves. The initial response of AVCF after the escape, including the lockdown, emergency count, and identification of the escapees, was fast, orderly, and effective.
2. Even with detailed planning, any major emergency will give rise to some unanticipated problems. An extraordinary situation such as the one presented here will demand quick and creative responses. For example, the search vehicles might have been effective if the inmates left the prison premises by car, but because of the speed and point-to-point nature of the helicopter's flight, the prison search effort was hours behind the escapees.
3. The problem with the duty officer, the investigators, and the relief search commanders all inappropriately joining the search underscores the importance of a well-trained, well-practiced, disciplined response to a major emergency. The long prison tradition of every available staff member responding to an alarm and trying to get to the scene as quickly as possible works against the kind of disciplined response necessary for managing a major emergency.
4. Prison security is designed from the inside out, rather than from the outside in. Prisons that may be extremely secure against the typical inmate escape attempt may be highly vulnerable to an assault from the outside. It is important for every prison to conduct an informal survey of its security against assaults from the outside. The answers to questions such as the following may be enlightening:
   - Which security systems would be ineffectual in the event of an outside assault?
   - What areas of the prison might civilian accomplices breach or disable?
   - How easily could someone throw in a weapon to a waiting inmate?
   - Could a heavy vehicle simply drive over perimeter fences?
   - How might an aircraft-assisted escape be planned?
5. Procedure should require perimeter posts to notify the shift commander whenever an aircraft is flying unusually low or appears to be approaching the facility. (A number of prisons and jails in this country are adjacent to airports and very close to established flight paths. For those institutions, notification should be limited to aircraft that appear to be out of established flight paths and flight patterns.)
6. The prison had not seriously contemplated a helicopter escape, although more than 20 such escape attempts from American jails and prisons occurred during the preceding 10 years. Helicopter escape attempts remain somewhat exotic because of the planning requirements but not necessarily because of resources. In 1989, the five-passenger jet

helicopter used in this escape was chartered for $475 an hour, well within the realm of possibility for many inmates' friends and family members.

7. Policy questions about the use of lethal force to prevent helicopter escapes remain difficult and somewhat controversial. There is some consensus that lethal force should not be directed at a helicopter that is apparently trying to land within a prison compound, in part because the pilot in an escape attempt will almost always turn out to be a civilian hostage or because the helicopter might be having mechanical problems and simply trying to find a safe place to land. There is also some consensus that the best way to deal with a potential helicopter escape is to prevent inmates from approaching and boarding a helicopter that is hovering or has landed. Many states specify that lethal force may be used against inmates who ignore verbal orders and/or warnings and attempt to move toward or get on board such a helicopter. There is less consensus about how to respond if a helicopter is taking off with inmates on board. The competing priorities of protecting the community against inmate escapes versus the risk that lethal force will kill the civilian hostage piloting the helicopter and the risk that the helicopter might crash into occupied buildings and cause a large-scale loss of life have led to different policies on this question.
8. This situation was extraordinary in that the superintendent actually saw the escape in progress and was able to issue orders to use lethal force. Most escape attempts that can be stopped with lethal force will not allow time for orders from a superior officer. An officer on a perimeter post will typically have to make a very quick decision about lethal force based on the agency's use-of-force policy and the officer's prior training, experiences, and expectations.
9. The situation described here, in which an officer was properly ordered to use lethal force but did not shoot, is more common than might be predicted. Some officers will "freeze up" and not fire, and it is not possible to predict who will and who will not fire until the situation occurs.
10. The prison should have several staff who are intimately familiar with the armory, its contents, its organization, and its procedures. Otherwise, the institution may have an emergency when the designated armory officer is unavailable, and critically important weapons or other equipment may not be available for staff or may not be adequately accounted for once the incident is over. In addition, staff at and above the shift command level should have more than a passing familiarity with the contents and organization of the armory.
11. An intelligence operation may be as important to solving an escape as the escape posts and search procedures.
12. Communications systems are seldom adequately tested for emergencies. Interagency compatibility problems with communications systems are often unaddressed until after a serious incident in which communications proved to be a major barrier.

Riot at Max: Montana State Prison

On Sunday, September 22, 1991, inmates of the maximum-security compound ("Max") of the Montana State Prison (MSP) rioted for several hours. Five inmates were killed and several were seriously injured. Five staff members were trapped and held hostage in a shower area for the duration of the riot.[1]

A riot at Max originating in the yard was planned at least as far back as late July 1991 and likely was being actively considered as early as May or June. Inmate discussion of a Max riot was common by the first days of August 1991. Inmate interview data were consistent with the conclusion that almost all of the inmates in the Max building knew that a serious riot was imminent and that it would start in the yard. Not all of the inmates knew the exact details of the plan.

Beginning of the Riot

At approximately 10 a.m. on Sunday, September 22, Max's five floor officers, including the sergeant, began to "bring the yard in." One of the three fenced exercise areas ("cages") of the East Yard was empty, and one of the three West Yard cages held a single inmate. The other four cages each contained three inmates. The officers moved the three inmates in the middle cage of the West Yard through the middle cage gate and brought them back into the Max building through the yard door, leaving both the cage gate and yard door open.

As the floor officers took the three inmates back to C-block, nine of the ten inmates left in the West Yard cages broke off pieces of fence in four separate locations, allowing all nine inmates to gather in the center cage on the west side. (For a substantial but unknown period of time before September 22, four portions of the fence had been prestressed by being worked back and forth.) Because the gate to this cage and the yard door to the west side of the Max building itself had been left open, the inmates had clear access to the inside of the building, and all nine hurried in, rushing the west unit control cage. A few split off and ran toward the east unit control cage (the satellite control cage).

Two inmate orderlies were working in the corridor, and the two sliding corridor doors had been left open. The inmates from the yard used plastic buckets filled with sand for putting out cigarettes to jam both doors open. They now had control of the corridors and floor area around both control cages; however, they could not get onto any of the six living units ("blocks").

Almost immediately, the inmates grabbed metal fire extinguishers and portable telephones and began attacking the two control cages. They soon broke the plate glass glazing that protects the polycarbonate security material (Lexan). When this glazing shattered, the control cage officers believed that the Lexan was giving way

[1] This case study is abstracted from "Riot at Max," the full report on the incident prepared by a seven-member Administrative Inquiry Team organized by the National Institute of Corrections at the request of the State of Montana.

The first Montana State Prison in Deer Lodge was one of the original western territorial prisons, as were legendary old institutions such as the prison at Florence, AZ, and Colorado's Old Max in Canyon City. The current facility opened in 1977, a few miles from the old prison.

The institution occupies a 58-acre site surrounded by thousands of acres of state land. Its perimeter is secured by a double fence topped with razor ribbon and five towers that are staffed 24 hours per day. There are 58 acres inside the perimeter fence; the institution includes 838 cells. An additional 40 inmates are housed in a single dormitory. There are three primary compounds within the perimeter fence:—Low Security Compound; the High Security Compound; and the Maximum Security Compound ("Max"). Max, a single building, is divided into two sides, east and west, each of which has a unit control room and three 16-cell, two-level podular living units ("A," "B," and "C" on the west side and "D," "E," and "F" on the east side).

In theory, inmates only leave their own compound to go to the infirmary or the Religious Activities Center. Food is brought into Max on insulated carts, and the inmates receive their meals in their cells. Staff, official visitors, and inmate visitors all use the same single entrance to the administration building and are searched at the front of the first floor of that building.

At the time of the riot, the average age of the inmate population at Max was 29; the average sentence was 28 years. The population was primarily white. Native American inmates constituted between 18 and 20 percent of the total population, and African American and Hispanic inmates each accounted for less than 2 percent. Before the riot, the number of inmates at MSP ranged between 1,150 and 1,196.

In 1991, MSP had 428 authorized staff positions (404 inside the main institution and 24 at the ranch or in industries), of which 275 were uniformed security staff. The inmate to staff ratio in 1990 was 2.76 to 1, up slightly from 1980, when it was 2.7 to 1. The institution had six or seven Hispanic staff and four Native American or part Native American staff, but no African American staff. There were 14 female correctional officers, including one at the rank of sergeant.

and that they were about to be taken hostage. The officers in both control cages now climbed ladders that lead to escape hatches on the roof.

The west unit control cage officer had locked the five floor officers into C-block. These officers observed the inmates build fires from inmate clothes and blankets and move them against both control cages. The fire at the main control cage (west) was extinguished by automatic sprinklers, but the fire at the satellite (east) cage burned intensely against the cage door and window, melting an area of the window in the control cage door. Inmates then apparently used a broom handle to make or enlarge a hole in the partially melted window and reached through this hole to the control

cage keys, which had been left in the inside of the door lock. Once the inmates were inside the two control cages, they had access to every living unit and cell in the building.

Initial Emergency Response

Conditions in Max were deteriorating rapidly. Water on the floor was ankle deep in some places, and smoke from the fires was getting thicker in the building. The smoke evacuation system was inoperative. Part of a sophisticated fire alarm system that included both the command post power override switches for the control consoles and an intrusion alarm system that monitored the status of the building's three roof hatches and three external doors, it had been broken for months, but security staff had not been notified of the problem.

When the shift commander heard that two officers were on the roof of Max, he detailed available staff to the Max compound. Some of the responding officers helped the control cage officers leave the roof. By the time the officers got down from the roof, about 10 minutes after the riot began, smoke was coming out of the roof escape hatches. The control cage officers confirmed that the sergeant and the four floor officers were locked in C-block and safe at least temporarily. The shift commander then radioed the staff surrounding the Max building to report back to the command post. At about this time, administrative notifications were begun, starting with the warden.

Before they received the order to return to the command post, the officers around Max had heard an inmate yelling that the inmates were trying to break into the control cages and that if they did so, the protective custody (PC) inmates would all be dead. Staff observed one PC inmate in his cell appearing bloody and beaten, an inmate trying to break into a counselor's office, and inmates beating on the control cage windows with mop handles and other instruments. When the group of staff reported back to the command post, they believed the floor officers were in one of the lower C-block cells.

The first top administrator to arrive was the associate warden (AW) for treatment. He did not assume command of the institution but worked in parallel with the shift commander, concentrating on events inside Max. The AW directed two staff members to take an AR–15 rifle and a .357 revolver, go to the lower level of C-block in Max, break out a window of the cell where the floor officers were hiding, and use the weapons to cover their escape. The two officers broke out a window in lower C–7, but the cell was empty. Inmates in an adjoining cell wrote a note to the officers saying that the staff members were in the lower C shower room, which has no external window.

Two other officers were sent to the basement crawl space beneath the Max building. They found water and smoke problems on both sides of the building and heard screaming and hollering coming from the east side, whereas the west side was relatively quiet. At about this time, staff around the building heard inmates screaming that the inmates had taken over the control cages. One inmate wrote a note saying that all of the inmates were out. These events appear to have occurred some time between 10:30 and 11 a.m.

The warden arrived at approximately 10:40 a.m. and went to the command post. He waited until the shift commander had a few free moments to brief him, then assumed command clearly and decisively. Shortly after 11 a.m., the warden asked for blueprints of the Max building and directed the assistant commander of the Disturbance Control Team (DCT) to meet with his team leaders and other necessary staff to

develop a preliminary plan for retaking the Max building.

At about this time, a sergeant in the command post succeeded in reaching an inmate in one of the control cages by phone. The inmate demanded that the inmates be allowed to meet with the media and told the sergeant that they would throw a letter over the fence to the media and that they had control of the officers and the PC inmates. MSP's single trained hostage negotiator was not yet on the scene. Eventually, however, the negotiator replaced the sergeant and negotiations continued intermittently throughout the incident, providing additional information about conditions and events inside the Max building. The negotiations held out the potential for resolution without force and were later used as a diversion to help cover the approach of the DCT assault team.

At approximately 11:15 a.m., the warden assigned a captain to contact the state cabinet secretary and keep his office briefed. At 11:20 a.m., the negotiator called the inmates, telling them that it was difficult to reach the media because it was Sunday. At 11:45, the inmates called back, demanding that correctional officers move away from the building and fence outside Max or they would bring up a correctional officer hostage and cut off his head. Ten minutes later, the negotiator told the inmate on the phone that media people would be brought in to speak with the inmates if staff could surround the building and contain the incident.

Most of MSP uses low-band radios, and the prison authorities were concerned that the inmates in Max could monitor these. The warden ordered all available high-band radios to be collected and distributed to key staff members, who were assigned code names.

Disturbance Control Team Retakes Max

By approximately noon, the rest of MSP had been locked down. Medical facilities had been checked and readied for emergency cases. A physician was standing by, ambulances had been requested, and the first ambulance had arrived at the institution. Towers had been double posted and additional high ground spotters and/or snipers had been deployed.

The DCT assistant commander returned to the DCT assembly and dressing area in the armory as additional DCT members continued to arrive, were briefed, and outfitted themselves. DCT had established their plan for retaking Max. They planned to use an institution fire truck to carry the team to the back of the building, where they would enter through the back door. As a diversion, they planned to introduce a staff member into the Max compound with a video camera and tell inmates that it was a media person. In preparation for this plan, an institution fire truck was driven to the warehouse, where most of its equipment was removed so it could carry the team.

In the meantime, the command post received a report that a beaten and bloody inmate had been seen at the Max sally port. The negotiator called the inmates and asked to arrange the removal of the injured inmate, offering to turn off the water to the automatic sprinklers. The inmates on the phone denied the request and repeated their demand to communicate with the media. They also said that lights were failing and ceilings were coming down in the building because of the water. The warden's decision to assault Max appears to have followed the inmates' refusal to negotiate over the injured inmate's release.

