Chief Jail Inspector’s Network
Proceedings of the Annual Meeting

June 18-19, 2012
National Institute of Corrections
Jails Division

14th Annual
Chief Jail Inspector’s Network Meeting

Record of Proceedings

NIC Event # 12J2701
July 18-19, 2012
National Corrections Academy
Aurora, Colorado
# Table of Contents

## Day One

- Introductions and Overview ................................................................. 2
- NIC Information Center ........................................................................ 3
- National Sheriff’s Association Update .................................................... 3
- ACA Jail Standards Update .................................................................. 5
- Iowa, Minnesota and Indiana Standards/Inspections .............................. 7
- Federal Agency Update – U.S. Marshal’s Service ................................. 10
- Suicide Prevention: Current Research, Policies and Procedures
  and Legal Trends ................................................................................ 14

## Day Two

- Legal Issues in Today’s Jail ................................................................. 18
- Prison Rape Elimination Act ................................................................. 25
- Surviving in Hard Times: Marketing the Jail Inspection Process ............. 31
- Evaluations/Close-Out ......................................................................... 33

Appendices ............................................................................................ 35
Introductions and Housekeeping

Danny Downes, NIC Correctional Program Specialist, opened the meeting at 8:00 a.m. and passed out the agenda to the group. He emphasized that the agenda was subject to change, as the needs of the group changed. (Refer to Appendix I for the Revised Agenda.) Danny informed the group that seven states and the U.S. Marshal’s service were represented at the meeting. He then gave a brief overview of his background and experience. This was followed by a PowerPoint presentation that offered an overview of NIC and the services provided to agencies throughout the United States. (Refer to Appendix II for a copy of the presentation.) He then went over the contents of the participant folder, daily schedule, breaks and seating arrangements. He passed around a participant list to enable the chief’s to make any necessary corrections to their contact information. The participants were then asked to introduce themselves to the group and provide information on their agency and their background. (Refer to Appendix III for a complete participant list with contact information. Danny then introduced the guest presenters for the meeting:

**Kathy Black-Dennis** – the Director of Standards and Accreditation for the American Correctional Association.

**Carrie Hill, Esq.** – an attorney and criminal justice consultant. She is the editor of *Corrections Managers Report* and counsel to the Hill Law Office in Maple Grove, MN. Ms. Hill is well known as an expert in legal issues involving jails and other correctional facilities.

**Lindsay M. Hayes** – the Project Director for the National Center on Institutions and Alternatives, with an office in Mansfield, MA. Mr. Hayes is nationally recognized as an expert in the field of suicide prevention with jails, prisons and juvenile facilities.

Danny also introduced Cheryl Paul, former NIC Correctional Program Specialist. Cheryl was tasked with documenting the proceedings of the meeting and completing a report for dissemination to the participants.
NIC Information Center

Susan Powell, Public Services Coordinator, provided the group with an overview of the resources available from the NIC Information Center. She explained that the library provides access over 18,000 corrections related resources including training plans, research reports, program evaluations and more. Many resources are available on-line at http://nicic.gov/Library/.

Susan also explained that the Information Center also provides a research service. This service enables corrections professionals to ask questions and be directed to information and resources through the Information Help Desk.

The group then took a tour of the Information Center, returning to the meeting with stacks of resource materials.

National Sheriff’s Association Update

Denny Macomber, Chief of the Jail Standards Division of the Nebraska Crime Commission, gave a report on NSA activities over the past year. Denny has represented the Network at NSA for several years and has a seat on three committees: 1) Accreditation, 2) Jail Detention and Corrections, and 3) Ethics and Standards. He attended the January meeting in Washington, DC and the annual Congress of Corrections in Nashville, TN. Apparently all of the jail training at NSA in Nashville was cancelled due to a gas leak and explosion at the host hotel.

Denny explained that while some of the meetings are more productive than others, it is important for the chief jail inspector’s to have a presence with NSA. Carrie Hill mentioned that NSA’s Institute for Jail Operations provides some training that might be worth looking into. Go to http://www.jailtraining.org/ for more information.

Denny explained that the Prison Rape Elimination Act (PREA) was a hot topic at both NSA meetings. There seem to be a lot of questions about PREA and the implementation of the new standards. Tim Thompson commented that counties don’t have to comply with PREA standards, only if they hold federal prisoners. Carrie Hill responded that the problem is if you don’t comply and you have an incident it could expose the agency to liability, although there is no federal penalty for non-compliance with the standards.
Bill Wilson asked about housing state inmates or Immigration and Customs Enforcement (ICE) detainees – “would that situation require compliance with the standards or the potential for monetary penalties?” Carrie advised all jails that house either federal or state inmates should carefully look at their contracts with those agencies. Danny Downes commented that there will be a presentation on PREA later in the meeting, which will give everyone an opportunity to have their questions answered.

Denny then reported that ICE has another set of small jail standards. This involves a self-inspection process for small jails and would represent a major change for small jails and the inspection process.

Denny asked the group if someone else would like to assume the responsibility for being the representative to NSA. The volunteer would be required to attend one meeting a year; there are two meetings each year. The representative must be a member of NSA. He said if no one is interested he will still attend the meetings. He emphasized that there is a value for the chief jail inspectors to be a presence at the meetings and participating on the committees. Making contacts is one of the main advantages.

Bill Wilson mentioned that the purveyors of “private” standards, that is standards developed by individuals or companies and sold to state agencies to enable them to conduct self-audits, have made inroads in doing away with ACA jail standards. He also pointed out that NSA’s Institute for Jail Operations, www.jailtraining.org, is affiliated with this private standards company.

Prior to the break, Danny Downes asked the group if anyone would be interested in attending a one day meeting at the Academy to gain more information on the new PREA standards and how they will affect jails. A majority of the participants raised their hands. Danny will keep the group informed of the progress of this idea.
ACA Jail Standards Update

Kathy Black-Dennis began her report by asking the group if they have a copy of the Core Jail Standards. She mentioned that many copies had been distributed by NSA and NIC had mailed a copy to all of the countries jails.

Copies are available for purchase on the ACA website at https://www.aca.org/store/bookstore/view.asp?product_id=1164&origin=results&OS='&YMGHFREproduct_name=Core+Jail+Standards&YMGHFREkey_words=Standards &pagesize=10&top_parent=188. The price is $30.00 per copy. You can get reduced pricing for volume purchases.

ACA is now including a CD in the back of each paper book and is working toward development of an on-line version to automate the process. They are still working through how to do this without sharing proprietary information.

Kathy told the group that there is now a new accreditation process for the Core Standards. In this way more agencies will be able to get into accreditation. ACA is encouraging facilities to start their accreditation process with the core standards then move on to full accreditation. The Core Standards allow facilities to receive basic accreditation at a much lower price. In the Core Standards there are 45 mandatory standards and 134 nonmandatory standards.

ACA is now working to enable agencies to go paperless in the accreditation process – if it meets the needs of the agency and it is easy for the auditor’s to work with the system. It is not mandatory that agencies use a paperless process. John Dunn, Ombudsman/ACA Accreditation Monitor, with the Kentucky Department of Corrections, has more information on this process. If anyone in the Network would like to learn more about a paperless process, Mr. Dunn’s number is 502-564-4726.

ACA has hired Rick Frey, from Broward County Florida, to work with individual agencies who are interested in accreditation. Rick can be reached at 954-914-9782 or rickf@aca.org.

Kathy directed the group to some handouts available from ACA in the front of the room. She also provided the group with a copy of an article by Rod Miller, ACA’s Core Jail Standards Focus on the Basics (Refer to Appendix IV.) She emphasized that there is a flyer on how to become an auditor for ACA. ACA makes every effort to ensure that jail auditors have jail experience. ACA is looking for new people to do this work.
There is a new “Jail Reader”, *ACA Reader: Jails*, available on the ACA website. Kathy pointed out that the “Reader” has essays on training and management issues, technology, future concerns, security, health care and reentry. Many of the articles were originally featured in *Corrections Today* and *Correctional Health Today*.

A member of the group inquired about how often the standards were revised and how that process works. Kathy informed the group that anyone can make suggestions for standards revisions on the ACA website. When a suggestion is made, other people on the site can respond and make comments. The Standards Committee meets twice per year, at the conferences, and reviews all suggestions.

Kathy brought up the issue of audits for PREA standards. ACA is looking at an auditing piece. They have met and it still seems there are more questions than answers about the process. ACA will use current auditors as PREA auditors when the time comes. Also, if your facility is already accredited, ACA will not charge for the additional PREA audit. ACA is also looking at adopting PREA Standards as an addendum to the current CORE and Adult Local Detention Facility (ALDF) Standards. However, the process will be handled as two separate audits, as PREA audits are public information and ACA audits are not.

Kathy pointed out that the PREA Standards will become effective on August 19, 2012 with the first audits, of Federal Bureau of Prisons facilities, due by August 2013. Apparently, DOJ has not provided a clear auditing process at this point. ACA is working with them to finalize this process.

Kathy also mentioned that the auditors cannot have had a prior financial relationship with the facility being audited. What this means is not really clear and there are lots of unanswered questions, e.g. can ACA conduct PREA audits in accredited facilities, where they have previously done an audit, if they do the audit at no charge?

Kathy reiterated that local jails will not face monetary penalties for non-compliance with the PREA Standards.

Ralph Nichols asked if DOJ has to be responsible for the auditing process. Carrie Hill responded that all PREA auditors must receive training to be a PREA auditor.

Bill Wilson asked if ACA had lost any jails in the accreditation process, because they just want to comply with the Core Standards. Kathy said that a facility can move up to full ALDF accreditation after completing the Core accreditation, but they cannot move backward.
Kathy reported that ACA is in the process of updating their website to make it more user-friendly. In about two weeks the minutes of the Standards Committee meeting will be on the website. They will be meeting next week in Denver at the conference.

A member asked about the cost of ACA audits. Kathy told the group that a Core Standards audit is $6,000.00 plus up to $2,000.00 for the cost of the auditor. ALDF audits are $12,500.00 including the cost of the auditor(s). Someone remarked that in some states agencies use inmate funds to pay for the audit, but this varies from state to state.

Ralph Nichols asked about the auditing process. Kathy told the group that agencies must meet all of the applicable mandatory standards and 90% of the applicable nonmandatory standards to receive accreditation. The audit results can be used to track outcomes, trends, for training purposes and to improve operations.

More information on the Core Standards is available at www.nicicc.gov/nationaljailexchange.

Iowa, Minnesota and Indiana Standards/Inspections

Indiana

Ken Whipker, Director of the Indiana Department of Corrections, began this session by passing out the current and proposed new jail standards for Indiana. (Refer to Appendix V.) He described a three year development process in which 95 jails had input to the process and the fiscal impact of the new standards. He pointed out that anyone who built and operate their facilities under the old standards would be “grandfathered” in. However, if an agency makes changes to their facility, or builds a new facility, the new standards will apply. He reported that the new standards will be approved by the end of August, 2012 and become effective January 2013. Any new facilities constructed after January 1, 2013 will be under the new standards.

Ken went on to say that under the new standards inspectors have no ability to shut down a jail, only make recommendations to the agency for corrective action.

Mike Funk asked if there was any language in the proposed standards dealing with electronic communications for inmates, e.g. email. Ken replied that electronic communications for inmates was not brought up during the development process, but he sees most jails going paperless by using kiosks or other electronic means for
inmates to communicate with family and friends, rather than traditional mail. He has not seen anything written in other standards regarding this issue.

Tim Thompson commented that there is a resource posted in the “vault” on the Chief Jail Inspector’s Forum on the NIC website that has all the data and research behind why certain items should be included in jail standards. He feels that this is a valuable resource. He also commented that evidence based practices were used also in the Ohio Jail Evaluation process.

Denny Macomber asked who made comments on the proposed standards, besides the jail. Ken said they solicited comments from the Indiana Civil Liberties Union and the attorney general. He also commented that the state sheriff’s association was involved in the process and reviewed the document at every step in the process.

Bill Wilson asked if the proposed standards would go out for public comment. Ken replied that the document is not currently publically available. There were various comments in the group regarding the slow process in developing standards and many obstacles to overcome in the process. Gary Wion informed the group that California revises their standards every two years and the process goes very smoothly as they are use to the process.

**Minnesota**

Tim Thompson, Program Manager for Facilities Inspection and Enforcement for the State of Minnesota, provided the group with information on the Minnesota “Statewide Inspection System”. In this on-line system, every facility provides data on their facility into the system, including daily population, booking information, incidents, deaths, etc. This information is used by the inspectors to generate reports. It is used in the investigations of in-custody deaths and to ensure that facilities don’t exceed population caps.