In preparation for the assault, radio call signs were reviewed and confirmed and airspace over

the prison was restricted. DCT was reminded to move directly to C-block, where the staff hostages were believed to be held. The warden, who had previously agreed with the secretary's office to clear any actions that might be life threatening, used the open briefing line between MSP and the secretary's office to discuss the impending start of the assault. The secretary (and through him, the Governor's office) had been in regular contact with the warden and by then was well aware of the broad parameters of the plan.

The plan was put into action at approximately 1:10 p.m. The negotiator called the west control cage to inform the inmates that a media person was coming in to take pictures. Then, the acting director of the Corrections Division, who had been onsite for some time but was unknown to the inmate population, was given a video camera and went into the Max compound. However, the DCT team was unable to effect an entry as planned. When they got to the back of the building, they were unable to locate the proper key on the emergency key ring. They also found that the inmates had used belly chains, padlocks, and other restraints to barricade the doors. Even the proper key would not have allowed a quick entry.

The backup plan involved going down from the roof and in through the exercise cages in the Max yard. When DCT members got onto the roof they found this was unworkable because the inmates had also chained shut the yard gate door. The team pried open the roof escape hatches, which had also been barricaded, and threw small pyrotechnic tear gas canisters into the west and east control cages. Entry teams, heavily armed and wearing gas masks, went down the ladder into the west control cage. As members of DCT entered the cage, they realized that inmates on the loose in the west side of Max were unaware of their presence. When sufficient DCT officers were in the cage, they went directly to C-block, ordering all inmates encountered to strip and lie down in place on the floor. Unarmed DCT members secured the inmates with flex cuffs under gun coverage from other DCT staff.

DCT reached the lower C-block shower room without meeting inmate resistance and found the five staff hostages still locked in but physically unharmed. The tear gas was too thick to escort the five hostages, who did not have gas masks, to the front door of Max, and the sally port area inside the front door was also barricaded. DCT members retreated to C-block with the staff hostages and took them out through the roof escape hatch of the west control cage.

When the floor officers had seen that the inmates were taking over the control cages and retreated into the lower C-block shower, they took an inmate mattress and dragged it through the water on the floor and then used that to provide a barrier between the open grill of the shower door and the rioting inmates. Recognizing that the hostages' view was partially blocked by the mattress, the inmates hung a blanket or curtain in front of the shower door to further obscure the hostages' view of the inside of Max. On the two occasions when the inmates requested keys from hostage staff, the officers tried low-level verbal resistance until the inmates began to threaten to burn the officers out of their shower room. Under duress, the officers cooperated, but only enough to prevent being attacked.

Inside Max, the DCT members regained control of the building by securing one block at a time. They encountered no inmate resistance. The only incident of note occurred when a DCT member fired a warning shot with his revolver into the cell door of an inmate who was not complying. That was apparently the only shot fired on the day of the riot.

Inmates told DCT members clearing the west end of C-block that PC inmates had been killed. Moving to the east side, the officers found four dead inmates lying on lower D-block and one on upper D-block, along with a surviving PC inmate in very serious condition with a cut throat and another who had barricaded himself into his cell. All indications are that DCT quickly recognized the importance of maintaining the integrity of the crime scene and identified a command-level staff member to secure the scene. DCT found two other PC inmates unharmed in the unit laundry room. These inmates had used the washer and dryer to barricade the door and had protected themselves by spraying marauding inmates with laundry bleach. Another inmate was found badly beaten, but alive, just inside the front door.

Protective custody (PC) inmates, who were used as the unit orderlies, were in frequent contact with Max inmates. Some staff were careless about maintaining confidentiality regarding inmate informants, even teasing inmates about being "snitches" or "rats."

Some inmates reported that "getting the snitches" was a primary goal of the riot from the outset. Others said that the initial plan was simply to take over the west side of Max and the east side if possible, perhaps taking some floor officers hostage in the process. According to this view, the inmates did not expect to gain access to the control cages and the murders of the PC inmates were crimes of opportunity.

Staff Retaliation

As DCT finished the job of taking control of the remaining areas of Max and searching them, DCT members stripped and flex-cuffed the inmates on each block. The inmates from a block were then taken out in a group to the front door of Max and handed over to the restraint team waiting outside. Inside Max, groups of inmates secured by flex cuffs lay on the floor under DCT gun coverage. Most were naked. The corridors were filled with water, smoke, and tear gas, and the floors were thick with broken glass from various shattered interior windows.

As DCT officers led groups of mostly naked inmates to the front door, many suffered glass cuts on the bottoms of their feet. Inmates alleged that DCT officers beat, kicked, or used batons on inmates who were in restraints and offering no resistance. A substantial number of inmates were treated later that day for injuries other than cuts to the feet.

Outside Max, a sergeant had been assigned to assemble and coordinate a restraint team. By the time DCT entered Max, this group of officers had grown to 60 or 70 in number. The warden himself led the restraint team as they ran into the Max compound in a double line that assembled on either side of the front door of Max. Inmates referred to this group of staff as the "gauntlet." The Administrative Inquiry Team[2] received numerous, consistent inmate

[2] The seven-member investigative team NIC assembled some 3 weeks after the riot, at the request of the Montana Governor's office and the state attorney general's office.

MSP had serious systemic problems long before the riot. Staff salaries were unrealistically low (the beginning annual salary for a correctional officer in 1991 was $15,563, at least 15 percent below the national average), staff turnover was somewhat high (just over 19 percent in fiscal year 1991), and staff training was inadequate (there was no separate item in the budget for training). Correctional officers were not entitled to hazardous duty retirement or line-of-duty death benefits, although both of these accrued to state law enforcement officers. Critical policies and procedures were inappropriate, contradictory, or lacking (for example, MSP had no use-of-force policy) and other policies were regularly ignored. Security was inconsistent and, in many cases, far from rigorous. Perhaps most importantly, staff had no shared understanding of the institution's mission, goals, or values.

Staff professionalism at MSP was poor. Some staff regularly swore at, with, and about inmates. Taunting and demeaning of inmates was common, and little supervisory accountability was enforced at any level. Inmates housed in Max at the time of the riot described a pattern of physical abuse by staff; inmates who had been housed in Max during the years immediately preceding the riot but were no longer housed there corroborated this complaint. The inmates had little redress, as MSP's inmate grievance system was unmanaged and ineffectual and lacked credibility with the inmate population. The inmate disciplinary system also was poorly designed and inconsistently administered. Medical services were another source of widespread dissatisfaction and anger among the inmates, exceeded perhaps only by the parole board process. Overall, conditions within Max could only be described as harsh.

allegations that the inmates exiting Max, naked and handcuffed behind their backs, were forced to run through this gauntlet while the officers in the double receiving lines hit, kicked, tripped, or swung batons at the inmates. Subsequently, three separate staff members verified that handcuffed inmates coming through the gauntlet were in some cases kicked, punched, or hit with batons.

The inmates were then taken to "No Man's Land" (a yard area under gun coverage from towers). They were placed face down on the ground, handcuffed behind their backs. The small number of inmates still dressed were stripped at this point, and flex cuffs were replaced with steel handcuffs. Inmates alleged staff abuse also took place here, primarily in the form of staff kicking inmates as they lay on the floor. Two of the three staff that confirmed the abuse in the gauntlet also confirmed the abuse of inmates in No Man's Land. Inmates were on the ground for 6 to 7 hours, until they were moved to the Reception Unit between 8 and 9 p.m. Approximately 55 inmates were secured in Reception.

Treatment of Inmates After the Riot

The warden made sure that medical staff were onsite and mobilized before the assault on Max took place. As inmates came out of Max after the riot, gurneys were brought up near the building's front door, and very seriously injured inmates were put on the gurneys and promptly

taken to area hospitals. Inmates with less serious injuries were taken from No Man's Land to the infirmary. Of these inmates, the five or six most seriously injured stayed in the infirmary and the others were treated and then returned to No Man's Land.

The short-term stepdown plan, arrived at in the late afternoon and evening of September 22, included the decision to move the new intake inmates out of the Reception building and use this unit for the 50 to 65 displaced Max inmates. The institution would remain on total lockdown for the near term. A long-term stepdown plan was formed in the following weeks.

Max inmates held in the Reception Unit alleged that they were subjected to the following abuses for the first several days:

- Neither clothing nor mattresses were provided, and the inmates were denied hygiene items (e.g., toothbrush, toilet paper, tissues) and showers.
- Inmates were fed only two meals a day.
- CapStun (pepper spray) was used on inmates who refused to talk with the attorney general's investigative staff.
- Inmates were denied access to phones, mail, visitors, legal material, and legal counsel for 3 weeks.
- Some inmates were left naked and hog-tied on the floor for extended periods.

Official inquiry corroborated many of these allegations. The Reception Unit log confirms that the Max inmates were left naked and without mattresses for 4 to 5 days, although they did have blankets. The log first mentions towels, which would allow the inmates to wash in their cells, 4 days after they were moved to Reception. Showers appear not to have been allowed until October 15, more than 3 weeks after the riot.

Inmates were fed two meals a day, consisting mainly of cold sandwiches, primarily because of the complete lockdown. Without inmate workers in the kitchen, MSP was unable to produce regular meals. Even the treatment staff was put to work making sandwiches in order to feed the institution's 1,100 inmates, and the improvised kitchen staff worked 12-hour shifts.

The Administrative Inquiry Team found that the Max inmates held in Reception were not allowed phone calls, visits, recreation, personal possessions, or legal materials. Furthermore, the Reception Unit log reflects no attorney visits or phone calls to any Max inmate prior to October 4 and only a few legal calls or legal visits during the remainder of the 3 weeks they were held in Reception. During the week that the Administrative Inquiry Team was onsite, the attorneys of a few inmates from Max petitioned the court, claiming that the inmates essentially were being held incommunicado. The court directed MSP to allow these clients to see their lawyers immediately for unlimited lengths of time during working hours Monday through Friday.

The inmates' most serious allegation was that several inmates were hog-tied naked and left in that position for a long period of time. The Administrative Inquiry Team learned that the Max inmates began to be noisy and verbally abusive by September 27, after which the Reception Unit log includes intermittent entries about groups of inmates becoming loud or shouting obscenities. Management regarded this activity as a serious threat of further violence. The warden met with four of his top staff members to decide how to respond. They concluded that they had to do something preventative and decided to place six inmates the staff had identified as ringleaders in full restraints for 24 hours. The top managers understood full restraints to mean using handcuffs and leg irons to hog-tie someone naked on the floor. The MSP

policy statement on use of restraints defines "full restraints" as "the use of handcuffs with belly chains and leg cuffs."

DCT was assembled in case there was strong resistance from the inmates who were to be placed in full restraints. The six inmates were stripped, hog-tied, and left naked on the floor of their cells with instructions not to move or struggle against the restraints. The application of the restraints began shortly after 9 p.m. on October 9. None of the inmates put up any serious resistance, and DCT left the unit shortly after 10 p.m. The restraints were initially left on for between 5 and 7 hours and after that were removed for 10 to 15 minutes at approximately 3-hour intervals. During one break, shortly before noon the next day, October 10, the restraints were apparently removed for more than half an hour to allow the inmates to eat. After about 23 hours, five of the six inmates were released from the hog-tie position. One of the inmates had wriggled in order to get his hands below the level of his buttocks. He was reminded that he had been told not to move or change position and was left hog-tied for an additional 24 hours.

When the physician member of the Administrative Inquiry Team examined four of the inmates involved, more than 2 weeks after the restraints had been removed, he found substantial handcuff wounds and indication of probable injury to superficial nerves on the hands of all four inmates. His prognosis was that the handcuff skin wounds would heal with no greater residual injury than superficial scarring and that any impairment of nerve function would probably not be irreversible. However, because a possibility of permanent nerve damage still remained, he recommended a neurological consultation for each of the inmates who complained of numbness in their hands.

The Reception Unit log also shows other incidents in which inmates were chained, put in restraints, and/or had their coveralls taken from them. Nothing indicates that these inmates were suicidal. In these cases, various requirements of the MSP policy statement on restraints were violated. Mandatory reports were not written, medical and security checks were not performed and/or were not logged, and treatment staff were not consulted.

Staff Support Services

Members of the prison's treatment and counseling staff provided psychological screening for staff on the day of the riot. The five staff taken hostage and the two staff members who had escaped at the beginning of the riot were seen first, followed by all DCT members and any other staff member who had observed the bodies of the dead PC inmates or the murder scene, or who gave any indication of being traumatized. Every staff member sent for psychological screening was seen at least twice.

Approximately 1 week after the riot, the treatment staff organized a meeting for staff families. At this meeting, spouses were able to express their fears that a husband or wife would be killed in the prison, and feelings about the inmate deaths and the staff hostages were also explored. Due to heavy publicity in the small towns and rural area surrounding MSP, no one could avoid the topic, including young children. Thus, the meeting also gave some attention to how to discuss something like the riot with young children.

The staff who had been held hostage, including the two who escaped initially, were away from work for approximately 3 weeks, during which they received regular counseling. When they returned to work, they did not go back to Max, but were assigned to positions where they would

not have contact with inmates. A group counseling session was established to allow them to talk with each other about their adjustment.

The treatment and counseling staff wrote several memos that were distributed to all staff. These memos dealt with topics such as grief, death, fear, and hostage situations and identified some of the more frequent kinds of problems that staff or family members might be experiencing, thereby giving staff license to acknowledge those problems.

Lessons Learned

1. No matter how a "supermax" (super maximum-security) unit is built or operated, riots and inmate takeovers are never impossible.
2. If the tone of an institution is angry and harsh prior to a disturbance, the disturbance itself may quickly turn brutal and bloody.
3. No prison should operate without an emergency plan.
4. A committed and dedicated prison tactical team may be extremely effective, even without the benefit of sophisticated equipment or extensive training.
5. Chronic lapses in following day-to-day security procedures and security policies can render an otherwise relatively secure facility extremely vulnerable.
6. Potential warning signs and other intelligence suggesting a serious incident is imminent must be carefully evaluated, even though any institution will generate its share of false rumors about impending problems.
7. A perceived unreasonable delay in providing information and access to the media can quickly turn both the news coverage and the editorial comment about a correctional emergency more negative than necessary.
8. Thoughtful attention to the needs of traumatized staff and staff families in the aftermath of a major emergency will be much appreciated. Such efforts may be effective even in the absence of prior planning or prior recognition of their importance.
9. Strong leadership from the person in charge may be the most important need during a major prison emergency.
10. It is important that postemergency measures not be perceived as punitive by those inmates who have not taken part in the disturbance.
11. Staff retaliation after an emergency is more likely when staff professionalism is questionable before the emergency and when positive, hands-on leadership from administrators and middle managers is lacking.
12. Maintenance problems with security systems must be widely communicated to security staff.
13. All staff involved in an emergency situation must write individual, detailed reports before completing their tour of duty, and a supervisor or manager should review each such report for adequacy and clarity and either document approval of the report prior to relieving the staff member or return the report to the staff member for additions or corrections.
14. In the aftermath of a major emergency, inmates' basic needs and rights (e.g., clothing, food, attorney visitation) should be met as quickly as is practically consistent with security needs.
15. Protective custody inmates should not be in regular contact with administrative segregation and disciplinary inmates, particularly within a maximum-security unit.

16. Maximum-security inmates should not be allowed regular access to outside exercise areas without visual supervision from staff.
17. A tactical team's contingency plans for assault or hostage rescue will seldom go exactly as planned. Unanticipated problems are the rule, not the exception. The team should have a "plan B" in case "plan A" proves unworkable, and both plans may need to incorporate great flexibility.

The 1993 Midwest Floods: Missouri Loses Renz Correctional Center

Renz Correctional Center is a medium-sized (average population 550 inmates), high-security prison for female offenders situated within the flood plain of the Missouri River. The prison was opened in 1961 as Renz Farm and is affected when the Missouri flood stage reaches 29 feet.

In 1993, early spring flooding was very serious along much of the watershed of the Missouri and Mississippi Rivers. Eight counties in eastern Missouri were designated as disaster areas by Presidential declaration. The early spring floods were followed by continued rainy weather and some flooding in the late spring and early summer. Renz fine-tuned its evacuation plans and prepared for evacuation several times during the spring and early summer.

By late June, the facility had moved first floor property and equipment off the floor and had begun to move some critical property out of the institution. The river continued to rise, and on July 2, the Missouri Department of Corrections (DOC) began to evacuate inmates to the Chillicothe Correctional Center and the Central Missouri Correctional Center. Evacuation of all inmates took 2 days and was accomplished without violence, injuries, or escapes.

The Central Missouri Correctional Center was under a federal court order that imposed a population cap of 1,000 inmates. The DOC was able to obtain quick verbal permission from the court to exceed this cap because of the emergency evacuation and subsequently received a formal order granting the emergency exemption from the cap.

After the inmates were evacuated, corrections staff used boats to reenter the facility and remove as much equipment as possible. They moved other property and equipment to the second floor of the three-story main prison building.

When the Missouri River reached a crest of approximately 35 feet in mid-July, the staff were initially optimistic that the institution would be cleaned up, repaired, and eventually reoccupied in spite of the substantial damage. That was not to be the case. Heavy rains continued unabated in the northern part of the state, and the Missouri River began to rise again toward a new crest.

At the end of July, the river finally crested at 38.6 feet. Even after the crest, the water took a long time to recede. A 32-foot-high levy that protected the Renz complex was flattened, and after the water receded a new lake, 15 feet deep and spanning 15 acres, was left on the property.

Inspections revealed that the Renz facility was completely incapacitated and that restoration would be neither practical nor cost effective. Most of the property and equipment that had been moved to the second floor was lost to the flood waters. The river had raged through the Renz complex with such force that the entire 9-foot-high security fence, including 4,000 feet of razor ribbon, was lost to some unknown location downriver. The flood waters had remained so long that locks and other security devices throughout the facility had rusted and were beyond repair. Storage tanks had disappeared, and the compressor room had collapsed. The food service and medical units sustained serious damage.

The evacuation and rehousing of inmates from Renz was not the only emergency with which the DOC had to contend. The floods cut off all road access to the Algoa Correctional Center, and employees had to be ferried by boat to work and back. The rising flood waters in downtown Jefferson City threatened the Jefferson City Correctional Center (the old Missouri State Penitentiary), and inmates at that facility worked at sandbagging efforts within and around the prison as well as at other public buildings within Jefferson City.

During the course of the spring and summer floods, well over 1,000 inmates helped in community efforts to save flooded areas, sandbag and reinforce threatened levies, and clean up flood damage. All of Missouri's 16 state prisons were extensively involved in these efforts. The Missouri DOC documented more than 4,000 hours of staff time supervising inmates in community assistance efforts during and after the floods.

One hundred seventy-eight staff from the DOC's Board of Probation and Parole and 661 probationers and parolees from 28 of 29 district offices also contributed significantly to flood relief efforts across the state. Staff completed 1,638 hours and also contributed food, dry goods, and cash to relief projects. Probationers and parolees contributed 9,875 hours of relief work. Probationers ordered by the courts to perform community service contributed significantly to this effort.

Lessons Learned

1. The Missouri DOC's preexisting emergency preparedness system and facility emergency plans provided an appropriate and practical framework for the emergency response to the floods. In particular, the detailed evacuation plans at the facility level proved to be invaluable.
2. Inmate populations were kept well advised about the status of the floods, and the inmate reaction was one of cooperation and assistance.
3. The lack of a statewide communications system meant that various state agencies could not monitor each other's radio traffic or transmit to each other throughout the emergency.
4. Communications were taxed throughout the emergency, and access to phone lines was often a determining factor in responding to the emergency.
5. As has been the case during earthquakes, cellular telephones were one of the most valuable items during the floods.
6. Staff needed to be kept informed about many issues outside the affected facility, including road closings, emergency assistance if their homes were affected, and the availability of counseling and support.
7. Staff involved in the planning needed to be briefed regularly. Maintaining staff meetings was difficult but important. As extra help

became available, staff from the affected facility assumed supervisory and management roles, and outside staff were used in support roles and for logistical help.

8. Coordination between the DOC, county jails, and community correctional facilities should include planning for large-scale natural disasters. In particular, county and local facilities must have plans for temporary holding facilities and temporary transportation if they cannot use DOC facilities or transportation for an extended period of time.
9. The planning for moving inmates, staff, and equipment from the facility that was being evacuated proved far better than the planning for handling the inmates at the receiving institutions.
10. Access to inmate files and other inmate information and to the roster system for scheduling staff was compromised by the emergency. Backup systems would have been invaluable, and planning in these areas proved inadequate.
11. Comprehensive maps indicating emergency routes and primary choices for evacuation routes would have been most helpful during the floods, as would some sort of ID card system for those with major roles in the emergency response.
12. It is important for the Department to be able to document each request for assistance, the external agency it has asked for help, and the progress of the task.
13. Supplies of emergency food and water were inadequate to allow the remaining Renz staff to work within the facility after the inmates were evacuated.
14. Emergency supplies were inadequate for the length and severity of the emergency. Security and accountability for the supplies were both poor.
15. The Department needed more heavy equipment (e.g., forklifts, dump trucks, flat trailers) than it was able to locate during the emergency.
16. The DOC director's leadership was clear and evident as departmental resources were made available for community assistance wherever possible.
17. Staff efforts to assist with local community problems were extraordinary. Most of these efforts were voluntary.

The Morey Unit Hostage Incident

The Arizona Governor's Blue Ribbon Panel Report on Preliminary Findings and Recommendations

May 4, 2005

While there were no escapes or fatalities, the taking of hostages and the seizure of the tower reveal critical—and correctable—flaws in Arizona's prison system.

In the early morning hours of Sunday, January 18, 2004, inmates Ricky K. Wassenaar, serving 26 years in prison, and Steven J. Coy, serving a life sentence, attempted to escape from the Morey Unit of the Lewis Prison Complex located near Buckeye, Arizona, 50 miles southwest of Phoenix.

The Morey Unit, which opened in January 1999, is a cellblock-style facility that houses 840 inmates (designed capacity: 800). The unit houses a diverse population of Level 2, 3, and 4 inmates, including "protective segregation" inmates, i.e., those who are considered dangerous or in personal danger are segregated from the general prison population. The protective segregation population, and the number of inmates serving life sentences (100), at Morey is the largest of any unit in Arizona's corrections system.

The two inmates subdued the two correctional officers on duty and seized the unit's tower triggering a 15-day standoff, the longest prison hostage situation in the nation's history.

An account of the hostage taking and the negotiations that led to the inmates' surrender and the safe release of both hostages follows, along with a summary of findings and recommendations aimed at preventing future crises and addressing significant operational, administrative, and fiscal issues related to the Arizona Department of Corrections.

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The Hostage Taking

At 2:30 a.m. on January 18, the 19 members of an inmate kitchen work crew at the Morey Unit were released from their housing units to report for duty at the Morey kitchen.

At approximately 3:15 a.m., the kitchen office was occupied by Correctional Officer Kenneth Martin and a female civilian kitchen employee.[1] A member of the kitchen work crew, inmate Ricky K. Wassenaar, entered the kitchen office through the open door. Another inmate, Steven J. Coy, followed him in, positioning himself in the kitchen office doorway and blocking the only exit.

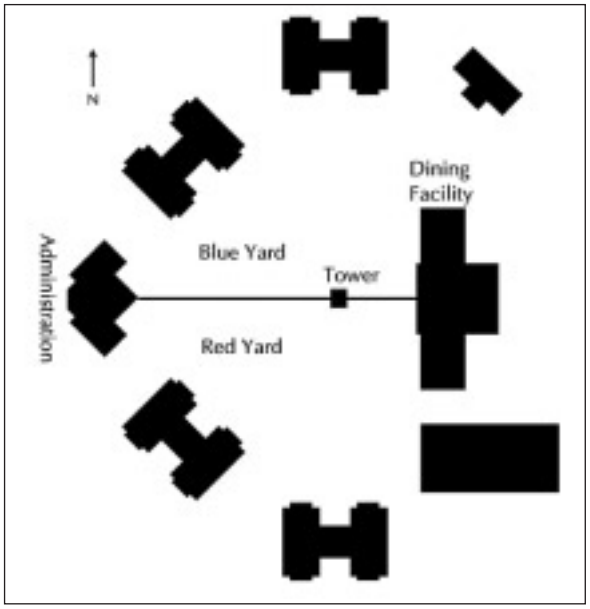
Wassenaar and Coy Seize the Kitchen

Wassenaar was armed with a "shank," a homemade knifelike weapon. Wassenaar approached Martin, produced the shank,[2] and told him that

[1] Martin was the only officer assigned on duty in the kitchen, consistent with facility operations and procedures.

[2] The two inmates underwent a pat-down search by Correctional Officer John Cooper before they left their housing unit. However, they were not patted down, as required by post order, upon arriving at the kitchen. Further, at the time this report was prepared, it was not known whether or not the two inmates were escorted from their housing unit to the dining facility.

"this is an escape" and "I've got nothing to lose." He ordered Martin to remove his uniform shirt (to which Martin's Department of Corrections identification card was attached) and boots. After Martin complied, Wassenaar handcuffed Martin to a cage in the toolroom inside the kitchen office. The other inmate, Coy, who also possessed a shank, brought the female worker into the toolroom, ordered her to lie down on her stomach, and tied her hands and feet together with electrical wire.



Morey Unit, Lewis Prison Complex, Buckeye, Arizona

With Martin and the female kitchen worker immobilized, Wassenaar and Coy left the toolroom for a short time and then returned. Coy removed Martin's pants and gave them to Wassenaar, who put on Martin's uniform, boots, and jacket and then shaved off his beard with an electric razor.[3] Wassenaar asked Martin for the kitchen telephone number, and Martin complied.

Wassenaar went to the kitchen work area, where he advised the other inmate kitchen workers of his escape attempt and invited them to join him. When none of them, including the inmates working outside on the loading dock, accepted his invitation, he locked them in the kitchen dry storage area.

At about 4:15 a.m., an hour after he first entered the kitchen office, Wassenaar left the kitchen carrying a 30-inch stainless steel stirring paddle. Coy remained in the kitchen office. Wassenaar walked through the dining area and exited into the Morey Unit's Red Yard, using Martin's key to unlock the door. Shortly after Wassenaar left the kitchen area, inmate Coy sexually assaulted the female kitchen worker.