Tim demonstrated the various reports available on the system – deaths, incident reports. He pointed out that if a report documents a standards violation, e.g. 30 minute bed checks were not done in a specific facility, they will send a letter to the facility to ensure the problem is fixed. Each facility will print out their logs for 30 minute checks and send them to the inspectors for review.

Bill Wilson commented that there may be a legal issue if data is missing regarding checks. Lots of facilities use electronic, paper and video to document various activities. With only electronic checks, there is the possibility of employees hacking
the system to falsify checks. Staff can also just “hit the button” and not actually check on the inmates.

Tim went on to further explain the functionality of the system. It allows him to see each inspector’s workload and look at the status of every facility in the state. He can also make notes and changes to specifics for facilities and inspectors.

The section on rules and compliance lists all of the rules. This feature allows the inspector to go through each rule following the inspection and make notes on compliance with the rule. The final inspection report is developed from the information entered in the system by the inspector. The report contains information on areas of non compliance, suggested remedies and due dates for the facility to come into compliance.

Tim also informed the group that the system also works with information from other agencies who have access to the system, e.g. state law enforcement.

Several participants had questions about the system:

- A question was asked regarding who has access to these reports, specifically the press. Tim responded that they do provide information to the press.
- Who maintains the system? One full time IT person. Once information is added to the system, it will stay in the system, so in the future the inspector only has to verify the information.
- Bill Wilson commented that Virginia has a similar system.
- Mike Funk commented that all of his jurisdictions submit their inspection information in writing.

**Iowa**

Delbert Longley, Chief Jail Inspector from the Iowa Department of Corrections, gave a presentation on the process Iowa has used for updating and modifying their state jail inspection standards. (Refer to Appendix VI for a copy of the PowerPoint presentation.) He provided the group with the background of how the jail inspection process developed in Iowa.

Del then provided the group with a copy of the Iowa Department of Corrections *Jail Inspection Report*. (Refer to Appendix VI.) He went over each step of the inspection process in Iowa discussing potential problems and the process used by the inspectors to identify and help remedy those problems. Each step on the Report relates to a written standard, with a narrative describing the standard.
Of special note were:

- Section 50.10 (3) Conflict of Interest - Business transactions with prisoners (this does not involve smuggling of contraband).
- Section 50.13 (f) Suicide prevention - Following 69 suicide attempts and 9 suicides in 2009, the code was revised to require all jail staff to have suicide prevention training.
- Section 50.21 Discipline and Grievance procedures - Inspectors really take a close look at prisoner disciplinary procedures and the grievance process in each facility. There are 18 required procedures in this area.
- The form also has a specific section for direct supervision jails, Section 50.25.
- Jail built before 1984 do not have to comply with today’s standards. The form has a list of basic standards for inspection that apply to these older facilities.
- There is a separate Juvenile Detention Monitoring Report use for jails that house juvenile offenders, focusing on separation of adult prisoners and juveniles.
- There is an Inspection Checklist at the end of the Report that allows the inspector to check remaining items and finalize the report.

For a full copy of the Iowa State Jail Standards go to:

Federal Agency Update

Overview and Updates

Wolfgang Calvert, Senior Inspector, and Patrick Cortez, Senior Inspector, from the United States Marshal’s Service provided the group with an update on detention facility training, conditions of confinement and core detention standards. Wolfgang began the presentation by giving a few facts regarding the U.S. Marshal’s Service (USMS).

- The USMS subcontracts for jail space in every state and the U.S. territories. Jails that are actively housing federal inmates, or who will soon, are subject to inspection by the USMS.
- The structure of the USMS mirrors the geographical structure of the 94 U.S. District Courts. California, for example, has four districts.
• The USMS contracts with approximately 1800 facilities to house over 63,000 inmates.
• The way the districts are set up, any particular jail, depending on the location, may house inmates from more than one district.
• Detention facility inspectors actually go to jails for inspections.
• A new position, Detention Management Inspector, has been developed to work with jurisdictions with high federal prisoner populations.
• Information on prisoner management is also available on the USMS website. This provides guidelines for managing federal prisoners in a jail setting.
• The USMS is working with NIC on training issues. They just completed a survey on the status of jails in relation to policies and procedures and internet access.
• For the exact locations of district offices and other information regarding federal prisoners go to www.usmarshals.gov.

Wolfgang went on to discuss suicide prevention. The USMS wants to raise awareness of the suicide prevention training that is available on their website. The training lists expectations for suicide prevention training. He asked the group to please take a look and provide advice and suggestions for improvement.

Wolfgang reported that in 2014 the Office of the Federal Detention Trustee (OFDT) will become part of the USMS. The OFDT is currently responsible for procuring detention facilities to house federal prisoners, managing detention contracts and intergovernmental agreements (IGA’s) with the exception of those held by Indian, juvenile, or ICE. OFDT also has a group that documents the quality assurance review of county, state and private correctional facilities to ensure compliance with Federal Performance-Based Detention Standards. When OFDT merges with USMS they will take over facility inspections. The standards will probably closely resemble ACA Core Standards.

**Department of Justice (DOJ) Core Detention Standards**

Wolfgang then began a discussion of the DOJ Core Detention Standards. (Refer to Appendix VII for a copy of the PowerPoint presentation.) He made several important points regarding local jail responsibilities when housing federal prisoners.

• When the USMS turns over a federal prisoner to a local jail, the jail determines how the inmate will be housed and handled.
• Some of the group commented on the lack of important classification information provided for incoming federal prisoners. Wolfgang told the group
they need to request a USM 129 form, and for more in-depth information ask for the USM 130. Carrie Hill suggested that local jails have language in their contracts or IGA’s that require the USMS to provide both of those forms when they bring a prisoner for housing. Wolfgang also suggested that local facilities develop a relationship with Bureau of Prison facilities in their areas, as another conduit for information on a particular inmate. He emphasized that all information given to a jurisdiction is confidential. A discussion and questions continued around the lack of information. Carrie thanked Wolfgang for the information on the forms.

- There was a consensus that there is pressure on local facilities to house federal prisoners because of the revenue generated by those prisoners. However, if the lack of information hinders the facility’s ability to properly classify and house federal prisoners.
- The USMS only handle pretrial inmates, occasionally they have civil detainees, but they are housed like any other federal prisoner.
- Housing federal prisoners can lead to inspections by a number of agencies.
- Someone asked if a facility must be compliant with DOJ Core Standards prior to housing federal prisoners. Wolfgang responded that the determination to house federal prisoners or not house federal prisoners in a specific facility is up to the District Director. There are practical issues which must be taken into account, e.g. the need to house the prisoner in a location close to the court of jurisdiction. When problems arise, USMS will try to work with a facility to correct the problems, rather than move the prisoners.
- Another member of the group asked if federal prisoners ever sue after being held in a noncompliant facility. Wolfgang responded that a prisoner might allege this but . . . This was followed by considerable discussion among the chiefs regarding compliance and noncompliance with DOJ Core Standards and potential liability.
- Carrie Hill asked if the USMS would ever enter into a contract or IGA with a facility that states that the department’s policy and procedures would apply to all inmates, even federal prisoners. In that circumstance, would they still conduct facility inspections? Wolfgang stated that state requirements or standards supersede the DOJ Core Standards.

Wolfgang resumed the presentation with a brief discussion of IGA’s and then began a presentation on the detention *Facility Investigative Report*. Some of the more important points made during the remainder of the presentation follow.
USMS tracks staffing information, inmate capacity (with the total broken down by type of inmate, e.g. local, ICE, federal). This is based on a concern about crowding and/or not enough staff to safely monitor the inmate population.

Each facility is given a code, similar to a social security number, that remains with the facility for life, even if the name of the facility changes.

Each facility has a status, which may be subject to change, i.e. new, dormant.

Facilities with an IGA for housing federal inmates are able to access federal excess property.

Gary Wion from the California Board of Standards and Community Corrections mentioned that in California inspectors do not inspect housing units in jails when those housing units contain only federal prisoners. There was concern that this can lead to the housing of federal inmates in units that won’t pass the state inspection.

The form tracks written and verbal complaints made by prisoners. The information is compiled into statistics regarding complaints per inmate population.

Inspector’s conduct a visual review of the facility, looking for basic flaws in living areas, dayrooms, kitchen, and medical areas.

The Administrative/Management section of the form asks very generic questions regarding policy and procedures, internal inspections, records, admission and orientation, personal property and monies, releases, and accommodations for the disabled. There is no grading; a facility is either compliant or noncompliant in each area.

Wolfgang briefly went over the remaining areas on the form: medical/mental health screenings within 14 days, suicide prevention, detainee deaths (USMS is getting more involved in death investigations), involuntary medical treatment, infectious disease, medical staffing, security and control (post orders, pertinent logs, policy and procedure, control of contraband, use of force – tasers restraint chairs), emergency plans, food service (adequacy, special diets, inspections of subcontractor facilities), and access to legal paperwork, attorneys and law library.

Facilities with IGAs get cursory inspections, while contract facilities get full inspections.

Wolfgang made a final key point – he advised that each jurisdiction get to know the Detention Management Inspector in their district.
Jail Suicide Prevention: Current Research, Policy and Procedures and Legal Trends

Lindsay Hayes from the National Center on Institutions and Alternatives (NCIA) began his presentation on suicide prevention with an historical perspective on suicide in jails. In 1986 NCIA, with financial support from NIC, did the first suicide survey among jails. This survey was a self report but the jail inspectors helped to get accurate information. In 2010 NCIA released a follow-up report, *National Study of Jail Suicide: 20 Years Later* April 2010. The follow-up report provided an interesting perspective in the progress of suicide prevention in America’s Jails. For a full copy of the report go to [www.nicic.gov/library/024308](http://www.nicic.gov/library/024308). Both the 1986 report and the current report gathered data on the extent and distribution of suicides in local jails, as well as descriptive data on demographic characteristics of the jail facility.

Lindsay reported that the rate of suicide in jails has decreased, presumably due to improved screening, policies and procedures and training in jails. Many states are now incorporating suicide prevention requirements in their standards, however there needs to be guidance on what “suicide prevention” really means. Jurisdictions need a blueprint on what a suicide prevention program should look like. The need for some guidance in preparing a suicide prevention program led to the development of the “guiding principles for suicide prevention”.

Lindsay then went over the major findings from the study. (Refer to Appendix VIII for a copy of the PowerPoint presentation.) Some of the highlights of the findings were:

- Seven percent of all suicides were in custody on charges of sexual assault or murder of a child. Jurisdictions should consider immediate referral to medical or mental health when individuals are incarcerated on these charges.
- The percentage of suicides that occur in the first 24-hours in custody had gone down to 23% of suicides, from 51% in the 1986 study. This can be attributed largely to improvements in the initial screening of inmates, now we have to train staff to look for suicidal tendencies later in the incarceration.
- Almost 1/3 of suicides occurred between 3:01 p.m. and 9:00 p.m., dispelling the theory that most suicides occur during the middle of the night.
- Ninety-three percent of suicides were by hanging, with 66% using their bedding and 30% using their bunk as the anchoring device. Jurisdictions must ensure that there are no bunk holes or other anchoring areas in suicide cells.
• Eight percent were on suicide watch when they died.
• The theory of “No Harm” contracts is not effective.
• They did not find that more suicides occur during the holidays. This may be because staff has a tendency to keep a closer eye on inmates during those times.

Lindsay pointed out that having a prevention policy is not enough – a comprehensive program for suicide prevention includes training, levels of confinement/observation, and screening for past behavior. Tim Thompson commented that instead of writing policy requiring 15 minute checks for inmates on suicide watch; defer to mental health staff, either in-house or on-call. Bill Wilson commented that some jails use trained inmates to do constant supervision of suicidal inmates, this is used at Riker’s Island. Richard Kinney asked about the distinction between constant supervision and intermittent supervision. Lindsay replied that constant supervision should be used for high risk inmates, while staggered close observation should be used for inmates with a lower level of risk. Carrie Hill commented that the definition of constant supervision is very important – it means one on one, all the time.

The discussion turned to the use of CPR, with Lindsay pointing out that the study indicated that while 80% of staff was trained in CPR, it was used on 63% of the time in suicides. This could have two explanations: 1) the inmate was already dead or 2) the staff member refused to perform CPR. Someone asked if the use of defibrillators had any impact on suicide. Lindsay responded that it depends on how long the victim has been unconscious. Finally, Lindsay pointed out that it is essential to conduct a mortality review to include medical, mental health and correctional staff to assess the incident and take steps to prevent this in the future.

Lindsay then reviewed Table 43, from the class handout. (Refer to Appendix VIII.) The table provides a summary of the comparison of the two suicide reports. He informed the group that both reports are available from the NIC library.

Lindsay then began a presentation on the “Guiding Principles for Suicide Prevention.” He discussed the assessment of suicide risk as not being a onetime event, but an ongoing process. He pointed out that assessments should be done in private, not in the middle of a busy booking area, with numerous people listening. Intake screenings are time sensitive and need follow-up. He gave an example that the arrestee simply denying suicidal ideation, does not necessarily mean they are not actually suicidal.
Lindsay pointed out that any suicide prevention training does not take the place of “meaningful” suicide prevention training. Facilities that maintain a multidisciplinary approach to suicide prevention, avoid preventable suicides. “One size does not fit all” in suicide prevention.

One of the most difficult decisions can be taking someone off of suicide watch. Lindsay stressed that it is essential that a qualified mental health professional (QMHP), licensed by the state, master’s degree level or above, make that decision. Denny Macomber asked if using a telemedicine system is appropriate if the nearest QMHP is nine hours away. It seems that some jails and prisons are going to this type of system. Lindsay advised that you need to be careful of the misuse of this medium, if at all possible a QMHP should come to the facility for a face to face evaluation. Then Denny asked if there are limitations on what types of information can be relayed over the phone – is HIPPA a factor? Lindsay responded that there is no privacy issue when dealing with a suicide risk. Confidentiality for telemedicine does not exist. When using a remote system it is essential to document the name, agency, contact information and the advice given. If possible, the call should be recorded. Carrie Hill stated that there is a HIPPA exemption for law enforcement. Removing an inmate from suicide watch is never a “security decision, always a clinical decision”.

Lindsay moved on to discuss principle 13 – Lack of inmates on suicide precautions should not be interpreted to mean that there are no currently suicidal inmates in your facility, nor a barometer of sound suicide prevention practices. You can’t make the argument that your facility is housing more mentally ill and/or other high risk individuals and then state there are not any suicidal inmates in your facility today. He also highlighted principle 16 – the crux of prevention is programming, including the following elements: staff training, intake screening/assessment, communication, housing, levels of observation/management, intervention, reporting, and follow-up/morbidity-mortality review.

The next topic was standards of care. Lindsay mentioned some resources such as the National Commission on Correctional Healthcare, ACA, Homeland Security and ICE standards. He then passed out a copy of the Jail Suicide/Mental Health Update from Spring 2005. This document contains a guide for developing and maintaining a sound suicide prevention policy. (Refer to Appendix VIII.) He covered the following topics for the remainder of the presentation.
1. Initial training (8 Hours) recommended but not required
   a. Suicide research
   b. Staff attitudes
   c. Facility environment
   d. Identification of suicidal inmates
   e. Components of the plan
   f. Liability issues
2. Annual training (2 hours)
   a. Review of initial training
   b. Reviews of suicides and attempts
   c. Review of changes in department policy
3. Intake screening form completed by trained correctional officer or medical staff
   a. Past suicidal ideation/attempts
   b. Current suicidal ideation
   c. Prior mental health treatment
   d. Recent significant loss (job, relationship, death, etc)
   e. Hopelessness
   f. History of suicidal behavior in family or significant other
   g. Suicide risk during prior department confinement
   h. Transporting officer thinks there is a problem
4. Communication – 3 levels
5. Housing – avoid isolation, the decision on where to house should not be based on staffing levels or bed availability
   a. To the extent possible a suicidal inmate should be housed in GP, MH or infirmary, located close to staff
   b. Cells suicide resistant CA recommends cordless phones.
6. Levels of supervision/management
   a. Close observation – expresses suicidal ideation
   b. Constant observation – actively suicidal and shouldn’t even be in jail
   c. Upgrading, downgrading, and discontinuing suicide precautions – needs to be an arrangement to have this person assessed by a QMHP in a face to face interview.
7. Intervention – emergency response
   a. Housing units should contain an emergency response bag
   b. At least one Automated External Defibrillator (AED)
   c. Nonmedical staff should not wait to enter the cell or begin life-saving measures, this can show a lack of response and present liability
8. Reporting
9. Morbidity/mortality review
   a. Look at what happened, don’t exclude all of the disciplines this will severely jeopardize the integrity of the review.
   b. Possible precipitating factors
   c. Medical/MH services reports involvement
   d. Recommendations.

In the final segment, Lindsay did a brief case law review. (Refer to pages 11-18 of the handout in of Appendix VIII).

Lindsay asked if there were any more questions or comments. There were none, so the session closed for the day.

---

**Legal Issues in Today’s Jail**

The second day of the meeting opened with a presentation on legal issues from Carrie Hill, Esq. Carrie provided her contact information (clsh@comcast.net – 612-306-4831) and encouraged the network members to contact her with questions.

Carrie began the presentation by making three points: 1) policy and procedure in jails must be backed by case law; as the law changes, so does the policy; 2) incident reports must stand on their own, based on policy and procedure; and 3) jails must audit themselves regularly for constitutionality. She briefly went over the agenda for the presentation. (Refer to Appendix IX for a copy of the PowerPoint presentation.)

**Avoiding Deliberate Indifference**

Carrie emphasized that “the law does not require perfection, but you must do something”. She then discussed the test for deliberate indifference:

1. Is there a substantial risk of harm?
2. Did the jail staff have knowledge of the risk?
3. Did jail staff disregard the risk, despite their knowledge of the risk?
4. Did the conduct of jail staff cause harm?

Carrie then discussed a case, Starr v Baca, as an example of deliberate indifference. In this case officers opened a cell door to allow a rival gang member to enter a cell, despite requests by the inmates for help. Starr was stabbed twenty-three times, and
his cellmate was also stabbed repeatedly. Deputies did not respond to their pleas for help until the assaulting inmates left the cell. The deputies also assaulted Mr. Starr and delayed medical assistance. In this case the plaintiff held Sheriff Baca personally responsible because he knew about the conditions in the jail, based on numerous prior incidents of racially motivated beatings and deaths, yet he did nothing to remedy those conditions. Baca tried to show that he wasn’t personally responsible because of several legal precedences and the fact that the numbers of assaults in the jail system are increasing due to the increased sophistication of the inmate population as a result of release policies in the state prison system. The 9th Circuit sided with Starr and determined that Sheriff Baca could be held personally responsible for the actions of deputies in this case. The Supreme Court refused to hear the appeal.

Carrie went on to provide advice on handling incidents with potential liability:

- When assaults occur, punish the perpetrator both criminally and administratively, even if the district attorney won’t prosecute.
- Keep the criminal investigation completely separate from the administrative investigation – they will run simultaneously, don’t wait until the criminal complaint is completed.
- Discipline officers, when necessary and provide retraining.
- Make sure there is a rationale for what you do (Turner v Safley) and what you are doing in the interim to correct the situation.
- The totality of conditions in a jail cannot be unconstitutional, only individual conditions.
- The Office of the Sheriff must be proactive in addressing problems, rather than reactive in court.

A Network member brought up a situation regarding crowding in a jail where he was told that if you don’t look into the problem you won’t be responsible. The jail got an architect to deem that the facility had a higher occupancy rate to solve the problem.

**Using Internal Audits**

Carrie then spoke about using internal audits as a means to ward off claims of deliberate indifference. She emphasized that departments must know the law. Jurisdictions should create and train on policies and procedures that are based on legal guidelines.
Legal Definitions

Carrie then went over several legal definitions: the First Amendment, Religious Rights, the Fourth Amendment, the Eighth Amendment – Conditions of Confinement, and Eighth Amendment – Use of Force. (Refer to Appendix XII.)

This was followed by a brief discussion of incident reports. Carrie stressed the point that incident reports are not a group project; each report must stand alone and contain the facts of the incident, as seen by the reporting officer. They should answer the question, why did I do what I did.

Carrie then showed the group a video of an incident in an actual jail. In the video an officer repeatedly assaults an unarmed, unhandcuffed inmate, with seemingly no provocation. A supervisor takes out a taser and stands by while the assault occurs. There were numerous officers in the area watching. No one attempts to either restrain the inmate or prevent the assault. When it appears that a medical staff member is trying to intervene, she is accosted by the sergeant.

Carrie then discussed the video and the issues related to this conduct in a jail. She pointed out that it was obvious that this was not unusual conduct on the part of the officers, as they knew they were being videotaped. She also mentioned that in this case there was a $1.6 million verdict in favor of the plaintiff. Important points to remember when an incident of this type occurs included:

- Put everyone on leave who was a party to the incident and conduct a full investigation.
- Train, or retrain, on booking procedures, use of force, communications and use of restraints.
- When an incident occurs, lockdown the area. In the video an inmate worker came to clean up during the incident.
- Coordinate the actions of staff.
- Supervisors and managers must insure that there is a culture of professionalism. The video showed a complete lack of professionalism.

Inmate Communications

This section of the presentation began with a review of the First Amendment. (Refer to Appendix IX, pages 3-9.) Carrie informed the group that there are four factors to determine whether a first amendment violation exists: 1) safety, 2) security, 3) order
and control, and 4) discipline.  These are legitimate concerns when developing policies regarding inmate communications.  She also pointed out that there must be a rational connection between the regulation and legitimate governmental interests.  She mentioned the Turner v Safley test.  She also gave several examples of how the courts will usually only focus on one of the four factors when reviewing inmate claims.  How an agency defines specific types of mail matters e.g. privileged mail and personal mail.  Definitions can vary from state to state depending on state statutes or standards.

The discussion then went to the practice of limiting inmate mail to postcards.  Carrie pointed out that there has been litigation regarding this practice and in cases where there was a settlement, both regular mail and postcards were allowed.  She stressed that agencies should never implement post card only policies for legal mail.

Carrie then discussed the use of electronic communications for inmates.  She mentioned that the use of kiosks for electronic communication for inmates could prove to be a money maker for the jail.  Some issues she brought up in the discussion included:

- Jails will still have the ability to read incoming and outgoing email, only legal mail cannot be read.
- The systems can screen for “buzz words” to screen mail for gang activity or other illicit activities.
- The availability of electronic mail probably won’t eliminate regular mail, as not everyone has access to a computer or the desire to use electronic communications.
- Nebraska, Ohio and other states currently use Skype and other messaging services for inmate communications.
- The systems could also have other uses such as depositing funds for inmates or sending in grievances.

There was considerable discussion about electronic communications for inmates.  Denny Macomber pointed out that Nebraska has a system that allows for access for legal representation and indigent inmates.  Carrie mentioned that this may not totally address indigent mail issues; agencies may still have to provide free stamps and paper to indigent inmates.  Also, Carrie stated that if an agency wants to have some sort of checks and screen video communications, such as Skype, to enable the agency to stop the communication, there must be a clear rationale of the
circumstances for stopping the transmission. There must be a warning at the beginning of the transmission.

Carrie then brought up the topic of publications and the barring of publications. She began the discussion with the issues that have surfaced around unsolicited publications sent to inmates from *Prison Legal News* or *Convict News*. She said that these organizations will insist that it is legal mail, the agency will deny the publication, and they will sue and never go away.

Carrie explained that agencies that reject publications must do so on an issue by issue basis, there should be no “list” of banned publications. All banned publications must be returned to the publisher with a form (Carrie has a copy of the form available) explaining why the publication was returned. The rejection must be based on case law and clearly explained to the publisher. These publications cannot be simply put in the inmate’s property. She gave some examples of rules that should be given a second look.

- “No staples” policies – when inmates are allowed other material that contain staples.
- “No nudity” policies – when publications like National Geographic are allowed because of the educational value.

Carrie gave an example of a jail that didn’t allow publications to come into the facility, but subscribed to numerous publications that were available to the inmates, including *Prison Legal News*. The inmates were allowed to select the publications, with some limitations. She also made the point that length of stay and the size of the facility are relevant when making policy decisions regarding publications. Fire safety is not relevant when making policy decisions regarding publications or inmate mail.

**Strip Searches**

The next topic was strip searches. Carrie told the group that the issue of arrestee strip searches was “getting interesting”. The status of the inmate seems to be the key when strip searching an inmate. She went over the definitions relevant to strip searches. (Refer to Appendix IX, pages 9-13.) She pointed out that since Bell v Wolffish (1979), which allowed everyone to be strip searched, only in the past few years have more cases caused changes in strip search policies.
Carrie pointed out that it is important to balance privacy rights with safety and security. There is a four part test when looking at strip search policies:

1. The need for the search.
2. How intrusive is the search?
3. Who is doing the search
4. Where is the search being done?

Carrie made several points regarding strip search policies.

- When doing audits there should be a focus on search policies and procedures.
- The more intrusive the search, the greater the need for a rationale.
- Be sure to plan for a search policy for gay, lesbian, bi-sexual and transgender inmates, as those searches can present other issues.

She also pointed out that definitions are critical in search policies. (Refer to Appendix XII for definitions.)

Carrie then brought up recent court decisions that have a major effect on strip search policies and procedures.