Wassenaar Seizes the Tower

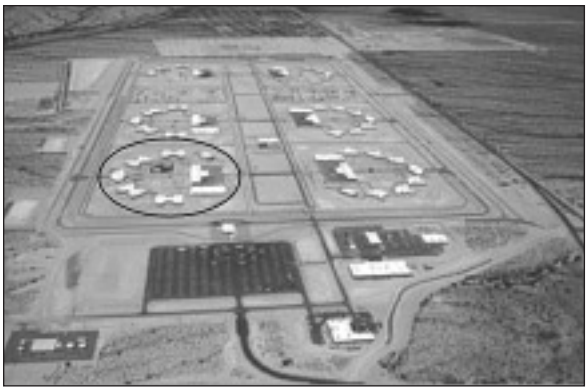
At about 4:20 a.m., Wassenaar approached the Red Yard gate area that surrounds the 20-foot tower and pressed the access buzzer in the intercom box at the gate. Upstairs in the tower were Correctional Officers Jason N. Auch and Jane Doe.[4] Auch looked at the monitor and, seeing what he believed to be a fellow correctional officer, buzzed the gate open, allowing Wassenaar to enter the tower area. Wassenaar then approached the lower tower door, which, like the entrance gate, was also locked and remotely controlled by Auch. Auch buzzed the door open.[5]

Auch went to the stairs to meet his presumed colleague. Wassenaar kept his head down as he climbed the stairs. As he neared the top he looked up, and Auch realized that he did not recognize the individual approaching him. Before Auch could react, Wassenaar struck him with the stirring paddle, fracturing Auch's orbital bone and temporarily incapacitating him.

[3] The razor belonged to Wassenaar. At the time this report was prepared, it was not determined how the razor made its way into the kitchen.

[4] "Jane Doe" is a fictitious name used to protect the female officer's identity.

[5] The post order for the tower (PO 051) did not require positive identification procedures.



The Lewis Prison Complex. The 800-bed Morey Unit (circled) opened in January 1999.

Unarmed, Officer Doe attacked Wassenaar, who overpowered Doe and cuffed her hands behind her. Wassenaar forced Doe and Auch to tell him where the weapons were, how to operate them, and how to operate the control panel. Wassenaar then ordered Auch to the lower part of the tower.[6]

Coy Remains in the Kitchen

At about 4:45 a.m., with the escape attempt still unknown to Morey Unit authorities, Correctional Officer Robert D. Cornett arrived in the kitchen to relieve Martin, 45 minutes ahead of Cornett's scheduled 5:30 a.m. shift. It struck him as odd that food was on the counters but he did not see any inmate kitchen workers. He saw Coy standing by the "food trap," a passthrough that is used to slide trays between the kitchen and the dining area. Coy's head was in the trap, and he seemed to be talking with someone. Cornett and Coy had a brief conversation, and Cornett walked past Coy toward the kitchen office. As Cornett made his way up the ramp to the kitchen office, Coy approached him from behind, pressed a shank against Cornett's waist, and ordered Cornett to keep going. Cornett did so.

Entering the toolroom, Cornett saw the bound female worker face down on the floor and Martin handcuffed to the front of the toolrack. Coy took away Cornett's handcuffs and radio, handcuffed Cornett to the right side of the toolrack, and went to the dining area. A few minutes later, the kitchen phone rang. Coy returned, picked up the receiver, said, "CO II Martin," and hung up. (It is possible that Wassenaar placed the call from the tower.)

A few minutes later, a call came in on Martin's radio from Correctional Officer Coy C. Kelley, checking on Martin's welfare. Coy held the radio to Martin's mouth and, complying with Coy's instruction, Martin responded by saying "Code Four" (indicating "situation normal").

Kelley also radioed the tower requesting clearance to move inmates across the yard. Doe, following Wassenaar's orders, advised Kelley that the yard was not clear, effectively denying Kelley's request.

Officer Observes "Horseplay"

Nevertheless, at about 4:50 a.m., Correctional Officers Kelley and Elizabeth M. Debaugh escorted inmates Jack R. Hudson, Jr., and Michael Sifford from Building Two to early recreation and chow. Their route took them past the tower where Wassenaar held his two captives.

As the officers and inmates walked past the tower on the Blue Yard side of the "spline" (a protected walkway) that separates the two yards, Kelley looked in the window at the base of the tower. The lights were out, and Kelley saw two correctional officers wrestling or engaged in what he later termed "horseplay." In fact, what he unknowingly witnessed was Officer Auch lying handcuffed on the floor of the lower tower.

Kelley later told investigators that he tried to get into the Blue Yard tower gate but that the gate was not operational, and that he tried to contact

[6] Tower personnel have access to weapons (an AR–15 assault rifle, a 12-gauge shotgun, and a 37mm launcher), but the weapons were neither loaded nor readily available to the officers.

the officers in the tower via the speaker box. Kelley and Debaugh proceeded toward the kitchen (Hudson had already continued to the dining area, and Sifford, who did not wish to eat, went directly to his job in the recreational area.).

Kelley and Debaugh entered the dining facility at 4:53 a.m. Hudson placed his personal items on one of the tables and went to the food trap. Hudson knocked on the door of the food trap, and when no food appeared Kelley and Debaugh also knocked. The officers then tried to radio Martin, telling him to open the kitchen door. There was no response.

At approximately 4:54 a.m. Kelley again knocked on the food trap and Debaugh sat at the first table in the chow hall. After no response at the food trap, Kelley joined Debaugh at the first table. Inmate Coy opened the food trap and said something that sounded like, "Heidi, Heidi, Ho." Kelley told Inmate Coy he needed to talk to Martin. Inmate Coy said, "Alright," and closed the trap. Kelley told Debaugh he believed he saw something through the tower window and did not feel right about it. Debaugh attempted to contact the tower via her radio and received no response. After waiting a few minutes, Kelley radioed Martin again and received no response.

The Chase From the Dining Facility

Five minutes after arriving at the dining facility, Kelley and Debaugh, who were standing just outside the kitchen door, heard the rattle of keys from the other side of the door. At approximately 4:59 a.m., Cornett opened the kitchen door at the direction of Inmate Coy, who was standing behind Cornett. Cornett believed he was opening the kitchen door for Inmate Thunderhorse but found Kelley and Debaugh instead. Officer Cornett later stated that he decided to try to get away from Inmate Coy to get help for the other staff in the kitchen.

Cornett ran into the dining area past Kelley and Debaugh, yelling "Call IMS, call IMS." (An Incident Management System report alerts staff of a situation requiring attention.) Coy followed and pinned Kelley against a wall. When Kelley tried to jerk the shank from Coy's hand, Coy slashed Kelley's face with the shank and pushed him to the floor.

Coy then followed Cornett, who fled through the exit door onto the Blue Yard. Debaugh radioed an alert on her radio advising that an officer was down and an inmate was chasing another officer on the yard. Her report activated the unit's IMS. Kelley and Debaugh then pursued Coy.[7]

The chase took them near the tower, to a point close to the blue gate entrance to the tower area, where Coy was stopped by several officers responding to Debaugh's IMS. Coy threatened the officers with his shank. The officers ordered Coy to drop his weapon and lie on the ground. After initially refusing to comply with their orders, Coy finally lay down with his arms spread, but he did not release the shank. As the officers approached him, he got back to his feet and again swung his shank at the officers. A couple of corrections officers attempted to subdue Coy with pepper spray, but, it was ineffective.

Wassenaar Foils Coy's Capture

Before the officers could take further action, Wassenaar, standing 20 to 25 feet away behind the blue gate near the base of the tower, fired through the blue gate an undetermined number of rounds (most estimates ranged from nine to ten) from an AR–15 rifle toward Jones and the other officers. Seeing what appeared to be a

[7] Immediately after DeBaugh issued the IMS, a male voice on the radio replied, "Negative, negative, negative." It is possible that the voice belonged to Wassenaar, trying to discourage responses to the IMS. Whether it was Wassenaar or a correctional officer, the "negative" response may have contributed to the belief among some officers that the IMS was a drill instead of an actual alert.

uniformed correctional officer holding the rifle, Jones asked the shooter whom he was firing at. Wassenaar shouted, "You, (expletive)." Jones directed all officers to clear the yard. Coy, standing alone in the yard, went to the Blue tower gate, from where Wassenaar let him into the tower. Wassenaar and Coy were now in control of the tower and of their hostages, Auch and Doe. Shortly after entering the tower, Coy sexually assaulted Officer Doe.

In all, Wassenaar fired approximately 14 rifle rounds during the early stage of the incident—approximately nine from the lower tower and at least five from the upper tower. While it may seem remarkable that Wassenaar's shots, from relatively close range, failed to hit any human targets, it is likely that firing through the gate restricted his ability to effectively aim the weapon.

As the other officers withdrew to the Administration building, Kelley, Debaugh, Jones, and Sgt. Andrew J. Kneidel ran to the dining facility, locked the outer door, and went to the kitchen. Kneidel found Martin and the female worker in the kitchen office. The officers also found and performed a head count of the inmates who had been locked in the dry storage area. All officers and inmates were removed from the dining facility by the Tactical Support Unit.

At the Administration building, Jones went into the Deputy Warden's conference room and started to account for his staff. Two officers were missing: Auch and Doe.

DOC Response

Captain Michael Forbeck was conducting perimeter checks at the Lewis Complex when he heard the shots fired by Wassenaar. After being briefed on the situation, Forbeck believed there was a risk of the two inmates rushing the Administration area, armed with weapons stored in the tower, in an attempt to escape. He organized a defense of the Administration area, with shotguns loaded with birdshot. He also contacted the other Lewis units; ordered a Complex-wide shutdown; ordered Tactical Support Unit (TSU) assistance for the Morey Unit; and notified the Buckeye Police Department, the Maricopa County Sheriff's Office, and the local fire department.

At 5:25 a.m. on January 18, approximately 25 minutes after Debaugh issued her IMS from the Morey dining facility, Department of Corrections (DOC) Southern Regional Operations Director Meg Savage received a page from the Lewis Complex, advising her of a serious, unspecified inmate disturbance. Within the hour:

- The duty officer at the Lewis Complex was advised of the hostage situation, as was DOC Division Director Jeff Hood, who, in turn, notified Lewis Complex Warden William Gaspar.
- The DOC Tactical Support Unit (TSU), based at Perryville, was activated and placed on standby.
- DOC contacted the Arizona Department of Public Safety (DPS) to request the assignment of hostage negotiators.

Shortly after 6:30 a.m., Dennis Burke, Chief of Staff to Governor Janet Napolitano, was notified of the incident. He in turn notified the Governor and other key staff members. DOC Director Dora Schriro, who was out of state at the time of the incident, returned to Arizona and arrived at the Command Center at 11:30 a.m. The Command Center had been established earlier in the morning at DOC headquarters in Phoenix.

The DOC Inmate Management System (IMS) policy establishes a command structure to respond to critical incidents. The incident is managed locally by the onsite Incident

Commander (IC) and, depending on the seriousness of the situation, also from Central Office by the agency Incident Commander. During the Morey hostage situation, three command centers were established: two onsite command centers (one to manage the events occurring in the tower and another to manage the day-to-day complex operation and complex perimeter security and coordinate tactical maneuvers occurring at the Lewis Complex Rast Unit), in addition to the agency command center.

At the Lewis Complex, by 7:45 a.m. TSU snipers were positioned on buildings surrounding the tower, and DPS hostage negotiators, operating under DOC authority, and a DPS SWAT team were onsite. A Command Post was set up in the Warden's conference room. (By the time the incident was resolved, a total of 30 negotiators had been deployed—10 of whom actually conducted negotiations—from DPS, DOC, the Phoenix, Tempe, and Glendale police departments, the Maricopa County Sheriff's Office, and the FBI.)

Over 16 law enforcement agencies provided support and assistance during the course of the incident:

- DPS deployed over 230 officers, with a core element during the incident of about 75 detectives and officers and surveillance specialists.
- The Maricopa County Sheriff's Office provided over 100 field force personnel.
- The FBI assigned approximately 100 personnel.

One FBI commander noted that at any given time at Lewis there was over 300 years of experience in seeking negotiated and/or tactical solutions.

From the moment they were deployed, the tactical teams were authorized to utilize their use-of-force policies.

Timeline

The following summary chronology and timeline of the 15 days of the hostage situation contains approximate times, and the panel will continue to examine the various accounts and will supplement any significant discrepancies as they are discovered.

Sunday, January 18

7 a.m. Wassenaar phones Captain Barbara Savage, Morey Unit Chief of Security, to advise her that Auch has a head injury and needs medical attention. Wassenaar wants to trade Auch for a lieutenant or sergeant. Savage refuses. Wassenaar demands a helicopter and a pizza. He also warns that if either of the inmates is killed, the other will kill the hostage officers.

8:05 a.m. A DPS negotiator makes phone contact with Wassenaar. The call lasts seven minutes.

8:20 a.m. Wassenaar demands that he receive handcuff keys and that he be allowed to talk to Warden Gaspar and Governor Napolitano. He repeats his demand for a helicopter.

8:20–11:20 a.m. Negotiators have various conversations with Wassenaar, in which he backs off from his demand for a helicopter, demands an AM/FM radio, describes the hostages' injuries, and allows officers to speak briefly to one hostage.

11:19 a.m. Negotiators on the phone with Wassenaar play a tape-recorded message from his sister, pleading for him to end the situation peacefully.

11:38 a.m. Negotiators share with Wassenaar the plan to deliver a handcuff key in exchange for bullets.

12:36 p.m. Wassenaar demands to talk to a television news crew.

12:30–5:30 p.m. Various phone conversations occur between negotiators and Wassenaar.

5:25 p.m. A DPS robot delivers an AM/FM radio to the inmates.

Throughout the day, the Special Operations Unit of the Arizona Department of Public Safety developed a series of detailed, comprehensive tactical resolutions of the hostage situation, based on a variety of scenarios.

Evening. Negotiations continue on conditions for delivering a key to the inmates.

Monday, January 19

Negotiations via phone and/or radio continue from time to time throughout the day.

6:52 a.m. DPS robot delivers a radio battery for the two-way radio already in the tower, plus one handcuff key, a radio charger, and cookies.

7:52 a.m. Inmates return the handcuff key along with three shotgun shells and nonlethal rubber ball rounds used for crowd control.

1:08 p.m. DPS robot delivers cigarettes, hygiene supplies, bottled water, and styrofoam cups.

1:18 p.m. Inmates turn in wooden, nonlethal projectiles.

3 p.m. At the Command Center, Governor Napolitano and key staff members receive their daily briefing from DOC Director Schriro, key DOC staff, and interagency personnel (Governor's daily briefing) along with periodic phone updates throughout the day and night.

Tuesday, January 20

Negotiations via phone and/or radio continue from time to time throughout the day.

12:30 p.m. Governor's daily briefing.

1:22–1:38 p.m. DPS robot delivers one handcuff key, bottled water, soap, coffee, and cigarettes. In return, inmates allow negotiators to visually confirm the correctional officers being held.

9:51 p.m. DPS robot delivers cheeseburgers, french fries, soft drinks, cigarettes, and coffee. In return, inmates turn in numerous types of prescription drugs, two handmade shanks, a canister of Mace, and a cartridge for a 37mm firearm.

11 p.m. A health and welfare check is conducted with hostages via two-way radio.

Wednesday, January 21

Negotiations via phone and/or radio continue from time to time throughout the day.

8 a.m. Governor's daily briefing.

12:20 p.m. DPS robot delivers Tylenol and three small cups. In return, inmates return two pepper spray gas canisters.

12:22 p.m. Inmates fire pepper spray gas into the yard after they discover that a nearby fence had been cut.

7:29 p.m. Negotiators receive voice confirmation of the alertness of both hostages.

Thursday, January 22

Negotiations via phone and/or radio continue from time to time throughout the day.

9:30 a.m. Governor's daily briefing.

10:29 a.m. Wassenaar asks to speak to a television reporter, answering questions the reporter would fax to him.

12:15 p.m. Negotiators give inmates Interstate Compact letters from other states to review.

3:20 p.m. Both correctional officers appear briefly on the roof, allowing for a visual welfare inspection.

9:30 p.m. Governor's daily briefing.

Friday, January 23

Negotiations via phone and/or radio continue from time to time throughout the day.

9 a.m. Governor's daily briefing.

4:50 p.m. Wassenaar demands to speak to a reporter on live radio.

8:45 p.m. Negotiators discuss with Wassenaar the terms of releasing one correctional officer.

Saturday, January 24

Negotiations via phone and/or radio continue from time to time throughout the day.

10 a.m. Governor's daily briefing.

3:15 p.m. DPS robot delivers roast beef, dried beans, summer sausages, tortillas, potato chips, soft drinks, cheese, tuna, mayonnaise, and candy bars. This represents half of the food the inmates requested. The other half would be delivered after the safe release of an officer.

3:20 p.m. *First hostage release.* The inmates release Correctional Officer Auch from the tower (negotiators had made several overtures to the inmates to release Officer Doe first). He is examined by medical personnel and interviewed by TSU members before being transported by ground ambulance and helicopter to Good Samaritan Hospital in Phoenix. Auch was treated for injuries, including an orbital fracture that required surgery. He was also interviewed at the hospital by members of the DOC Criminal Investigation Unit, who were gathering information to support the eventual criminal referral against the two inmates.

3:38 p.m. SWAT team members deliver second half of the food request: cheeseburgers, french fries, pizzas, cigarettes, and cheese.

7:15 p.m. Negotiators hear the voice of Correctional Officer Doe during a conversation with Coy, confirming her alertness.

Sunday, January 25

Negotiations via phone and/or radio continue from time to time throughout the day. Family members of one inmate arrive in Arizona to serve as third-party intermediaries.

10 a.m. At the Command Center, Governor Napolitano and key staff members receive their daily briefing from DOC Director Schriro, key DOC staff and interagency personnel.

Monday, January 26

Negotiations via phone and/or radio continue from time to time throughout the day.

10 a.m. Governor's daily briefing.

Tuesday, January 27

Negotiations via phone and/or radio continue from time to time throughout the day.

10 a.m. Governor's daily briefing.

5:05–5:10 p.m. SWAT team members deliver towels, blankets, and washcloths. In return, inmates move Doe to the observation deck, making her visible to negotiators for a welfare check.

5:32 p.m. Wassenaar asks to be interviewed on radio as a term of his release, as confirmation that the State will make good on the terms.

Wednesday, January 28

Negotiations via phone and/or radio continue on and off throughout the day. Family members of the other inmate arrive in Arizona to assist in negotiations.

9 a.m. Governor's daily briefing.

12:28 p.m. SWAT team members deliver hygiene products for the inmates and Doe in return for a health and welfare check of Doe.

2:21 p.m. Negotiators hear Doe in the background of a phone call with Wassenaar, confirming her alertness.

Thursday, January 29

Negotiations via phone and/or radio continue from time to time throughout the day.

9 a.m. Governor's daily briefing.

3:40 p.m. SWAT team members deliver cinnamon rolls, tortillas and cigarettes, in return for a health and welfare check of Doe conducted by a paramedic.

10 p.m. Governor and key staff meet with Director Schriro and key DOC staff regarding the progress of negotiations, including a demand by Wassenaar to be interviewed on radio. The Governor recommends that the radio interview of Wassenaar not be played live without an agreement by the inmates to surrender and release Officer Doe safely.

Friday, January 30

Negotiations via phone and/or radio continue from time to time throughout the day.

10 a.m. Governor's daily briefing.

3:36 p.m. SWAT team members deliver cinnamon rolls, Pedialite, Gatorade, and cigarettes, in return for a health and welfare check of Doe.

7:16 p.m. Doe is interviewed by a physician for a health and welfare check.

Saturday, January 31

Negotiations via phone and/or radio continue from time to time throughout the day.

10 a.m. Key staff to the Governor receive the daily briefing at the Command Center from Director Schriro and key Corrections staff and interagency personnel.

3:56 p.m. SWAT team members deliver an onion, bread and Gatorade.

5:22 p.m. Wassenaar appears on the observation deck holding a shotgun backwards in his right hand.

7:17 p.m. Doe is interviewed via phone by a physician for a health and welfare update.

8:08 p.m. SWAT team members deliver tuna, Pedialite and cigarettes.

Sunday, February 1

9:20 a.m. A third-party intermediary, an uncle of inmate Coy, is on the phone.

10:04 a.m. Wassenaar identifies the negotiator with whom he wants to deal and discusses surrender demands. Additional demands are made once the designated negotiator is onsite.

10:14 a.m. Doe's voice is heard; she says that she is "fine."

11:04 a.m. Cigarettes are delivered to inmates.

11:29 a.m. Inmates make demands:

- Turn on power for bathroom access.
- Wassenaar: talk to his sister.
- Coy: hear a tape of his ex-wife.
- Property in van.
- Paperwork confirming no DOC or county custody for future court proceedings.
- Clothing.
- Steak, beer, and pizza.

11:52 a.m. Governor Napolitano arrives at Central Command.

12:35 p.m. Negotiators play a tape of Coy's ex-wife.

12:51 p.m. Doe is observed on the roof of the tower with Wassenaar. She does not leave hatch area.

1:26 p.m. Call with Wassenaar's sister.

2:04 p.m. Wassenaar calls to say that the power is not turned on, there will be no contact with Doe, and he will have additional demands in 24 hours. If, by that time, the power is not turned on and the additional demands are not met, there will be no contact for 48 hours, and he will have additional demands.

2:39 p.m. The power is switched on.

2:46 p.m. Wassenaar fires 37mm multiple baton rounds (nonlethal).

2:57 p.m. Wassenaar reports no power.

3:13 p.m. Two inmate uniforms, including underwear, socks, and shoes, and copies of revised paperwork are delivered to the inmates. Wassenaar states that he may have disabled the power in the tower. Steaks, baked potatoes, beer, and soft drinks are delivered to the tower.

3:39 p.m. DOC Director Schriro gives the Governor a status report.

3:41 p.m. A key is delivered to the inmates to allow them to access the first floor to use the bathroom and to clear obstacles and traps to facilitate opening the door and the exit of the inmates and hostage.

3:47–4:18 p.m. The key is determined to be unusable, and a second key is delivered.

4:25 p.m. Coy is seen at the hatch.

4:39 p.m. Governor Napolitano calls for an update.

5:16 p.m. Contact is initiated to discuss specifics of the surrender process. Coy says to call back.

5:19 p.m. Governor returns to Central Command.

5:31 p.m. Contact is initiated to discuss specifics of the surrender process. Coy says to call back.

5:45 p.m. Contact is initiated to discuss specifics of the surrender process. Coy says to call back.

5:52 p.m. Wassenaar calls. There is discussion about the specifics of exiting the tower.

6:17 p.m. Wassenaar appears on the roof in an orange uniform, signifying that the door is clear for opening by the tactical team.

6:20 p.m. The tactical team approaches the tower, opens the door and props it open with a sandbag. The team then retreats approximately 10 yards.

6:25 p.m. *Hostage situation comes to an end.* Wassenaar walks out with his hands up. He complies with the order to turn around and lay on the ground and is restrained. Doe exits the tower next; she is recovered by a tactical team and removed to the Administration building and an awaiting ambulance. Coy exits the tower and is taken into custody and restrained.

6:32–7:08 p.m. Doe is examined and treated in the ambulance. She is then flown by helicopter to Good Samaritan Hospital in Phoenix, where she is treated for injuries sustained during the hostage incident, interviewed by DOC Criminal Investigation Unit (CIU) investigators, and reunited with her family.

6:51 p.m. Governor Napolitano and Director Schriro depart the Lewis Complex for Good Samaritan Hospital.

7:34 p.m. Wassenaar and Coy are taken to the Morey Unit's Blue side visitation strip area/noncontact visitation area, where they are photographed by DOC CIU investigators, strip-searched by Bureau of Prison (BOP) personnel, and provided with BOP jumpsuits. Their clothing and other evidence seized from the inmates are placed in containers and maintained by a CIU special investigator.

Medical staff check the inmates' vital signs prior to transportation to the federal corrections institution in Phoenix, where they are isolated from each other.

Wassenaar and Coy are served with search warrants for personal characteristics by a DOC criminal investigator. The search warrant is executed by SANE (Sexual Assault Nurse Examiner) staff from Scottsdale Health Care, who collect the sexual assault protocol as directed by the search warrant.

Wassenaar and Coy are advised of their Miranda rights. Wassenaar invokes his right to counsel, and Coy declines to be questioned.

Findings and Recommendations

Governor Napolitano's February 10, 2004, action plan for investigating the incident at the Morey Unit included the appointment of an Administrative Review Panel made up of law enforcement and corrections professionals to: (a) reconstruct the sequence of events leading up to the inmates' seizure of the Morey Unit tower, (b) identify issues that directly or indirectly contributed to the incident or could give rise to similar incidents, and (c) recommend practices to improve security and staff safety.

The Administrative Review Panel comprised:

- Roberto Villaseñor, Assistant Chief, Tucson Police Department.
- John Phelps, Deputy Director, Arizona Office of Homeland Security.
- Michael Smarik, Division Director, Support Services, Arizona Department of Corrections.

The Administrative Review Panel consulted with the following subject matter experts throughout the review process: Lt. John Stamatopoulos, SWAT and Bomb Commander, Tucson Police Department; Thomas McHugh, Administrator, Criminal Investigations Bureau, Arizona Department of Corrections; and Greg Lauchner, Administrator, Special Services Bureau, Arizona Department of Corrections.

Many of that panel's recommendations are incorporated into this section, and the Blue Ribbon Panel acknowledges, with deep gratitude, the painstaking and professional manner in which the Administrative Review Panel fulfilled its mission.

Contents: This preliminary report's findings and 69 recommendations are presented in an order that parallels the chronology of the attempted escape and hostage taking. The issues discussed are:

- A. Inmate security.
- B. Yard security.
- C. Kitchen security and procedures.
- D. Tower security, procedures, and usage.
- E. Defensive tactics, techniques, and procedures.
- F. Communications.
- G. Individual and unit response.
- H. Interagency delivery of tactical, intelligence-gathering, and negotiation activities.
- I. Resolution of the hostage situation.
- J. Administrative, policy, and budget issues.

A. Inmate Security

Lethal weapons in the possession of inmates constituted a leading causative factor in the hostage situation.

Finding: Inmates were searched upon departure from their housing unit, but the kitchen security post order requiring a pat-down search of the inmate kitchen crew upon arrival was not followed. This provided an opportunity for inmates to retrieve weapons or other contraband secreted in the yard and to go undetected at the kitchen.[8]

Finding: Officers conducted hurried and less-than-adequate pat-down searches of Wassenaar, Coy, and the other members of the inmate kitchen crew. The panel concluded from other officer statements and indicators that the quality of this pat-down search was not unusual.

Finding: Same-sex pat-down searches are preferable but not mandated.

Finding: Although the panel could not determine how the shanks in this incident were made or brought into the dining facility, it is clear that without their use Wassenaar and Coy's effectiveness would have been greatly reduced.