- Powell v Barrett (2008) found that reasonable suspicion is not required before strip searching an arrestee as part of the booking process and moving them to general population.
- Bull v City and County of San Francisco (2010) and Edgerly v City and County of San Francisco (2010) also found that reasonable suspicion was not required to strip search arrestees going into the population. San Francisco provided great statistics on contraband in the facilities that helped bolster their arguments.
- In 2012 the U.S. Supreme Court, in a 5/4 opinion) upheld Bell v Wolfish and justified strip searches of all arrestees entering the inmate population. Carrie recommended that agencies should use the language from the court when developing their policies and procedures. One issue that was not addressed was inmates who will not be in general population, who won’t have contact with other inmates. Also, the term “general population” was not defined by the courts.

Carrie then provided some “non legal” advice to the group.
• There is a problem with standards that are not based on case law. Given the new case law, state standards should be reviewed and, if appropriate, revised based on this new case law.

• There should never be cross gender strip searches. These are unconstitutional, barring exigent circumstances.

• Never strip search inmates coming back from court with release orders.

• Forced clothing removal can be done by any gender and can be videotaped. This can happen when an order has been given to the inmate prior to the search – “either you remove your clothes or we will do it for you and once we start we won’t stop”.

Transsexual and transgender strip searches can have issues according to Carrie. She suggests that when an individual of unknown gender comes into a facility that the individual is pat searched by a female officer first. Based on the results of the pat search a determination of who shall conduct the strip search can be based on genitalia. She also suggested that there be rules on how these searches are done. Agencies should be careful about allowing the inmate to choose which gender will do the search. Have two officers present during the search to protect both the inmate and the officers. Kristi Dietz told the group that in Wisconsin they do these searches using a barrier with a camera on the officer, but not on the inmate.

Carrie again brought up the importance of definitions in policy development for strip searches. She brought up a 2011 decision in Byrd v Maricopa County Sheriff’s Department. In this instance female cadets were allowed to pat search male inmates in their boxer shorts, despite male officers being present at the officer’s station. The court ruled that while if the search were actually a pat search of a partially clothed inmate, it might have been reasonable. However, because Byrd was subjected to a cross-gender strip search while nearly nude, the search was patently unreasonable.

As a final issue, Carrie brought up the use of body scans, in the place of strip searches. The scans can detect contraband without the inmate having to remove his/her clothing. She personally likes the “Secure Pass Body Scanner” which was developed by medical people. The Bureau of Prisons is putting them in all of their facilities and other states are also using this technology. This process is less intrusive and does not require officers to touch the inmates.
Prison Rape Elimination Act (PREA)

Following the lunch break, Carrie Hill and Richard Kinney did a presentation on PREA and the new requirements, at the request of the participants. (Refer to Appendix IX pages 21-41.)

Overview - Carrie and Richard began their presentation by providing a brief overview of the requirements put forth in the PREA standards. Carrie mentioned that there have been some changes to the final draft of the standards that should be reviewed by agencies. There are several points that were made about the standards:

- There are four categories of facilities: adult prisons and jails were lumped together, and lock-ups, community confinement facilities and juvenile facilities placed in separate categories. Jail advocates had made an effort not to be in the same category as prisons, but to no avail.
- The standards may not “impose substantial additional costs compared to the costs presently expended by Federal, State, and local prison authorities”.
- There are several dates that are important to be aware of:
  - Effective date: August 20, 2012
  - Compliance date: August 2013
  - First audits (1/3 of facilities) will be completed by August 2014. They will start with the federal facilities.
  - All facilities must be audited by August 2016
- An increase in reported assaults may be the result of increased reporting on the part of inmates in the facility, rather than an increase in actual assaults.
- Language barring retaliation for reporting abuse should be part of any new policies and procedures.
- Meeting PREA standards may not be the highest standard to be set – it may not be enough to meet the constitutional minimum.

The presenters then tried to clarify the applicability of PREA standards to jails. Carrie pointed out that while the final standards do apply to jails, currently there is no financial penalty for noncompliance. However, unified systems, systems where the prison and jail systems are one entity, are subject to financial penalties for noncompliance. She also mentioned that penalties involve withholding federal money to states, that penalty could also trickle down to jails with states withholding money to counties.
Carrie when on to state that PREA is not mandatory in local jails and there is some potential that the courts could determine that Congress overstepped their bounds by applying the standards to local jails. It is also not clear what the implications of noncompliance in a jail that houses state inmates.

There were numerous comments and questions from the group. The participants noted that there is a lot of insecurity in the jail community, especially those jails that contract with their states to house state inmates. There was also a comment about the potential for counties to raise the per diem rates for state inmates to cover the cost of PREA. Another participant asked about jails that house parole violators and the state reimburses that agency to house the parolee. This could also extend to local jails that house federal inmates.

Danny Downes commented that on numerous occasions county jails testified before the commission asking not to be lumped together with prisons, but their arguments did not seem to make an impact. Carrie also testified before the Commission, right after the rape victims. Everyone representing the jail attempted to make the Commission understand the challenges of implementing PREA in jails, especially small jails. Denny Macomber commented that in Nebraska the state reimburses the jails as soon as an inmate is sentenced to prison. He was wondering about the implications of this practice. Carrie replied that as the inmate was already under the care, custody and control of the county it may not have the same implications as counties that house state inmates under contract with the state. However, she pointed out, the duty to protect inmates far exceeds PREA standards.

**Definitions** - Carrie then went over the definitions established in the standards. (Refer to Appendix XII.) The definitions are very specific and encompassing. She also discussed former inmates reporting their abuse after release.

Carrie went on to discuss the definition of sexual abuse. The definition has two categories: inmate on inmate abuse and staff on inmate abuse. She went over the definitions. The definition of staff on inmate abuse clarifies contact unrelated to official duties. The extensive definition also includes voyeurism. As the potential for inmates to claim voyeurism is high, Carrie recommended that jails install privacy screens for toilets and showers. Richard pointed out that sexual harassment is also considered abuse. He expressed his hope that all jails already have a sexual harassment policy. He also told the group that it is important that staff be aware of repeated acts of harassment by inmates. Carrie presented a list of steps that should be taken to prevent sexual abuse.
**PREA Coordinator v PREA Compliance Manager** - The discussion then turned to the requirements for a PREA Coordinator versus a PREA Compliance Manager. Carrie clarified that the Coordinator is no longer required to be a full time position; however, the designated Coordinator “must have sufficient time and authority to perform the required responsibilities”. She recommends that the coordinator be of a high rank and be someone within the jail. The PREA Compliance Manager position is used for agencies that have more than one facility. Each facility must have a designated Compliance Manager. This position does not need to be an upper management position, as is required for the Coordinator.

**Inmate Screening** - Carrie then went on to discuss the screening process for identifying inmates who may be at risk for abuse or be abusers. It is up to each agency to develop a screening form. She also emphasized that the inmates need to be aware of PREA. It should be explained in the inmate handbook, in an orientation video or any other method. If you have no other options, the agency can conduct a class with the inmates.

**Transgender and Intersex Inmates** - The next topic involved transgender and intersex inmates. Carrie made several points to the group regarding the screening and housing of transgender inmates.

- Housing and programming must be reviewed twice per year.
- They shall be allowed to shower separately from other inmates.
- Lesbian, gay, bisexual, transgender or intersex inmates may not be housed in dedicated housing unless it is court ordered.

Carrie then discussed the limits PREA has put on housing at risk inmates in protective custody (involuntary segregated housing). Inmates cannot be segregated unless there has been an assessment of available housing and no alternatives can be found. There were several comments from the participants regarding the feasibility of implementing this standard.

**Supervision and Monitoring** – Carrie pointed out that the standards allow for video monitoring of inmates, but never in lieu of actual supervision by staff. She pointed out that the language in the standards is rather “wishy-washy” regarding where you can and can’t place cameras. Two points were made regarding supervision requirements.

- Staff of the opposite gender must announce their presence when entering a unit.
• No staff should monitor a camera that is likely to view inmates of the opposite gender while they are showering, dressing, etc.

This information sparked discussion in the group regarding the feasibility of implementing this standard. There were several questions regarding opposite gender officers announcing themselves – would once at the beginning of a shift be sufficient or must they announce themselves each time they enter a unit? What about in direct supervision facilities, would this eliminate any cross gender supervision? Danny was asked to get clarification on this issue. There was also discussion on what “monitoring a camera” actually means.

**Staffing Levels** – Carrie told the group that the bottom line is that facilities can determine staffing levels based on their needs. There were no specific staffing ratios put forth in the standards. However, the standards do provide 11 factors to consider when facilities determine their staffing levels. There was concern that in states where the jail inspector’s determine staffing levels that there might be a conflict with PREA.

**Unannounced Rounds** - Carrie pointed out that PREA requires unannounced supervisory rounds. This is an effort to deter staff sexual abuse or harassment of inmates. The standards also prohibit staff members from letting coworkers know they are coming into a unit.

**Youthful Inmates** – Under the PREA standards any inmates under age 18 will be referred to as youthful inmates, they are no longer considered to be juveniles. Carrie informed the group that the standards do not forbid the placement of youthful inmates, who are under the supervision of an adult court, in adult prisons and jails. However, the standard imposes three requirements for housing youthful inmates in adult jails:

1. No youthful inmate may be placed in a housing unit where he or she will have contact with any adult.
2. Outside of housing units agencies must maintain “sight and sound” separation to prevent adults seeing or communicating with youth or provide direct staff supervision when youthful inmates and adults are together.
3. Agencies need to avoid placing youthful inmates in isolation and afford them daily large muscle exercise and access to special education services, and access to other programs and work opportunities.
This information spurred much discussion in the group. There were questions regarding why PREA did not incorporate the Office of Juvenile Justice and Delinquency Prevention (OJJDP) standards regarding confining juveniles in adult facilities. Richard commented on the conflict between PREA and OJJDP – in the summary DOJ had decided not to incorporate OJJDP standards. A comment was made that this was because there were no jail representatives on the PREA Commission. This standard was viewed as a major problem in states that routinely house juveniles being tried as adults in adult facilities and treats those juveniles as adults. Carrie commented that the conflicting laws and standards are going to be confusing to the courts.

**Searches** – Carrie opened the next section with the PREA definitions of pat searches, strip searches and exigent circumstances. She again emphasized that definitions matter. The standards ban cross-gender pat down searches of female inmates in adult prisons and jails. Small jails, with less than 50 beds, will have five years to comply with this standard. Exigent circumstances were defined as those situations that are “temporary or unforeseen”. Carrie pointed out that the PREA strip search definition does not incorporate the new Supreme Court definition and that agencies should use the Supreme Court language in their revised policies. The same for the language defining body cavity searches. Carrie went on to discuss cross gender strip searches. These too are forbidden except under exigent circumstances.

**Gender Nonconforming, Intersex or Transgender Inmates / Searches and Staff Training** - Carrie then addressed searching inmates who are “gender non-conforming”, intersex or transgender. She told the group to pay attention to the definition of “gender non-conforming” – defined to mean “a person whose appearance or manner does not conform to traditional societal gender expectations”. While the definition of “intersex” states “a person who’s sexual or reproductive anatomy or chromosomal pattern does not seem to fit typical definitions of male or female”. This is also referred to as hermaphroditic. In the case of transgender inmates the definition focuses on the inmate’s “gender identity (internal sense of feeling male or female) is different from the persons assigned sex at birth”. She advised the group to focus not as much on gender issues, but on the issue of safety and security of the inmate or other inmates, predator or prey.

PREA standards around the searching of this segment of the inmate population state that inmates can’t be searched for the sole purpose of defining the inmate’s gender. However, Carrie told the group that the inmate can be asked about gender or it can
be discovered as part of a routine medical exam. She feels that there is a lot of potential for litigation in these cases.

Carrie went on to tell the group that all staff must be initially trained on these issues with a refresher training every two years. She emphasized that this standard includes every facility and the initial training must be done by August 2014.

**Detecting and Reporting Sexual Abuse** – Carrie began this session by making the group aware of steps each facility must take to detect sexual abuse, educate their inmates about PREA and have a process for both external and internal reporting of sexual abuse. Policies must be in place to make inmates aware of the facility policies regarding a zero tolerance for sexual abuse and how to report abuse. This extends to inmates who do not speak English and those inmates with disabilities. Inmates should be oriented to this information during the intake process and they should attend a class or watch a video presentation on the subject within the first 30 days of incarceration. Carrie pointed out that the rules state that inmates who are currently incarcerated should receive this education within one year of the effective date of the PREA standards.