Recommendations

1. Review and enforce search procedures upon arrival at the kitchen. Determine where other gaps in search coverage may exist that would provide inmates opportunities to pick up contraband and weapons as they transit areas.
2. DOC should continue to practice cross-gender pat-down searches when necessary.
3. Establish a Special Contraband Squad (SCS), either statewide or with one squad in each of the two regions, the sole function of which would be to conduct random, unannounced searches of prison units for contraband and weapons. SCS searches would be supported by the latest available detection equipment technology and trained canines. The SCS would be specially trained in the latest detection methods, uses of equipment, and methods employed by inmates to secret contraband. The selected unit would be

[8] It is possible that the shanks were hidden in the kitchen. Although records indicate that a contraband search of the kitchen occurred at 1:00 a.m., there is no evidence as to the quality and extent of the search. The inmates may have had their weapons when they left the housing unit (which would indicate that the pat-down was insufficient), or the weapons were in the yard, or the weapons were in the kitchen, possibly implicating an absent civilian kitchen worker.

placed on lockdown as soon as the SCS arrives onsite, and the SCS would be accompanied by unit mid-level and base-level supervisory staff during the search. All areas of the selected unit would be searched during the lockdown. No shift change or movement of inmates would be permitted during the search. Only those officials with an absolute need to know would be informed of the pending search and then only at the last minute.

4. All incoming staff, contractors, and visitors and their possessions should be scanned and/or searched for contraband prior to gaining access to the unit. If contraband is detected, discretionary progressive punitive measures should be imposed, ranging from a warning to dismissal and/or prosecution.
5. All post orders should be reviewed to assure that explicit direction is given relative to inmate search requirements prior to movement within the unit perimeter and when the inmate returns from travel outside the unit. The review should focus on minimizing the ability of inmates to access hidden contraband prior to entering less secure areas. Consideration should be given to changing search methods on a random rotational basis to disrupt predictability. Search requirements should be strictly enforced by supervisory personnel, including personal unannounced oversight.
6. Shanks are a continual and recurring problem in the corrections world. Current procedures and methods for preventing the manufacture and uncovering the concealment of fabricated weapons must be emphasized and regularly tested. Additionally, DOC should consider whether state-of-the-art detection systems not already employed could be brought to bear in this area. Technology notwithstanding, the last line of defense for the detection of fabricated weapons is the individual vigilance and competence of correctional officers and their leaders.
7. DOC should review protocols for unit contraband searches to emphasize thoroughness, unpredictability and consistency.

B. Yard Security

Finding: Inmates may hide weapons or contraband under gravel.

Recommendation

8. Consider removing gravel or other soft materials from the yards and replacing them with a more stable groundcover that is less likely to provide cover for weapons or contraband.

C. Kitchen Security and Procedures

The following factors created conditions in the kitchen area that significantly compromised security and, thus, contributed to the incident.

Finding: The inmates were too familiar with officer routines.

Finding: Kitchen duty was inappropriate for the two violent offenders.

Finding: Kitchen office door was left unsecure. Open access to the kitchen provided the opportunity for inmates to take control of unit personnel, communications systems, and weapons.

Finding: Delivery of kitchen utensils required hand-to-hand delivery via open kitchen office door. The doors to the kitchen and toolroom must be opened to pass kitchen tools to inmates. It became impractical and inconvenient to repeatedly open and lock those doors when the kitchen was active.

Finding: Kitchen post required only one officer. Inmates could easily overpower the solitary officer on duty during the graveyard shift, unobserved by the rest of the unit. When the incident began, Correctional Officer Martin by himself was in charge of 19 inmates.

Finding: The kitchen area was unmonitored. Although the dining halls outside the kitchen areas were monitored by video cameras, there were no audio or video monitors in the kitchen area.

Finding: A contract kitchen worker was absent without explanation on the morning of the incident and has refused to cooperate with the investigation.

Recommendations

9. Rotate inmates' work assignments and schedules so that they have less opportunity to familiarize themselves with officers' routines and work habits.
10. Dangerous inmates should be limited in their work assignments, and inmates with life or long-term sentences should be strictly limited in their range of job duties.

Adult Prison Population

- There are approximately 32,000 inmates in the DOC system.
- There are 6,146 CO IIs.

11. DOC or other appropriate authorities should interview the contracted kitchen staffers who worked at the Morey Kitchen for at least six months preceding the hostage incident. Any potential complicity should be thoroughly investigated.
12. The door to the Kitchen Office should remain locked at all times unless it is opened to allow a correctional officer to enter or exit. A standoff distance should be established in the kitchen that an inmate cannot cross. If this area is occupied, the door should remain locked until it is clear (e.g., a line painted red at the entrance to the ramp that leads up to the office).
13. DOC should consider methods that will eliminate the need to pass kitchen utensils in a hand-to-hand manner. For example, a passthrough security drawer to deliver utensils, operated by the kitchen officer, could be installed.
14. Utensils and tools should be secured. This action may be less necessary at low-level units, but the administration at such units should utilize caution before implementing such a policy.
15. Two correctional officers should be posted in the kitchen area at all times.
16. Place high-resolution video cameras in the kitchen area to provide visibility of inmate activities from the facility's main control area. Camera feed should be live-monitored instead of merely being recorded for after-the-fact review.

D. Tower Security, Procedures, and Usage

The following factors created conditions regarding access to the central tower that significantly compromised security.

Finding: Excessive tower access points exist. Multiple entryways into the tower provided inmates opportunities for access. (Wassenaar entered from the Red Yard, Coy from the Blue.)

Finding: There were no established positive identification protocols.

Finding: The tower was subject to multiple uses for which it was not intended. Uses included storage of a variety of items, including medicine for distribution to inmates. The panel believes that this offered inmates opportunities to gather intelligence about the tower, such as design, layout, the function of the spline gates and doors, etc.

Finding: Inmate movements were not observed from the tower. There is no evidence to indicate that the movement of Wassenaar, Coy, and other kitchen crew inmates was observed by officers as they moved from their housing units to the kitchen. Wassenaar's exit from the kitchen and movement to the tower was also unobserved. Such lack of observation provided opportunities for inmates to circumvent security and reduced the unit's situational awareness.

Finding: Tower post duties were inadequately defined. Post order duties lacked specificity and did not clearly require observation of the yard at all times, particularly when inmates were present.

Finding: Post order instructions regarding weapons deployment were not followed. Officer Doe reported that she could not reach the AR–15 to defend herself from Wassenaar. Even if she had reached it, the weapon was unloaded as directed by unit supervisors.

Recommendations

17. DOC should review the need to staff the central towers at Lewis and other architecturally similar institutions in the DOC system.

Recommendations 17–26 should be considered if a decision to staff the central tower is continued.

18. Nonremovable listening devices should be installed in the tower.
19. DOC should improve cameras, camera location and lighting at all controlled entry points to the tower to allow for positive identification of persons seeking entry.
20. The tower should be accessed only at one entry point. The panel recommends limiting access from the Administration building spline. Lewis Post Order 051 should be revised to include specific instructions on entry and exit from the tower. The practice of "buzzing in" people from the upper floors or not confirming identification on a face-to-face basis should be considered a serious breach of performance standards.
21. On the longer term, DOC should review the operational and tactical merits of maintaining lethal and less-than-lethal weapons and munitions in a central tower location within a secured perimeter.
22. DOC should require post-specific training pertaining to the tower.
23. Only shift-assigned tower staff, tower relief staff and shift supervisors should be allowed to access the tower without the shift commander's direct approval.
24. DOC should review tower design and make modifications necessary to allow full operations from the second level.
25. DOC should review, modify as needed, and strictly enforce tower post orders to ensure consistency of tower operation, with emphasis on security.
26. The tower should always be staffed with two qualified officers, both armed with sidearms at all times. When granting access to the tower, one officer should remain at the observation level while the second officer acquires positive identification.
27. Tower and munitions should be kept at "at the ready" at all times when the tower is staffed. Weapons stands are probably the

most effective way of keeping weapons ready accessible.

E. Defensive Tactics, Techniques, and Procedures

Finding: Correctional officers were unable to defend themselves or others using individual or small unit defensive tactics. This was a major factor in the ability of the inmates to subdue officers, escape capture and seize the tower.

Finding: Use of OC pepper spray canisters was ineffective. Studies have shown that it is nearly impossible to use pepper spray to thwart an attack by an individual armed with an edged weapon, where the attacker is closer than 21 feet from the intended victim. Further, an OC canister is an ineffective tool against a knife because it is not possible to get close enough to produce the desired results.

Finding: Post Order 051 is inconsistent with Department Order 804 Inmate Behavior Control. Six sections specify when an officer is authorized to use lethal force. Section 1.2.6 is the only section that discusses serious bodily harm;[9] all other authorized uses of lethal force have to be predicated on a belief that an inmate is attempting to use lethal force or attempting escape. Unfortunately, "serious bodily harm" is not contained in PO 051. Section 051.06.8.1 reads, "Deadly force is justified when it is immediately necessary to protect any person from attempted use of unlawful deadly physical force by another and to prevent an escape." As the "ultimate safeguard," the tower officer and all staff must have confidence and trust in each other. They must trust that, if they are attacked by an inmate posing a threat and showing intent of serious bodily harm, lethal force will be authorized.

[9] ". . . when it is necessary to prevent an inmate from taking another person hostage or causing serious bodily harm to another person . . ."

Recommendations

28. Modify PO 051.06.8.1 to include Department Order 804.07.1.2.6. Reinforce the knowledge and understanding of that order in training and exercises.
29. Consider adding other, more effective less-than-lethal weapons for day-to-day operations of correctional officers. This consideration should be to integrate such systems into standard operations rather than limiting those capabilities to special situations.
30. All DOC employees and contractors who directly interface with inmates should receive realistic training in self-defense tactics. Such training should be integrated into inservices refresher training programs.
31. Correctional officers should receive enhanced and realistic training in hand-to-hand, weapons, and small-unit defensive tactics. Such training should be integrated into inservices training. Consider requiring minimum qualification standards and recognition/certification programs for advanced proficiency, which would be considered in assignment decisions and operational planning.

F. Communications

Finding: Monitoring throughout the facility does not appear to take full advantage of technology.

Finding: Officers have little ability to covertly request assistance. After they were taken hostage, Officers Martin and Doe were forced to respond over unit communications systems to other officers in the facility. Their forced responses falsely indicated that they were secure.

Recommendations

32. DOC should review current communication systems with the emphasis on improving performance. Such review should include reducing dead areas, the benefits of encryption, specialized distress capability, battery dependency, and radio durability.
33. DOC should review units' audio and visual monitoring capabilities and consider retrofitting key facilities with embedded sensors and cameras for regular monitoring of activities.
34. Establish a simple distress signal. Evidence suggests that inmates had gathered intelligence on communication procedures and radio codes. A distress signal would therefore need to sound natural and part of a routine response.
35. DOC should also consider investment in personnel monitoring—"man-down" or personal alarm—systems.

G. Individual and Unit Response

Finding: Correctional officers lacked situational awareness. The collective lack of awareness regarding this incident not only affected facility security but exposed officers and facility employees to harm.

Finding: There was ineffective response to an armed inmate in the dining area. When Coy exited the kitchen, there were three officers in the dining area. Officers were not equipped or trained to respond effectively as a team to an armed inmate.

Finding: Many officers failed to respond appropriately to IMS calls. The frequency and manner in which IMS simulations occur led to complacency on the part of most officers on duty at the time of this incident. No codes or practices exist to differentiate between an IMS simulation and actual occurrence.

Finding: Many officers in the Morey Unit have less than a year in uniform.

Recommendations

36. Training (IMS simulations) should not occur during duty hours. Occasionally, if supervisors want to test the performance of their staff on a fire drill or lockdown, on-unit training would be recommended. However, training designed to test and evaluate tactical responses, arrest procedures, use of lethal and less-than-lethal force, and even medical response should never be conducted where it could compromise security or be viewed by inmates. Exceptions may be made only with the written approval of the DOC Director. Training should be as realistic as possible, but there should be no doubt in any staff member's mind about whether a situation is a simulation or a real event. This is accomplished by never blending duty assignments with training scenarios.
37. DOC sergeants must be recognized as a focal point of the agency and given the power to address issues immediately. The first-line supervisor is the unit's eyes and ears and can identify training deficiencies, operational issues and performance problems. The sergeant should be highly visible as he or she moves about the unit and conducts surprise inspections at various posts; this would help to eliminate reported unauthorized visits to the tower and the leaving of assigned posts. It would also help address the allegations of officers bringing food into the unit from outside the prison, propping doors open, conducting quick and ineffective pat searches, etc.
38. On-duty training opportunities should be explored, such as daily training items that are presented and discussed at briefings or when supervisors conduct inspections. These training items can consist of incident

scenarios that are read or presented, requiring officers to discuss their answers with their supervisors.

H. Interagency Delivery of Tactical, Intelligence-Gathering, and Negotiation Activities

Finding: State and local law enforcement agencies regularly convene to practice tactical maneuvers. DOC does not routinely participate in those activities, nor do those activities regularly occur on the grounds of a State prison complex.

Finding: State and local law enforcement agencies do not regularly convene to practice negotiations. DOC does not participate in those activities when they do occur, nor do those activities occur on the grounds of a State prison complex.

Finding: DOC and State and local law enforcement agencies do not know enough about State correctional facilities' amenability to intelligence-gathering technologies and tactical maneuvers.