**PREA Audits** – Carrie began the last session discussing the audit process for PREA. She made several important points about the auditing process:

- Audits will be done every three years, with the initial audits completed by August 2016.
- There is currently no auditing instrument available.
- All auditors must receive training and be certified by DOJ. The training will be available on-line.
- The National PREA Resource Center is available to assist agencies at [http://www.prearesourcecenter.org/](http://www.prearesourcecenter.org/).
- There are three ratings in the audit – Exceeds standards, meets standards and does not meet standards (which requires corrective action).
- Individual states/governor will decide who does the audits. The auditor cannot be under the jurisdiction of the Sheriff, they must be an outside party.
- “Full compliance” can be achieved through compliance with all standards.
- Jurisdictions must differentiate between substantiated charges, allegations, and malicious (deliberately fabricated) allegations for reporting purposes.

Carrie provided a list of potential resources on the web. (Refer to Appendix IX page 41.)
There were numerous comments from the network members regarding these issues. Denny pointed out that jurisdictions must be careful where they receive their information regarding PREA. Richard reported that in New York allegations of sexual abuse increased dramatically after the standards were released. He cautioned the group to not be alarmed by this. Danny emphasized the importance of being proactive. One of the worst jails in the initial study, in terms of allegations of sexual abuse, turned things around when the director took charge of the situation. He cautioned the group to do as much as they can to not leave themselves exposed.

As the legal issues segment lasted until 3:15 p.m., several sessions on the agenda were tabled until the next meeting.

Surviving Hard Times: Marketing the Jail Inspection Process

Denny Macomber and Shannon Herklotz presented the last session of the meeting. They discussed strategies used in Nebraska to keep their agency afloat during severe budget cuts. (Refer to Appendix X for a copy of the PowerPoint presentation.) Denny began the session with an overview of the situation in Nebraska. Nebraska implemented jail standards in the 1980's. The jails in Nebraska enjoyed many years of good relationships with the inspectors, compliance with the standards, and collaborative problem solving when issues arose. However, several years ago the governor of Nebraska thought things were going so well he questioned the need for jail standards and the inspection process and proposed the elimination of the Jail Standards Division. The employees of the Division read about their potential elimination in the newspaper.

How Was the Jail Standards Division Saved?

Denny reviewed the process used by the Division to save their organization. First, they did a good job of marketing their services. They then elicited support from numerous groups to lobby on their behalf including: Nebraska Sheriff’s Association, Nebraska Association of County Officials, Nebraska Insurance and Risk Management Association, Nebraska County Attorneys Association, the ACLU and the Federal Prosecutor for the State of Nebraska. This support was essential in saving the Division.

Additionally, Denny reported they collected data regarding litigation in states without jail standards compared to states with jail standards. There were also people in the
state who looked at data comparing the money saved by cutting the Jail Standards Division and the cost of replicating those services.

Denny then made several points regarding strategies for marketing, providing products and services, cutting costs, and self promotion. He emphasized the importance of doing your job well, ensuring your product meets the needs of your consumer and networking. The Jail Standards Division runs the academy so he has the opportunity to meet everyone who works at a jail in Nebraska.

An additional tool the Division used was to emphasize the services provided to jails that they could not do on their own, e.g. monthly and annual reports on data collected in all of the state’s jails and providing assistance in problem solving (they don’t just inspect facilities but help solve problems). They also compiled information on the value provided for the dollars spent i.e. sharing a training facility, capital resources and expertise. Denny pointed out those jails that pass inspections get reduced insurance rates and reduced costs for litigation.

Denny also stressed the importance of self promotion. It is essential that agencies be available, that they evaluate everything to ensure they are meeting the needs of their consumers. He emphasized that who works in your organization does make a difference.

Denny then reviewed a list of basic marketing questions each agency should ask, e.g. what is our goal as a jail inspection agency, who are our core customers, etc. (Refer to Appendix X for a complete list.)

Finally, Denny went through a list of survival strategies:

- Know your customers
- Know what they need
- Conduct task analyses
- Build relationships
- Go to events – network
- Be innovative
- Create value
- Educate and foster learning
- Provide leadership – be a good person
- Be knowledgeable – know your stuff
Tim Thompson talked about the importance of attending state and national Sheriff’s Association and NACO conferences to get to know those people so you will have access when you need it.

Del Longley stressed the importance of getting legislative support for the inspection process.

Bill Wilson commented that the new governor in Virginia wants to cut the Board of Corrections and asked if he can have some of the data on litigation. Denny told him to look at newspaper articles at corrections.com or in law journals.

Denny closed the presentation by telling the group that 11 agencies were disbanded in Nebraska during cutbacks — the Jail Standards Division was the only agency to survive.

**Evaluation/Closeout**

Danny began the closeout session by passing out hotel evaluations. He tabled two presentations, Montana Update with Steve Metzger and the OJJDP Update with Richard Kinney and Tim Thompson, until the next meeting. He asked the group to please email him with recommendations for additional agenda items for the next meeting at d2downes@bop.gov. He can also be contacted through the Network Forum.

Danny then mentioned that one of the deputy directors approached him about opening the Forum to the deputy directors. He pointed out that the Forum hasn’t been very active recently. He felt that it might improve the Forum if more people were participating. Tim Thompson asked that the directors be given more time to make the Forum work. Gary Wion commented that the director’s need to remind each other to use the Forum, perhaps through monthly phone reminders. A suggestion was made to either allow Network members to access the Forum through email or, at a minimum, get email notices of postings on the Forum. There was a motion to allow deputy directors to become part of the Forum, it was seconded and passed.

Danny committed to starting work on development of a one day PREA workshop. He will work with Carrie Hill and Dee Halley (NIC PREA coordinator) on this project.
Finally, a suggestion was made for a topic for the next meeting: performance based standards – implementation, inspection and monitoring.

The meeting was adjourned.
APPENDICES
APPENDIX I

REVISED AGENDA
CHIEF JAIL INSPECTORS’ NETWORK

July 18-19, 2012
National Corrections Academy, Aurora, CO

Wednesday, July 18

8:00 am  Introduction and Overview .......................... Danny Downes
          NIC Information Center Overview .................. Susan Powell

8:30 am   NSA Update ............................................................... Denny Macomber

9:00 am   Jail Standards Update ........................................... Kathy Black-Dennis

9:30 am   Iowa, Minnesota and Indiana Standards/Inspections
          Delbert Longley
          Tim Thompson
          Ken Whipker

10:30 am  Federal Agency Update .................. Wolfgang Calvert/Patrick Cortez, USMS

12:00 pm  Lunch

1:00 pm   Federal Agency Update con’t

2:00 pm   Suicide Prevention ............................................ Lindsay M. Hayes

5:00      Adjourn

Thursday, July 19

8:00 am   Legal Issues ............................................................... Carrie Hill

12:00 pm  Lunch

1:00 pm   Prison Rape Elimination Act .................. Carrie Hill/Richard Kinney

3:30      Marketing/Survival Strategies ............... Denny Macomber/Shannon Herklotz

4:30      Evaluation/Closeout .......................... Danny Downes

5:00      Adjourn
CHIEF JAIL INSPECTORS’ NETWORK MEETING

INTRODUCTION AND OVERVIEW

NIC DIVISIONS

- Jails
- Prisons
- Community Corrections
- Academy
- Office of Offender Workforce Development
- Research and Evaluation
- Administration

NIC ASSISTANCE

- Training
- Technical Assistance
- Information Services

NIC is a small federal agency within the Department of Justice, Bureau of Prisons.

NIC was established to be the primary source of federal assistance to state and local correctional agencies.
HOUSEKEEPING

- Participant folder
  - Altitude awareness
  - Meals and hotel information
  - Cell phones
  - Smoking
  - Emergency data form
  - Name badge
- Schedule, Seating Arrangement, Breaks
- Participant list

PARTICIPANT INTRODUCTIONS

- Your name
- State, organization or area of authority
- How long have you worked in standards/inspections and/or law enforcement?

QUESTIONS?
APPENDIX III
PARTICIPANT LIST
National Institute of Corrections

Danny Downes
Adria Tafoya

FINAL PARTICIPANT LIST

12J2701

Chief Jail Inspector's Network Meeting

Aurora, Colorado

Wednesday, July 18, 2012 - Thursday, July 19, 2012
<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Position</th>
<th>Phone</th>
<th>Email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alves, Nelson</td>
<td>Auditor</td>
<td>508-279-3822</td>
<td><a href="mailto:nbalves@doc.state.ma.us">nbalves@doc.state.ma.us</a></td>
</tr>
<tr>
<td></td>
<td>Massachusetts Department of Correction</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>36 Dwinell Road</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Taunton, MA 2780</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calvert, Wolfgang</td>
<td>Sr. Inspector (GS-13)</td>
<td>202-307-9087</td>
<td><a href="mailto:wolfgang.calvert@usdoj.gov">wolfgang.calvert@usdoj.gov</a></td>
</tr>
<tr>
<td></td>
<td>US Marshals Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2604 Jefferson Davis HWY; CS-4 Suite 1100</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alexandria, DC 22301-1025</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Carson, Marilyn</td>
<td>Risk Management Safety Officer</td>
<td>302-272-2345</td>
<td><a href="mailto:Marilyn.Carson@state.de.us">Marilyn.Carson@state.de.us</a></td>
</tr>
<tr>
<td></td>
<td>State of Delaware</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>221 Tidbury Crossing</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Camden, DE 19934</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cortez, Patrick</td>
<td>Senior Inspector</td>
<td>202-527-2935</td>
<td><a href="mailto:Pedro.Cortez@usdoj.gov">Pedro.Cortez@usdoj.gov</a></td>
</tr>
<tr>
<td></td>
<td>United States Marshals Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2604 Jefferson Davis Highway, CS4-Suite 1100</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Alexandria, VA 22301</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dietz, Kristi</td>
<td>Director, Office of Detention Facilities</td>
<td>6082405052</td>
<td><a href="mailto:Kristi.Dietz@wisconsin.gov">Kristi.Dietz@wisconsin.gov</a></td>
</tr>
<tr>
<td></td>
<td>WI Dept of Corrections</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3099 E Washington Ave</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Madison, WI 53707</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Engen, Steven</td>
<td>Director of Staff Development</td>
<td>701-328-6652</td>
<td><a href="mailto:sengen@nd.gov">sengen@nd.gov</a></td>
</tr>
<tr>
<td></td>
<td>ND DOCR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3100 Railroad Ave</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Bismarck, ND 58501</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Title</td>
<td>Contact Information</td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td>--------------------------------</td>
<td>---------------------------------</td>
<td></td>
</tr>
<tr>
<td>Funk, Mike</td>
<td>Unit Manager</td>
<td>217-558-2200</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Illinois Department of Corrections</td>
<td><a href="mailto:mike.funk@doc.illinois.gov">mike.funk@doc.illinois.gov</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1301 Concordia Court</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Springfield, Illinois, IL 62794</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Herklotz, Shannon</td>
<td>Asst. Director of Inspections &amp; Jail Management</td>
<td>512-463-5505</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Texas Commission on Jail Standards</td>
<td><a href="mailto:shannon.herklotz@tcjs.state.tx.us">shannon.herklotz@tcjs.state.tx.us</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>300 W. 15th St., Suite 503</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Austin, TX 78711</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kinney, Richard</td>
<td>Deputy Director</td>
<td>518-485-2463</td>
<td></td>
</tr>
<tr>
<td></td>
<td>New York State Commission of Correction</td>
<td><a href="mailto:Richard.Kinney@scoc.ny.gov">Richard.Kinney@scoc.ny.gov</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>80 South Swan Street</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Albany, NY 12205-2467</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kishbaugh, Kay</td>
<td>Director</td>
<td>717-728-4057 - Work</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PA Department of Corrections</td>
<td>717-943-6762 - Cell</td>
<td></td>
</tr>
<tr>
<td></td>
<td>115 Yellow Breeches Drive</td>
<td><a href="mailto:kkishbaugh@pa.gov">kkishbaugh@pa.gov</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Camp Hill, PA 17011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Longley, Delbert</td>
<td>Chief Jail Inspector</td>
<td>515-725-5731</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Iowa Department of Corrections</td>
<td><a href="mailto:Delbert.Longley@iowa.gov">Delbert.Longley@iowa.gov</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>510 E. 12th St.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Des Moines, IA 50319</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Macomber, Denny</td>
<td>Chief</td>
<td>402-432-1034</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Nebraska Crime Commission</td>
<td><a href="mailto:dmacomber@radiks.net">dmacomber@radiks.net</a></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1444 North 37th Street</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lincoln, NE 68503</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Metzger, Steven
Sergeant/Training Officer
Yellowstone County Detention Facility
3165 King Avenue East
Billings, MT 59101
406-254-7923
smetzger@co.yellowstone.mt.gov

Nichols, Ralph
Director of Operations
State of Maine
111 State House Station
Augusta, ME 4333
207-287-4392
ralph.nichols@maine.gov

Ray, Howard
Executive Director
Maryland Department of Public Safety
Maryland Commission on Correctional Standards
115 Sudbrook Lane, Suite 200
Pikesville, MD 21208
410-585-3830
hray@dpscs.state.md.us

Thompson, Timothy
Program Manager
State of Minnesota
1450 Energy Park Drive - Suite 200
St. Paul, MN 55108
651-361-7147
timothy.thompson@state.mn.us

Vogel, Tom
Manager, County Jails Services Unit
MI Dept of Corrections
206 E. Michigan Ave., PO Box 30003
Lansing, MI 48846
517.373.4483
vogelta@michigan.gov

Whipker, Kenneth
Director
Indiana Dept. of Correction
302 W. Washington St Rm E334
Indianapolis, IN 46204-2738
317-232-5764
kwhipker@idoc.in.gov
Wilson, William 804-674-3499 ext. 1717
Local Facilities Supervisor
Virginia Department of Corrections william.wilson@vadoc.virginia.gov
6900 Atmore Drive
Richmond, VA 23225

Wion, Gary 9163241641
Deputy Director
corrections Standards Authority gary.wion@bscc.ca.gov
600 Bercut
Sacramento, CA 95691

Wood, Brandon 512-463-8236
Assistant Director
Texas Commission on Jail Standards brandon.wood@tcjs.state.tx.us
300 West 15th Suite 503
Austin, TX 78701
APPENDIX IV

ACA CORE JAIL STANDARDS
ACA's Core Jail Standards Focus on the Basics

By Rod Miller, CRS, Inc. and Connie Clem

The year 2010 brought a breakthrough in U.S. corrections with the introduction of new Core Jail Standards by the American Correctional Association (ACA). Until 2010, county jails could use ACA’s Performance Based Standards for Adult Local Detention Facilities (“ALDF standards”) to raise practices to a professional level. But jails did not have a national set of “minimum” jail standards that identified the conditions and practices required to operate a constitutional jail.