Recommendations

39. DOC and State and local law enforcement agencies should regularly convene to practice tactical maneuvers. Some scenarios should be conducted regularly on the grounds of a State prison complex.
40. DOC and State and local law enforcement agencies should regularly convene to practice negotiations.
41. DOC, with assistance from federal, State and local law enforcement agencies, should evaluate DOC's physical structures to identify in advance of untoward events their amenability to intelligence collection and tactical maneuvers. This information should be kept onsite at each institution and updated regularly.

Tactical Rules of Engagement for Double Hostage Situations

1. Both inmates on roof, 100% positive identification, clear shot: Green light, shoot to kill.
2. One inmate with both hostages on roof, 100% positive identification, clear shot: Green light, shoot to kill.
3. Inmate, 100% positive identification, appears with lethal force directed at hostage(s): Green light, shoot to kill.
4. Inmate appears with lethal force, non-threatening: Red light, do not shoot.
5. Inmate appears on roof with one hostage: Red light, do not shoot.

In options 2 and 3, activation will also initiate the assault on the tower.

I. Resolution of the Hostage Situation

Finding: It is the policy of DOC that there are no negotiations with hostage takers. Despite that policy, in the situation at the Morey Unit there were ongoing negotiations during the entire 15 days.

Finding: With regard to the tactical response, the panel received testimony from correctional employees (who were not part of the tactical teams) that they had heard of opportunities to use lethal force toward the two inmates during the standoff, but they were foregone due to alleged counterinstructions from superiors. This testimony was later refuted by numerous members of tactical teams, including both lead

commanders of the tactical operation, DPS Colonel Norm Beasley and Maricopa County Sheriff's Office Assistant Chief Jesse Locksa. Indeed, Beasley categorically stated to the panel, "There was never an opportunity to tactically resolve this situation through sniper fire."

Finding: DOC's decision to transfer the inmates out of their system is a common corrections management practice after hostage situations. This practice preserves the integrity of the statewide security system; diminishes the inmates' status in the prisoner society; and reduces potential legal liability. Indeed, DOC houses approximately 100 inmates from other state systems, including several as a result of the Lucasville, Ohio, prison hostage incident in the early 1990s.

Recommendations

42. DOC should review the communications that occurred between negotiators and tactical staff relating to the cutting of the fence at the base of the Morey tower.
43. Due to the uniqueness of the situation and the virtually impenetrable characteristics of the tower, the lack of acceptable tactical solutions available to authorities made negotiations a practical necessity. To be consistent with other law enforcement and correctional agencies, DOC should eliminate its nonnegotiation policy.
44. The use-of-force provisions of the rules of engagement (above) were appropriate and should be applied to future situations where their use may be applicable.[10] At the Morey Unit, circumstances did not permit the exercise of those provisions.

[10] After the first hostage was released, the tactical rules of engagement were revised to reflect the change of circumstances.

J. Administrative, Policy, and Budget Issues

Inmate Classification

Finding: The DOC inmate classification system[11] is cumbersome and unreliable and has not been evaluated since the 1980s. Other correctional jurisdictions have developed more effective and efficient systems.

Recommendations

45. DOC should assess its inmate classification needs and seek national assistance in the enhancement, overhaul or replacement of its present system. DOC's policies and procedures regarding protective segregation should be reviewed as part of the assessment.
46. Public and Institutional (P&I) scores should be more closely examined, and the officers who work with an inmate should have meaningful input into that inmate's score.
47. Classification scores should be less vulnerable to override.
48. Create a system that better ensures that more dangerous inmates do not work in sensitive areas.

Inmate Assessment, Programming, and Reentry

Finding: Good prison security and management require more than just good correctional officers; it takes a team approach.

Recommendation

49. DOC should evaluate the methods by which, upon intake, it assesses offenders' criminogenic and programming needs. It should further endeavor to provide appropriate levels

[11] Classification determines an inmate's housing situation, work assignments, recreational opportunities, and supervision levels.

of programming in areas such as mental health treatment, drug treatment and education. Programming should also be enhanced to assist offenders in successfully reentering society upon release from prison.

Training

Finding: Testimony received from DOC employees strongly suggests that uniformed and civilian staff are undertrained and, in some cases, untrained in many areas, some critical.

Recommendations

50. As appropriate to carry out their responsibilities and ensure their personal safety, officers, supervisors and civilian employees should receive continuing education and practical training in areas that include, but are not limited to, the following: self-defense, weapons training, hostage situations, post-specific training, weapons and contraband searches, Fire Arms Training Simulator (FATS), cross-training with other law enforcement agencies, Arizona Peace Officer Standards & Training (POST) certification, and structured on-the-job training and mentoring.
51. At the Correctional Officer Training Academy (COTA), cadets should receive one full additional week of training dedicated to self-defense and receive additional training in hostage situations, rape prevention, and weapons.
52. Standards for admission to and graduation from COTA must not be compromised in response to vacancy rates or other temporary situations.
53. New COTA graduates should enter service as a CO I. After a defined probationary period, and additional on-the-job training, they should become eligible for promotion to CO II.

Correctional Officer Turnover

A DOC survey covering the two-year period from November 2001 through October 2003 reveals the following:

- There are 6,146 CO IIs in the DOC system.
- There were 1,721 CO II resignations during the survey period.
- Not adjusting for multiple resignations from the same position, the two-year turnover rate was approximately 28%.
- 570 of the 1,721 resignations (33%) occurred during the employees' first 12 months on the job.
- 1,008 of the resignations (58%) occurred during the first two years.
- 1,268 of the resignations (73%) occurred during the first three years.
- Only one in four CO IIs had more than three years of experience.

Source: Governor's Office of Strategic Planning & Budgeting

54. DOC should implement a comprehensive and systematic "Back-to-Basics" (B2B) program to ensure that core elements of security are being adhered to across the board. The B2B initiative should be designed to enable every prison to review security in regard to layout, personnel, habits, traditions, training and other issues. B2B should include interviews with line staff to find out how they actually do the job and how they should do the job, so that it can be determined whether security is being

compromised by not adhering to post orders, or whether officers have devised a better way to get desired results.

55. Civilian employees should receive training to help them understand and function safely in a prison work environment.

Experience and Staffing

Finding: Inexperienced officers, when placed together in high-risk settings, are more likely to fail in the performance of their core functions than if they are teamed with more experienced officers.

Finding: Correctional facilities are understaffed. Correctional officer positions remain unfilled while the prison population grows every month. At the Lewis Prison Complex, of which the Morey Unit is a part, about 200 (or 19%) of the 1,029 officer positions are vacant, on some days forcing management to scramble to provide the minimum coverage. Of the 800-plus positions that are filled, half of the officers have two years or less of service (including their seven weeks of training at COTA). In many instances, junior officers are led by other junior officers who have been prematurely promoted in order to meet pressing needs. At the time of the hostage taking, 14 of the 20 officers on duty were hired in 2003 (i.e., had one year or less of experience).

Recommendations

56. DOC should formalize the blending of experienced and inexperienced officers, leading to "mentor/student" bonding that can enhance long-term officer success and retention. The mentoring program should be formalized as a structured, agencywide Correctional Training Officer (CTO) program that features formal training and rewards for experienced officers, at all levels and positions, who act as mentors.

57. Additional staffing is necessary for all assignments within DOC in order to combat fatigue and burnout and to foster proper employee inservice training needs. Current "bare bones" staffing does not allow for the remediation of any of the above.

Pay, Recruitment, and Retention

Finding: DOC officers are underpaid, both in absolute terms and in comparison to the pay scales of other jurisdictions. The DOC pay scale leads to family hardships, low morale and high attrition. A sergeant with ten years of experience testified at a public forum that he would be eligible for Food Stamps and AHCCCS benefits if his annual income were only $933 less. He also suffered a pay cut when he was promoted (most sergeants are paid less than the officers they supervise).

Finding: The Nevada Department of Corrections, which offers higher officer pay, recently set up a recruiting station at a Circle K near the COTA facility outside of Tucson to lure academy graduates. After being trained at a cost to Arizona taxpayers, half of the class went to work for the State of Nevada.

Finding: There is pay inequity between new recruits and experienced officers. Elimination of the "Correctional Officer I" position during the previous Administration created a situation in which a recent academy graduate enters service as a CO II, perhaps earning as much as a veteran officer at the same grade.

Finding: Standards have been lowered. Qualifications for sergeant have been diminished in recent years in order to fill vacancies at that level.

Recommendations

58. DOC should undertake a comprehensive analysis of its pay scale, including a comparison with the pay scales of federal, county and municipal correctional entities in Arizona and of surrounding states.
59. DOC should consider the reinstatement of merit increases and longevity pay.
60. DOC should restore the CO I position, reexamine the qualifications for Sergeant, and undertake a comprehensive review of DOC's promotional policies to ensure they are based on merit and performance, not "good old boy" relationships.
61. Pay must be commensurate with experience and merit, and any promotion should result in higher pay.
62. DOC should consider ways of communicating to the public the difficulty of and danger associated with correctional service.
63. Survivors of officers killed in the line of duty should receive benefits comparable to the families of police officers and firefighters.

Starting Compensation for Correctional Officers

	Base Pay	Hiring Bonus[1]	Incentive Bonus[2]	Total
DOC	$24,950	$2,600	$2,495	$30,045
Maricopa County	31,000	0	0	31,000

[1]Generally expires after the second year of service.

[2]Available only to CO IIs at Lewis, Florence and Eyman.

Professionalism

Finding: At the time of the hostage situation, the Morey Unit suffered from complacency and a general lack of professionalism. While most staff performed admirably during the incident, there were many administrative errors in the preceding months and years. During the panel's investigation it became evident that numerous deficiencies in supervision and performance contributed to the hostage situation.

Recommendations

64. The DOC Director should utilize all available information to determine what, if any, disciplinary action or change of assignment is appropriate for those staff involved.
65. A systemwide review should take place to determine whether this problem is pervasive in the system and, if so, to identify and implement steps that could remedy the problem.

Operational Audits

Finding: In 2000, DOC discontinued the practice of conducting comprehensive operational audits of prison facilities.

Recommendation

66. Operational audits should be reinstated to help ensure effective management of prison facilities.

Staff/Inmate Communication

Finding: Good staff/inmate communication is important to maintaining good prison security and operations.

Recommendations

67. DOC is encouraged to take steps to review current policies, practices, and protocols that promote indirect, as opposed to direct, supervision of offenders and that inhibit good communication between officers and offenders.
68. DOC should consider piloting a prison management system, such as "Unit

Management," at a prison that is architecturally and operationally receptive to such a concept.

Sentencing

Finding: The DOC system suffers from overcrowding. In the last year, DOC has set the highest records of overcapacity and the Lewis facility has regularly housed inmates in excess of its design capacity.

Recommendation

69. The State of Arizona should undertake a comprehensive review of its sentencing statutes.

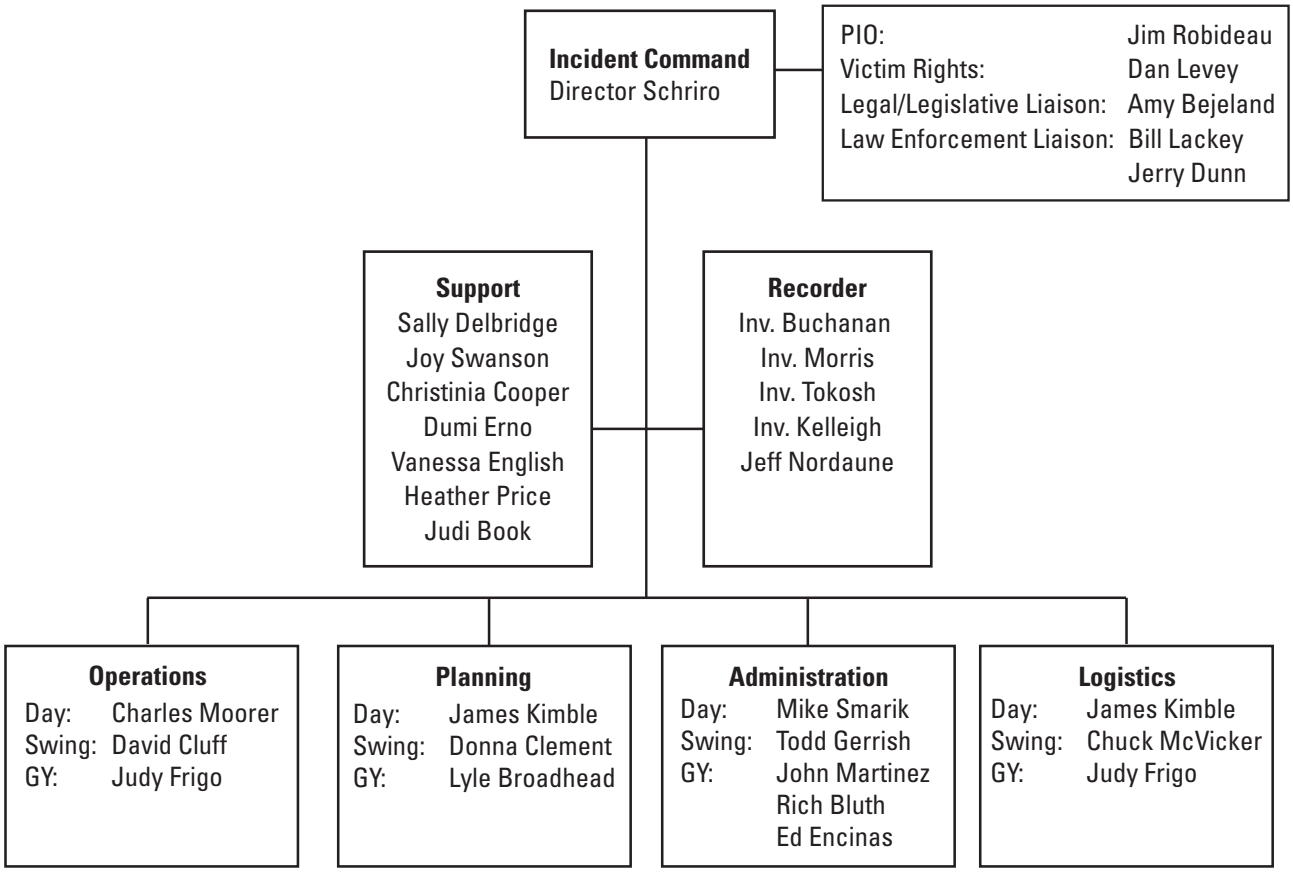
Conclusion

The hostage-taking incident that occurred at the Morey Unit was a tragic event that resulted in serious physical and emotional injury to correctional officers and facility employees. Like other prison crisis situations in Arizona and elsewhere, it demonstrated the incredible dangers and challenges faced by corrections professionals every day.