The new Core Jail Standards have been field tested and revised, and jails around the nation are already using them. At ACA’s summer conference in 2011, it was decided that jails will receive accreditation if they meet the new standards, changing an earlier policy that offered certification rather than accreditation.

ACA invited many corrections professionals to help develop the Core Jail Standards. The new standards are a distillation of their combined professional insight and expertise. Each contributor brought a unique perspective to the development process, and the Core Jail Standards have a different meaning to various stakeholders.

This article answers typical questions about how the standards were developed—from the point of view of one participant who was closely involved in the process from the very beginning.

• What are the Core Jail Standards?
• Why do we need jail standards?
• Why do we need the new Core Jail Standards?
• Who developed the Core Jail Standards?
• What makes a standard “core”?
• How do the Core Jail Standards compare to national and state standards?
• How were the Core Jail Standards field tested?
• How are agencies using the Core Jail Standards?
• What tools is ACA making available for jails that may seek certification on the Core Jail Standards?
What are the Core Jail Standards?

The Core Jail Standards are a new set of standards developed and maintained by ACA to address unmet needs in the detention field. They are a smaller offshoot of ACA’s full ALDF standards, which have provided the basis for ACA accreditation for many years.

Traditionally, ACA standards have been developed within a form and structure that responds to three primary criteria:

1. They must be *legally defensible*—providing guidance for jail operations at or above constitutional minimums established by the courts.

2. They must be *flexible*—allowing agencies to use varied ways to achieve compliance with the intent of each standard.

3. They must promote *advanced professional practice*—defining what *should* be done, not just what *must* be done.

The new Core Jail Standards encompass just the first two of these criteria, by focusing on minimum requirements to operate a constitutional jail. The ALDF standards extend further, to the third criterion of advanced practice; they exceed the minimum requirements comprised by most state jail standards and defined in court cases to measure the constitutionality of facilities and operations.

ACA’s ALDF standards have evolved over the past 40 years through four phases of development. (See Figure 1.)

**Figure 1. Evolution of ACA’s Standards for Adult Local Detention Facilities**

<table>
<thead>
<tr>
<th>ALDF, First Edition (1970s)</th>
<th>Standards are based on the experience of the field, as reflected in the practices of the Federal Bureau of Prisons.</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALDF, Third Edition (1990s)</td>
<td>Standards are updated based on new research wherever possible.</td>
</tr>
<tr>
<td>ALDF, Fourth Edition</td>
<td>Standards are translated into a performance-based template, shifting the focus to outcomes and</td>
</tr>
</tbody>
</table>
The Core Jail Standards are the first national set of minimum standards for guiding the operation of constitutional jails. They are a distilled version of the essentials in jail management.

The Core Jail Standards are especially useful for:

• Jails located in states that have no state jail standards;
• Jails whose states’ standards do not address all of the requirements for operating a constitutional jail; and
• Standards writers who want to have a reliable description of basic minimum requirements for operating a constitutional jail.

Why do we need jail standards?

There are three main reasons why jail standards are an important asset for jail leaders and managers.

1. **Jail standards establish the foundation for sound jail design and operation.** A jail’s policies and procedures translate professional standards into daily operations. Training prepares employees to implement these procedures and thereby run a constitutional jail. Ongoing employee supervision ensures consistent implementation of procedures and high levels of performance for the overall agency.

2. **Standards provide the basis for evaluating operations and measuring compliance.** Jail managers agree that jail standards increase professionalism, reduce liability, improve operations, and increase consistency of jail operations.

3. **Jail standards are relevant to jails of all sizes.** While larger jails often have more resources for responding to the challenges they face, smaller facilities must find ways to deal with the same issues. Standards help managers in any size jail to anticipate the problems that may occur and prepare responses in advance.

Why do we need the new Core Jail Standards?

In 2004, the working group that developed the fourth edition of ACA’s ALDF standards also identified the need for a set of national minimum jail standards. At that time, ACA published only its “professional” standards, including the ALDF and a separate set of standards for small jails. The ALDF standards are an indicator of professional excellence and are worthwhile to meet, but the 2004 ALDF working group acknowledged that it is not necessary for all jails to operate at that level. In the more than 40 years that the ALDF standards have been in existence, only 5% or less of the nation’s 3,200 jails have been accredited at any given time.
The working group recommended that ACA discontinue the small jail standards and replace them with minimum standards that could be used by jails of all sizes. The needed standards would incorporate essential elements of the ALDF standards, elements of states’ jail standards, and court-defined indicators of constitutional levels of operation.

Several factors illustrate both the need for standards and the difficulty of defining and encouraging a common, national level of jail professionalism and accountability.

• Only 32 states currently have any form of jail standards.
• Many states have only voluntary jail standards.
• In some states that have jail standards, the law does not give any agency enforcement powers or define a process for enforcement.
• Standards vary in scope and content from state to state.
• Some states have reduced their inspection and enforcement efforts in recent years in response to budget pressure.¹

The ALDF working group recognized that practitioners who have been working with the ALDF standards might consider the Core Jail Standards rudimentary. But more than 95% of the nation’s jails are not involved with ALDF accreditation—and it is these jails that are the primary audience for the Core Jail Standards.

Who developed the Core Jail Standards?

Dozens of stakeholders donated hundreds of hours of labor to create the Core Jail Standards. Contributors are recognized at the end of this article. They include the 2004 working group already mentioned. A 2008 team later worked very hard to produce an initial version of the Core Jail Standards. The standards were field-tested, and a 2009 working group completed a revised version.

ACA anchored the process, convening committees to draft the Core Jail Standards and providing staff support. To form the working groups, ACA Executive Director Jim Gondles asked the National Sheriffs’ Association (NSA) and American Jail Association (AJA) to designate committee members. This ensured that jail administrators from jails of all sizes, and sheriffs from a variety of counties, added their experience and expertise.

The National Institute of Corrections (NIC) funded travel to some meetings. In the home stretch, Federal Bureau of Prisons (BOP) Director Harley Lappin (now retired) personally chaired work sessions and brought BOP resources to the table. The ACA Standards Committee reviewed two drafts of the core standards before adopting them by a unanimous vote in August 2009.

¹ Florida eliminated state jail standards and enforcement efforts several years ago. In July 2011, the State of Ohio reduced its jail inspection bureau to a single employee.
What makes a standard “core”?

ACA’s performance-based ALDF standards were the starting point for drafting the minimum Core Jail Standards. The ACA Standards Committee required that the new core standards would be drawn from existing ALDF standards in order to reduce confusion in the field and to ensure consistency between the two ACA publications.

The 2008 working group adapted the content of the ALDF standards, distilling them to present the content that describes the operations and conditions that are necessary to operate a constitutional jail.

Each ALDF standard includes five components:

1. **A Performance Standard**—the condition to be achieved and maintained;
2. **Outcome Measures**—quantifiable data for evaluating the extent to which the desired condition has been achieved;
3. **Expected Practices**—specific actions and activities that should be implemented to reach compliance with the performance standard;
4. **Protocols**—written tools that provide direction to staff, such as policies, procedures, post orders, and training curricula; and
5. **Process Indicators**—sources of evidence that the expected practices are being properly and consistently implemented according to the protocols

An “expected practice” is similar to a traditional standard as they appeared before the standards were re-written in the performance-based format. The working group reviewed the “expected practice” language from each ALDF standard for its suitability to be carried over as a core standard—in whole, in part, or in principle.

An example of an ALDF standard is given in Figure 2.
Figure 2. Example of Performance-Based Standard: Contraband Control

<table>
<thead>
<tr>
<th>Performance Standard</th>
<th>2C. Contraband is minimized. It is detected when present in the facility.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome Measures</td>
<td>Incidents of contraband, ÷ ADP and weapons, substances Admits</td>
</tr>
<tr>
<td>Expected Practice</td>
<td>Procedures guide searches of facilities and inmates to control contraband.</td>
</tr>
<tr>
<td>Protocols</td>
<td>Written policy and procedure. Training curriculum.</td>
</tr>
<tr>
<td>Process Indicators</td>
<td>Records and logs. Inmate and staff interviews. Observation.</td>
</tr>
</tbody>
</table>

A 2009 memo\(^2\) described the process:

We examined each expected practice and tried to find the practice—or portion of a practice—that represented minimum requirements. One of our benchmarks was to ask, “Would a jail find itself in trouble with the courts if it did not comply with X practice?” As we applied this to each ALDF expected practice, we often found one or two sentences of an expected practice that hit the nail on the head. We extracted this language for use in the draft. We often found additional language that exceeded what we found to be a “minimum” requirement. In these cases we extracted the “core” language from the larger ALDF expected practice.

The memo went on to explain the process of extracting the core language from the broader ALDF expected practices.

We felt it was imperative to discard the higher-than-minimum language. We had all worked with practitioners who turned to the ALDF standards as a source of basic guidance but were quickly turned away by the language that exceeds minimum requirements. This is not a criticism of the ACA standards, but rather an acknowledgement that ACA has always promulgated the higher level of “professional” practice in its standards.

Figures 3 and 4 show how examples of how the Core Jail Standards relate to their ALDF counterparts.

---

\(^2\) Memo to Core Jail Standards Committee prior to March 2009 meeting. Rod Miller. February 25, 2009.
Reaching a consensus on what was “core” required tapping into the substantial experience evident around the table every time a committee met. Three other types of resources were always at the table:

1. The ALDF Standards, 4th Edition;
2. Mandatory minimum jail standards from several states; and
3. Caselaw, primarily from The Detention and Corrections Caselaw Catalog, summarizing more than 8,000 federal court decisions that address issues in detention and corrections.

**How do the Core Jail Standards compare to national and state standards?**

By definition, the Core Jail Standards are a subset of ACA’s broader professional ALDF standards. The core standards are not only shorter in form, they also address a narrower range of issues. There are only 138 expected practices in the Core Jail Standards, as compared with almost 400 expected practices in the current ALDF standards.

State standards vary widely in breadth and scope. Figure 5 illustrates the scope of the Core Jail Standards, the ALDF standards, and the range of state standards. This comparison uses two hypothetical state examples, one a state with basic standards (low scope) and the other with more ambitious standards (high scope).

**Figure 5. Scope of ALDF, Core, and Selected State Jail Standards**

States jail standards take different approaches with regard to:

- Scope of the standards (aspects of jail management and operation that are addressed);

---

3 Published by CRS, Inc., Gettysburg, Pennsylvania. The 20th and 21st editions were available in 2008 and 2009; the 22nd edition was released in 2010. Information at [http://www.correction.org](http://www.correction.org).
- Level of detail provided in the standards;
- Provisions for inspection; and
- Duty and authority to enforce compliance.

For example, Figure 6 compares the scope of the first draft of the Core Jail Standards to Michigan’s minimum standards for jails. With a total of 32 provisions, the Michigan jail standards are considered to have a very narrow scope. Several functional areas are not addressed at all by the Michigan standards.

**Figure 6. Comparison of First Draft of the Core Jail Standards to Michigan Minimum Standards for Jails**

<table>
<thead>
<tr>
<th>Functional Area</th>
<th>Number of Core Standards</th>
<th>Number of Michigan Counterparts</th>
<th>Percent of Core Standards Addressed by Michigan Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>20</td>
<td>14</td>
<td>70.0%</td>
</tr>
<tr>
<td>Security</td>
<td>37</td>
<td>5</td>
<td>13.5%</td>
</tr>
<tr>
<td>Order</td>
<td>1</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Care</td>
<td>40</td>
<td>12</td>
<td>30.0%</td>
</tr>
<tr>
<td>Program and Activity</td>
<td>12</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Justice</td>
<td>15</td>
<td>1</td>
<td>6.7%</td>
</tr>
<tr>
<td>Administration and Management</td>
<td>10</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>135</strong></td>
<td><strong>32</strong></td>
<td><strong>23.7%</strong></td>
</tr>
</tbody>
</table>

By contrast, the jail standards developed for use in Tennessee by the Tennessee Corrections Institute address a broader range of issues, providing 86 standards. Figure 7 shows how the issues addressed in Tennessee’s standards compare with the field test draft of the Core Jail Standards. (Different versions of the Core Jail Standards were used for these comparisons, with a different total number of standards.)
Figure 7: Comparison of Field Test Draft Core Jail Standards to Tennessee Jail Standards

<table>
<thead>
<tr>
<th>Functional Area</th>
<th>Number of Core Standards</th>
<th>Number of Tennessee Counterparts</th>
<th>Percent of Core Standards Addressed by Tennessee Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety</td>
<td>18</td>
<td>14</td>
<td>77.8%</td>
</tr>
<tr>
<td>Security</td>
<td>35</td>
<td>23</td>
<td>65.7%</td>
</tr>
<tr>
<td>Order</td>
<td>1</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Care</td>
<td>39</td>
<td>20</td>
<td>51.3%</td>
</tr>
<tr>
<td>Program and Activity</td>
<td>11</td>
<td>9</td>
<td>81.8%</td>
</tr>
<tr>
<td>Justice</td>
<td>16</td>
<td>11</td>
<td>68.8%</td>
</tr>
<tr>
<td>Administration and Management</td>
<td>11</td>
<td>8</td>
<td>72.7%</td>
</tr>
<tr>
<td>Total</td>
<td>131</td>
<td>86</td>
<td>65.7%</td>
</tr>
</tbody>
</table>

How were the Core Jail Standards field tested?

The first draft of the Core Jail Standards was field tested in 2008 in the U.S. Army disciplinary barracks at Fort Knox, Kentucky, leading to the facility’s accreditation. In May 2009, ACA asked Mackinac County, Michigan, to field test the final draft to provide insights to the ACA Standards Committee for its meeting in early August. Although the short time frame was daunting, Sheriff Scott Strait agreed to take on the challenge.

NIC assisted by sending former Hillsborough County, Florida, jail director David Parrish to Mackinac County to review the county’s preparations and identify deficiencies. His insights proved invaluable, and his encouragement gave Mackinac officials the confidence to finish the process. The county also received additional assistance from the NIC Information Center, the U.S. Army (which provided sample policies and procedures), and other sources.

By late July 2009, the county’s preparations were complete. ACA sent David Haasenritter, the head of the U.S. Army’s jail system, to conduct a formal audit. Mark Flowers, ACA’s standards and accreditation director, also participated in the audit.

Haasenritter opened the audit by warning Sheriff Strait and Jail Administrator Tim Ahlborn that even though it was only a field test, the audit would be taken seriously. According to Sheriff Strait, “He made
sure that we had done everything right. At the end of the two-day audit, it was clear that Mackinac County had made the grade.”

The Mackinac County jail formally received accreditation from ACA at the association’s annual conference in Nashville on August 10, 2009. At the accreditation hearing the day before, the five-member Commission on Accreditation panel had praised the county and thanked its representatives for advancing the profession by testing the standards on short notice.

The Core Jail Standards had been adopted the preceding Friday by the ACA Standards Committee. During testimony to the committee before its vote to adopt the standards, Sheriff Strait told members that he had been “looking for a road map” that would help him operate a safe, secure, and constitutional jail. Now that road map had arrived.

How are agencies using the Core Jail Standards?

The new standards apply to jails of all sizes. During their development, many larger jails had expressed a strong interest in the new standards and asked that ACA set no size limits for the application of the standards.

ACA officials decided to make the Core Jail Standards available to the field at no cost, with the hope that this would make them accessible to the counties that most needed the guidance they provide. (See note at the end of this article on how to obtain a copy of the Core Jail Standards.)

ACA also has developed a new, lower-cost audit process for accreditation using the Core Jail Standards. Costs to agencies are typically around $6,000 plus travel expenses for the auditors.

Any jail can use the Core Jail Standards for self- and peer audits of their jail facilities and operations. A self-audit form is also available for agency use.

Agencies are using the new standards in a variety of ways.

- Because state jail standards do not address all of the areas that pose liability, Michigan sheriffs and jail managers are developing a self- and peer-audit system that uses the core jail standards. The Michigan Sheriffs Association is exploring strategies for organizing a system of peer audits that would offer sheriffs and jail managers the opportunity to have their facilities and operations evaluated by an independent group of practitioners. NIC has provided technical assistance to the effort, which is being led by Sheriff Mike Lovelace in Marquette County.

- Tennessee officials were using the Core Jail Standards as a reference in a 2011 revision of the state’s jail standards.

- The Bureau of Indian Affairs has used the core standards as the foundation for jail guidelines that are being finalized in 2011 and will be applied in tribal jails.
Several other state governments have indicated that the core standards will be helpful as they to review and update their jail standards.

What tools is ACA making available for jails that may seek certification on the Core Jail Standards?

ACA is developing several new tools to help managers implement and comply with the Core Jail Standards.

- Outcome measures are being defined for each of the standards that will include a detailed explanation of each term and element.
- An Excel-based program will make it easier to deploy outcome measures and to use them to identify trends (see Figure 8).
- A compilation of federal court decisions that underpin the Core Jail Standards will help jail managers understand and communicate the related legal issues.
- A “how to” manual will explain the standards and provide guidance for agencies that want to move toward compliance.

Figure 8. Sample of Excel-Based Program for Outcome Measures
Conclusion

The jail profession has responded with interest to the Core Jail Standards. In 2010, NIC sent the Core Jail Standards to every city and county jail. The standards have found practical uses at the local level, providing jail managers with needed guidance. By late 2011, several jails had received certification or accreditation on the Core Jail Standards, and many more have begun working with ACA to prepare for accreditation reviews.

The Core Jail Standards are a good idea whose time has come. They represent a new paradigm for ACA, which continues to provide professional standards to all of the disciplines that comprise the field of corrections. While the ACA professional standards continue to evolve, for the first time, there’s something that has been proven helpful and accessible to all agencies. This will be of great benefit to jail leaders, jail workers, and jail residents throughout the country. We salute the working groups, the supporting agencies and organizations, and the pioneering jail jurisdictions that have been early adopters.

Resources

ACA has given permission for the author to share the Core Jail Standards with jails in an electronic format. A self-audit tool is also available. To request either of these files, contact Rod Miller at rod@correction.org.

About the Author

Rod Miller is the founder of Community Resource Services, Inc., a non-profit organization established in 1972 that provides services to clients at the local, regional, state, and national levels. Rod has authored many texts on such topics as staffing analysis, vulnerability assessment, jail planning and design, standards and jail inmate work programs. CRS, Inc., publishes the Detention and Corrections Caselaw Catalog and the Detention and Corrections Caselaw Quarterly. Rod can be reached at (717) 338-9100 or rod@correction.org. See www.correction.org for more details.
## Appendix A. Participants in the Core Standards Development Process

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>2000 ALDF Working Group</th>
<th>2008 Working Group</th>
<th>2009 Working Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Parrish, Hillsborough County, Florida</td>
<td>✓</td>
<td>Chair</td>
<td>Vice Chair</td>
</tr>
<tr>
<td>Harley Lappin, Director, Federal Bureau of Prisons</td>
<td></td>
<td></td>
<td>Chair</td>
</tr>
<tr>
<td>Sandra Bedea-Mueller, Ocean County Department of Corrections, New Jersey</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mark Fitzgibbons, Beaufort County Department of Corrections, South Carolina</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jerry Frey, Hampden County Sheriff's Dept., Massachusetts</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Steve Ingle, Executive Director, AYA</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Owen Quarnberg, Utah Sheriffs' Association</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tom Rosazza, Colorado Springs, Colorado</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blake Taylor, South Carolina Department of Corrections</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hal Wilbur, Broward County Dept. of Corrections, Florida</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>John Bittick, Sheriff, Monroe County, Georgia</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stanley Glanz, Sheriff, Tulsa County, Oklahoma</td>
<td>✓</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>David Goad, Sheriff, Alleghany County, Maryland</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Robert Hall, Grand Traverse County Sheriff’s Office, Michigan</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sid Hamberlin, Bonneville County Sheriff’s Office, Idaho</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Margo Hurse, Jackson County Detention Center, Missouri</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ted Kamatchus, Sheriff, Marshall County, Iowa</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mike Pinson, Arlington County Sheriff’s Office, Virginia</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gwyn Smith-Ingley, Executive Director, AJA</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Everette Van Hoesen, Sheriff, Kay County, Oklahoma</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jeffrey Beard, Secretary, Pennsylvania Dept. of Corrections</td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Ron Budzinski FAIA, Peoria, Illinois</td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>David Haasenritter, Army Review Board Agency</td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Jim Hart, Hamilton County, Tennessee and University of Tennessee technical assistance team</td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Jamie Haight, Federal Bureau of Prisons, Washington, D.C.</td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Virginia Hutchinson, Chief, NIC Jails Division, Washington, D.C.</td>
<td></td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>John May M.D., Armor Correctional Health Services, Florida</td>
<td></td>
<td>✔</td>
<td></td>
</tr>
</tbody>
</table>
### National Jail Exchange – http://NICIC.gov/NationalJailExchange

<table>
<thead>
<tr>
<th>Name</th>
<th>Affiliation</th>
<th>Role</th>
</tr>
</thead>
<tbody>
<tr>
<td>David Ward, Frederick County Sheriff’s Office, Maryland</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rod Miller, CRS, Inc., Gettysburg, Pennsylvania</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jim Gondles, Executive Director, ACA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mark Flowers, Director of Standards and Accreditation, ACA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jeff Washington, Deputy Executive Director, ACA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bob Verdeyen, Former Director of Standards and Accreditation, ACA</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


The National Jail Exchange is an ongoing electronic journal focusing on providing information to jails practitioners and is sponsored by the National Institute of Corrections (NIC). The contents of the articles, the points of view expressed by the authors, and comments posted in reaction to the articles do not necessarily reflect the official views or policies of the National Institute of Corrections.

To write an article or to learn more about the National Jail Exchange, visit the homepage for this journal at: [http://NICIC.gov/NationalJailExchange](http://NICIC.gov/NationalJailExchange).
Amends 210 IAC 3-1-1 to add new definitions to provide greater clarity throughout the administrative rule. Amends 210 IAC 3-1-2, concerning administration and organization, to provide clarification for jail management and level of supervision and to provide parameters for required written report. Amends 210 IAC 3-1-3 concerning fiscal management regarding the internal handling of monies. Amends 210 IAC 3-1-4 concerning jail personnel and the establishment of policies, including a code of ethics, that is to be provided to new employees. Amends 210 IAC 3-1-5, concerning staff training and development, to add a minimum of hours of documented training required of jail commanders in addition to the orientation and training needed prior to job assignment and required certified training. Amends 210 IAC 3-1-6, concerning management information systems and inmate records, to add new requirements for information that is to be obtained regarding the intake of an offender and make provisions for written procedures prior to the release of an offender. Amends 210 IAC 3-1-7, concerning physical plant, to add and update the minimum requirements for all inmate living, activity, and receiving areas in addition to new construction and renovations for adult detention facilities in order to bring them into compliance with applicable ACA standards. Amends 210 IAC 3-1-8 concerning the commissary. Amends 210 IAC 3-1-9, concerning safety and sanitation, to add provisions for maintenance of safety data sheets and necessary cleaning materials to be made readily accessible. Amends 210 IAC 3-1-10 concerning clothing, bedding, and personal hygiene. Amends 210 IAC 3-1-11 concerning medical care and health services. Amends 210 IAC 3-1-12, concerning diet and food preparation, to add time for review of diets, menus, kitchen facilities, and kitchen workers. Amends 210 IAC 3-1-13 concerning jail policies for security and control. Amends 210 IAC 3-1-14 concerning the supervision of inmates. Amends 210 IAC 3-1-15 concerning inmate rights. Amends 210 IAC 3-1-16, concerning mail and telephone communication, to add provisions for jail officials to monitor an offender’s incoming and outgoing mail correspondence and telephone communications. Amends 210 IAC 3-1-17, concerning written rules for discipline of inmates, to add rules of inmate conduct for the maintenance of order and discipline among inmates. Amends 210 IAC 3-1-18, concerning inmate classification, to add written procedures for overriding an inmate’s objective classification result to accommodate local needs. Amends 210 IAC 3-1-19, concerning new inmate admissions, to provide for the establishment of written procedures for the reception, orientation, release, or transfer of inmates. Adds 210 IAC 3-1-20 concerning suicide screening and prevention. Effective 30 days after filing with the Publisher.