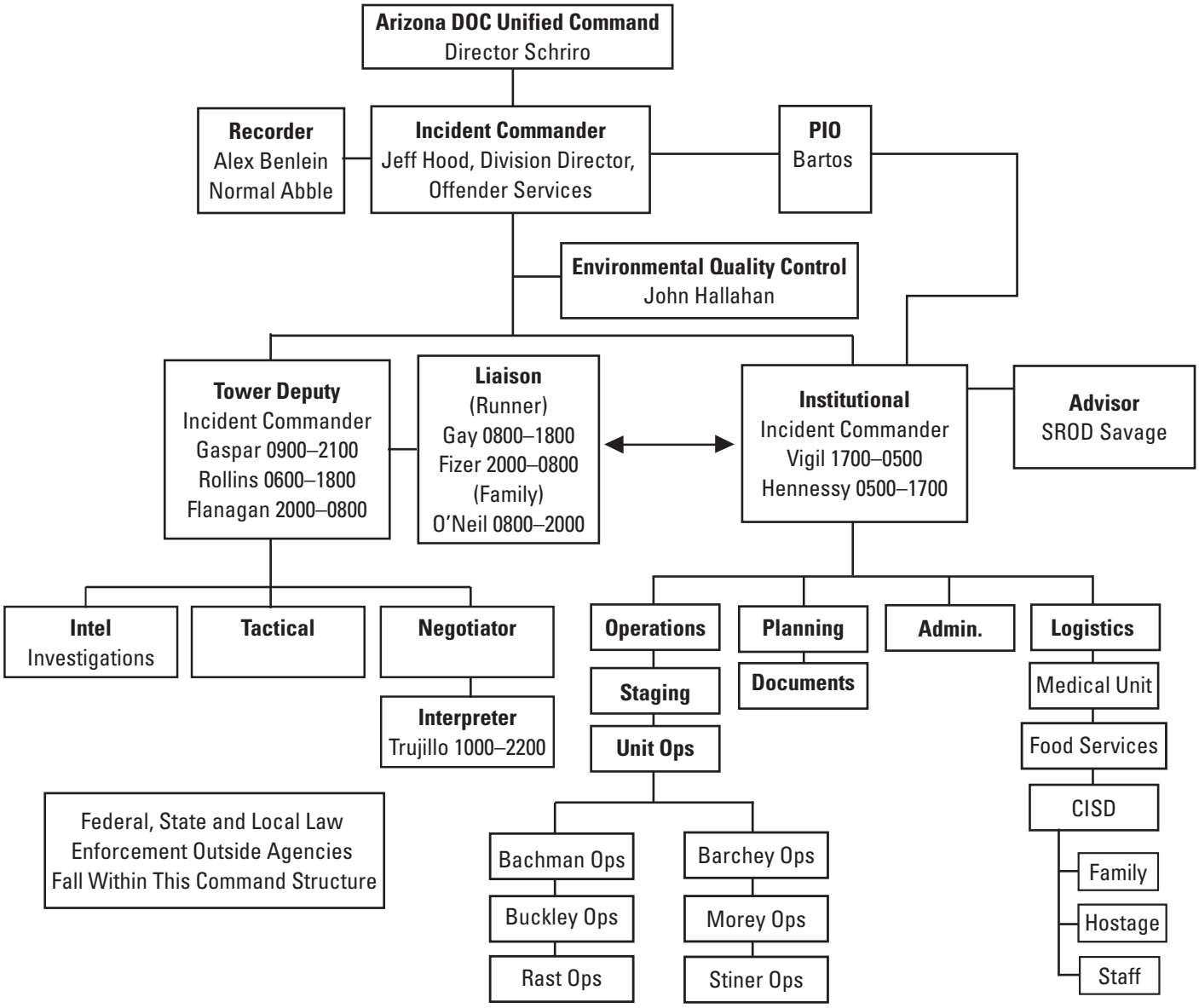
The two inmates exploited a series of small but critical gaps in security that were further compounded by institutional complacency and a collective lack of situational awareness. Once faced with the reality of the deadly situation inside the tower—the facility's most secure and impenetrable feature—correctional officers and their leaders responded quickly and effectively to establish the conditions that ultimately led to the successful release of hostages and recapture of inmates without loss of life.

The lessons learned from this incident revalidate the necessity of adequately and properly resourcing corrections operations. Of equal importance is the need to acquire the essential qualities of a competent and proud organization. Such qualities can be obtained only by investing in the people that dedicate themselves to the corrections mission. They must be well trained and well led; and recognized often and fairly compensated. Although one can never guarantee that such an incident will not occur again, the panel believes that much can be done to reduce that risk.

DOC Central Office United Command Structure



Lewis Unified Command Structure



Hurricane Andrew: Florida Department of Corrections

On August 21, 1992, information from the U.S. Weather Service suggested that a tropical storm named 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 Department to monitor the storm's progress. It also advised each facility within the Department to designate a contact person in case the threat worsened. At Dade Correctional Institution (CI), the superintendent directed the duty officer, the shift officers in charge, and the control room officers to monitor the storm's development by all means possible, including weather band radio, commercial radio, and TV.

On Saturday, August 22, the tropical storm had 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 were used to remove loose items from the ground or to tie down or otherwise secure equipment. The superintendent also organized a contingency plan for a department heads' meeting at 9 a.m. the following day to discuss evacuation plans.

On Sunday morning, August 23, 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. DOC headquarters called a meeting of key personnel from the facilities within the likely path of the hurricane to begin preparation of those institutions. An immediate decision was made to direct a small facility in the Florida Keys, Big Pine Key Road Prison, to evacuate north out of the Keys to Lantana Correctional Institution. That evacuation was completed without incident over the course of the next 9 hours.

At Dade CI, department heads and supervisors reported for the 9 a.m. hurricane preparation meeting. The superintendent decided to evacuate Dade Work Camp (with 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 more than 150 miles per hour and seemed highly likely to strike Florida at Florida City, which would subject Dade CI to the full force of the center of the hurricane. Dade is located 20 miles west of the coast but is only 6 feet above sea level, and the force of the 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 Department decided to evacuate all inmates from Dade CI to other state institutions.

To accommodate the approximately 1,000 inmates from Dade CI, DOC located space at five other state prisons. Two of these potential transfer sites were then eliminated because they also were 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 Department were dispatched toward Dade CI to begin transferring inmates: approximately 100 to Glades CI, 150 to Martin CI, 450 to the South Florida Reception Center, 250 to the Central Florida Reception Center, and approximately 100 to another state facility.

DOC also decided that the 76 inmates at the small Copeland Road Prison should be evacuated to Hendry CI—a situation it quickly assessed as a timing problem. Although DOC had adequate transportation, space, and other resources to house the relocated inmates on an emergency basis, it was not immediately clear that these 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 profile. The administration decided to move all close-custody inmates first, with minimum- and medium-security inmates to follow. Staff gathered inmate folders and medical records to transport 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, the last inmates being evacuated arrived at the Central Florida Reception Center. Approximately 1,000 inmates had been moved on short notice to locations all over the southern half of Florida with no injuries to staff or inmates and no 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 poststorm damage. At the South Florida Reception Center the decision was to "defend in place" rather than to evacuate inmates. Staff were called to the institution to help maintenance staff tie down or secure equipment judged to be 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, it caused only moderate damage to DOC facilities, with the exception of Dade CI, where the damage was severe. No other facilities were rendered uninhabitable. At Dade, sections of the roof were ripped away, allowing the wind-driven rain to soak large areas of the facility. Windows were broken, the perimeter fence was essentially destroyed, and some outbuildings were completely destroyed. The skeleton staff who stayed at the institution during the storm were shocked at the extent of the damage.

Late on 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 homes. The superintendent and assistant superintendent toured the institution grounds with

other staff to assess the damage and then attempted to make contact with DOC headquarters or another institution to request help. An individual correctional officer arrived from Broward CI. 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.

In addition to the damage it did to the institution, the storm completely destroyed the homes of approximately 400 Department staff members. The following day, Tuesday, August 25, 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 the staff were experiencing. The next day, August 26, a meeting was held at DOC's central office to begin developing plans for rebuilding Dade Work Camp (target for completion: 45 days) and the main prison.

On August 25, the day after the storm, the Civil Air Patrol established a radio communications post at Dade CI, the state fire marshal arrived, and a National Guard unit set up camp on the grounds to provide perimeter security. DOC initiated a number of recovery programs for staff, including providing free gasoline, water, ice, clothing, food, and household goods, as available. The administrative building of the main unit was kept open as a shelter for staff and family members who were without housing. Tools, roofing materials, electric generators, and other supplies were made available to employees at no charge. The Department also coordinated applications for Federal Emergency Management Agency funds and established a toll-free number for staff and their families to use in arranging assistance.

DOC began to identify temporary housing locations for homeless staff and their families—a total of 1,000 people—and coordinated donations of money to assist them. It also made a major effort to keep track of and communicate with the staff who were on special assignments to other institutions. Many of these staff had storm damage problems with their homes or other difficult situations resulting from the hurricane. Actual reconstruction work on Dade CI and the Dade Work Camp was initiated within 48 hours after the damage assessment was complete.

Lessons Learned

1. The Florida DOC's comprehensive emergency planning system provided an appropriate framework for responding to the specifics of the hurricane.
2. Because of the uncertainty of the hurricane's path and the risks involved in evacuating large numbers of high-security inmates, it was not practical to evacuate several institutions, nor was it practical to evacuate days before the storm hit. These circumstances made fast, clear decisionmaking and leadership critically important for DOC once the storm's landfall was certain.
3. Staff performed admirably at many locations throughout the state, despite great stress on some individual staff members. Staff gave first priority to their duty to DOC and the state, even in cases where their homes were threatened or the fate of loved ones was uncertain. Numerous staff volunteered for particularly hazardous duty, such as remaining at Dade CI for the duration of the hurricane. Individual acts of bravery and compassion were common.

4. 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. DOC's commitment to keeping inmates well informed contributed to this cooperative spirit.
5. With some emergencies, particularly some types of natural disasters, the aftermath may be more challenging than the response to the event itself.
6. After the hurricane struck, communication with the most seriously damaged areas of the state was initially impossible and remained very difficult for a long time. Cellular telephone service was disabled (a situation that has not always occurred with other natural disasters, such as floods and earthquakes), because so many transmitter and repeater locations were damaged over such a wide area.
7. Approximately 2 weeks after the hurricane, 22 staff from Dade CI still had not reported to the institution or the Department. In a matter of days, DOC organized teams to go into the local community to search for these staff. After the search teams failed to locate any of the 22 missing staff, further efforts were instituted to try to find them.
8. Because of the difficulty in establishing communication after a natural disaster, facilities should establish a date, time, and place for staff to report before they leave during an evacuation. For similar reasons, facilities should establish a toll-free number for emergency assistance and disseminate that number to staff before the actual event.
9. A mechanism for tracking employees temporarily assigned to different facilities would be a useful addition to the Florida DOC's emergency plan.
10. After the hurricane, the problems of dealing with large numbers of homeless staff were more difficult in many ways, and required more creativity, than the formidable problems of repairing badly damaged facilities.
11. When a large-scale evacuation of inmates is anticipated, DOC authorization of an emergency inmate processing and receiving policy will give the receiving institutions flexibility in intake procedures. Alternatively, such an emergency policy may be a regular part of a Department's emergency plans.
12. Whenever practical, medical records should accompany evacuated inmates to the receiving institution. As a backup, it is helpful if some basic medical information is available in a database or online so that it can be accessed from any institution.
13. Lack of potable water will become a crisis for an institution long before food delays or cold food cause serious problems. Also, arranging for food from external sources during a communitywide emergency is far easier than arranging for large quantities of potable water.
14. Departments should be prepared to move food items from one facility to another and, if possible, should have at least one vehicle (a 24-foot truck, for example) designated for food service use only.
15. 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.
16. The absence of attendance and leave records may put the Department in a difficult position with regard to issuing paychecks. The distribution of paychecks to employees in the aftermath of a communitywide disaster may also be challenging, and depositing paychecks directly to bank accounts may not be possible either if electronic fund

transfers are not available, as was the case in Florida during the aftermath of Hurricane Andrew. In such emergencies, the Department may have to make arrangements to pay employees in cash.

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

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