IC 4-22-2.1-5 Statement Concerning Rules Affecting Small Businesses

210 IAC 3-1-1; 210 IAC 3-1-2; 210 IAC 3-1-3; 210 IAC 3-1-4; 210 IAC 3-1-5; 210 IAC 3-1-6; 210 IAC 3-1-7; 210 IAC 3-1-8; 210 IAC 3-1-9; 210 IAC 3-1-10; 210 IAC 3-1-11; 210 IAC 3-1-12; 210 IAC 3-1-13; 210 IAC 3-1-14; 210 IAC 3-1-15; 210 IAC 3-1-16; 210 IAC 3-1-17; 210 IAC 3-1-18; 210 IAC 3-1-19; 210 IAC 3-1-20

SECTION 1. 210 IAC 3-1-1 IS AMENDED TO READ AS FOLLOWS:

210 IAC 3-1-1 Definitions

Authority: IC 11-8-2-5; IC 11-12-4-1
AFFECTED: IC 11-8-2-1; IC 11-12-4-2

Sec. 1. Definitions. (a) "Administrative segregation" shall mean means the physical separation of inmates who are:
(1) determined to be mentally ill;
(2) escape prone;
(3) assaultive or violent;
(4) undergoing a disciplinary investigation; or
(5) likely to need protection from other inmates;

where such administrative segregation separation is determined to be necessary in order to achieve the objective of protecting protect the welfare of prisoners and staff.

(b) "Arrestee" means a newly detained inmate awaiting arraignment.

Comment [A1]: I believe it is imperative that the word “department” be changed throughout this document to “Office of the Sheriff”. Typically “department” refers to the IDOC.

Comment [A2]: Whereas some of the proposed standards may appear to more appropriate for a policy, it is essential to remember that no such mechanism exists for a policy type issue to be relied to all 92 counties. Jail standards may at times seem to appear more appropriate for policy, however this level of depth is often essential due to the turnover of sheriffs as a result of term limits,
(c) "Bed" means a permanently installed fixture used for sleeping that is elevated at least twelve (12) inches off the floor.

(d) "Chronic care" shall mean medical service rendered to an inmate over a long period of time, i.e., for example, the treatment of:
   (1) diabetes;
   (2) asthma; or
   (3) epilepsy.

(e) "Commissioner" means the chief executive of the department.

(f) "Contraband" shall mean property the possession of which is that, if in possession, is a violation of an Indiana or federal statute.

(g) "Convalescent care" shall mean medical service rendered to an inmate to assist in the recovery from illness or injury.

(h) “Department” means the department of correction established under IC 11-8-2-1.

(i) "Director, detention services" means the staff member appointed as the commissioner's designee and agent who shall do the following:
   (1) Supervise the jail inspectors.
   (2) Oversee the inspection of all jails.
   (3) Ensure reports are properly prepared and distributed.
   (4) Provide technical assistance to counties upon request.

(j) "Disciplinary segregation" shall mean that status means the assigned status of an inmate, as a consequence or means of control resulting from a violation of jail rules, which consists of confinement in a cell, room, or other housing unit separate from inmates who are not on disciplinary segregation status.

(k) "Disturbance" means any unauthorized inmate activity that disrupts the normal operation of a jail.

(l) "Emergency care" shall mean care for an acute illness or unexpected health care need that cannot be deferred until the next scheduled sick call or physician's visit.

(m) "Indigent" means any inmate with a balance of less than fifteen dollars ($15) in his or her inmate trust account during the preceding thirty (30) days or sixty (60) days thereafter. How do the courts define this term? What happens if the inmate gets $15 on the 55th day?

(n) "Inmate" shall mean any person detained or who is confined in any jail governed by these rules.

(o) "Inspection" means an on-site visit to a jail by an inspector serving as an agent of the commissioner.

(p) "Jail" shall mean any secure county operated or privately contracted detention facility used to confine prisoners prior to appearance in court and sentenced prisoners. Inmates.

(q) "Jail administrator", unless expressly stated otherwise, shall mean a sheriff or other individual who has been assigned, designated, or delegated full-time responsibility and authority for the administration and operation of the jail by the sheriff.

(r) "Jail officer" shall mean a sheriff's employee whose primary duties are the daily or ongoing supervision of jail inmates.

(s) "Major disturbance" means a disruption in the normal operation of the jail that threatens:
   (1) staff control of the inmates; or
(2) the safety or security of the jail.

(t) "Medically trained personnel" means those jail staff trained to perform a specific medical function that does not require an independent medical judgment.

(u) "Medical preventive maintenance" shall mean those health services including health education, medical services, and instruction in self-care for chronic conditions.

(v) "Notice of noncompliance" means the report prepared and distributed by the jail inspector, which shall be deemed as statutory notice of noncompliance in accordance with IC 11-12-4-2.

(w) "Obscene materials" means material that, to the average person when applying contemporary standards, appeals to the prurient interest, which depicts or describes sexual conduct that, when taken as a whole, lacks serious literary, artistic, political, or scientific value. The term is defined at IC 35-49-2-1. IC 11-11-3-6 provides "in the case of a confined adult, the department may not exclude printed matter on the grounds it is obscene or pornographic unless it is obscene under Indiana law.

(x) "Operational capacity" means the total number of rated beds within a jail, including those located in temporary holding areas such as the following:
   (1) Booking.
   (2) Segregation.
   (3) Medical.

(y) "Overcrowding" means the total number of inmates exceeds the rated bed capacity of a jail.

(z) "Policy" shall mean a statement declaring the following:
   (1) Mission.
   (2) Purpose and ideological position.

(aa) "Procedure" shall mean a statement establishing the action plan to accomplish the policy.

(bb) "Prohibited property" shall mean property, other than contraband: that
   (1) the Jail Administrator sheriff does not permit an inmate to possess;
   (2) that exceeds the quantity authorized property; or
   (3) that is the personal or authorized property of another inmate.

Property that an inmate is otherwise permitted to possess may become prohibited property if it has been altered or due to the means by which it is possessed or used.

(cc) "Physician" shall mean an individual holding a license to practice medicine in Indiana issued by the medical licensing board of Indiana.

(dd) "Publishers only rule" means the material mailed to an inmate directly from the publisher, distributor, or an accredited institution of higher learning.

(ee) "Qualified medical personnel" shall mean individuals engaged in the delivery of a medical or health care service who have been licensed, certified, or otherwise properly qualified under the laws of Indiana applicable to that particular service.

(ff) "Rated bed capacity" means the total number of permanently installed beds.

(gg) "Secured perimeter" means that portion of a jail in which inmates are secured and inmate movement is
controlled by staff.

(hh) "Strip search" means the purposeful observation of the unclothed body, based on reasonable suspicion, solely for the purpose of:
(1) detecting contraband; or
(2) deterring the introduction of contraband into the jail.

(ii) "Temporary holding" means the status assigned to the following:
(1) Newly admitted inmates.
(2) Inmates in padded cells and detoxification cells.

(jj) "Unusual occurrence" shall mean any significant incident or disruption of normal jail procedures, policies, routines, or activities, such as the following:
(1) A fire.
(2) A riot.
(3) A natural disaster.
(4) A suicide.
(5) An escape.
(6) An assault.
(7) A medical emergency.
(8) A hostage taking. 
(9) Any other violation of jail rules or state laws.

(Department of Correction: 210 IAC 3-1-1; filed Jul 27, 1981, 10:30 a.m.: 4 IR 1808; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RF-4)

SECTION 2. 210 IAC 3-1-2 IS AMENDED TO READ AS FOLLOWS:

210 IAC 3-1-2 Administration and organization

Authority: IC 11-8-2-5; IC 11-12-4-1
Affected: IC 11-12-4-1

Sec. 2. Administration and Organization. (a) Each jail shall be managed by a single jail administrator, supervised by the sheriff, to whom all employees or units of management are responsible.

(b) Each Jail Administrator sheriff shall prepare annually and submit, not later than March 31 after the conclusion of each calendar year, a written report setting forth the annual statistical data and the extent and availability of services and programs to inmates and identifying major events that have occurred in the jail and unfunded operational needs. The report shall be directed to the circuit court judge, and copies shall be provided to the state jail inspector, president of the county council or city-county council, prosecutor, and president of the County board of commissioners. The report shall also be provided to the county auditor and be maintained as a public record. At a minimum, the report shall include the following:
(1) The total number of beds.
(2) The total number of bookings with at least the top ten (10) identified by offense.
(3) The average daily inmate population.
(4) The total number of jail and in-custody deaths by type (suicide, natural causes, homicide) with a summary of each occurrence.
(5) The number of escapes, with a summary of each occurrence.
(6) The total number of juveniles booked into the jail via waiver or direct file.
(7) The availability of services provided at the jail.
(8) A statement on the adequacy of jail staffing levels with major deficiencies identified.
(9) A statement on the maintenance and upkeep of the jail, with major deficiencies identified.
(10) Unfunded needs and projects essential to jail operation and maintenance.

(c) Each sheriff shall develop and maintain a manual of policies and procedures which that shall guide the operation of the jail. This manual shall be jail property. All policies and procedures must be in writing and bear the
signature approval of the sheriff. The sheriff shall encourage the participation of other community agencies in the development of policy for the jail through coordinated planning and interagency consultation. The advice and consultation of the sheriff's staff should also be sought in the development of policies and procedures for each jail. The manual shall be revised and updated as needed, reviewed annually, and distributed documented with the sheriff's signature page in the manual. The manual shall be made available to all employees. It shall include, but not be limited to, the following:

1. Statement of the:
   A. Mission;
   B. Philosophy;
   C. Goals; and
   D. Purposes;

2. Operations and maintenance of the jail.

3. Organizational structure of the jail, its staff and program with grouping of similar functions, services and activities into administrative sub-units; structure of the jail.

4. Delineation of channels of communication.

5. A procedure for the monitoring of operations and programs through required inspections and reviews.

6. A system of written reports to be directed to the sheriff or jail administrator, at the sheriff's request, regarding the normal operation of the jail, including, as at a minimum, the following:
   A. Information on major development.
   B. Serious incidents.
   C. Population data.
   D. Staff and inmate morale.
   E. Major problems and proposed plans to resolve them.

7. Staff training and professional development.

8. Staff-inmate communications and interactions.

9. Staff-inmate communications and interactions.

10. (Department of Correction; 210 IAC 3-1; filed Jul 27, 1981, 10:30 a.m.: 4 IR 1809; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

SECTION 3. 210 IAC 3-1-3 IS AMENDED TO READ AS FOLLOWS:

210 IAC 3-1-3 Fiscal management

Authority: IC 11-8-2-5; IC 11-12-4-1

Affected: IC 11-12-4-1

Sec. 3. Fiscal Management. (a) Each sheriff shall establish written procedures to govern the internal handling of monies. All such procedures shall be consistent with all requirements of the State Board of Accounts and state law.

(b) Each sheriff shall maintain fiscal records which will clearly indicate the annual costs for his county's jail. Any such records shall reflect all monies collected and disbursed during any budget period and shall be established in compliance with all requirements of the State Board of Accounts.

(c) Each sheriff shall prepare and present annually a budget request to the appropriate government funding body. The jail budget request should accurately reflect the needs and objectives of the subject facility.

(d) Each sheriff shall maintain a written inventory of county jail property. The inventory shall be reviewed and updated annually. (Department of Correction; 210 IAC 3-1-3; filed Jul 27, 1981, 10:30 a.m.: 4 IR 1809; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

SECTION 4. 210 IAC 3-1-4 IS AMENDED TO READ AS FOLLOWS:

210 IAC 3-1-4 Personnel

Authority: IC 11-8-2-5; IC 11-12-4-1
Sec. 4. Personnel. (a) Each sheriff shall establish written jail personnel policies and procedures that include a code of ethics, and a copy shall be provided to each new jail employee. (Department of Correction; 210 IAC 3-1-4; filed Jul 27, 1981, 10:30 a.m.; 4 IR 1810; readopted filed Nov 15, 2001, 10:42 a.m.; 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

SECTION 5. 210 IAC 3-1-5 IS AMENDED TO READ AS FOLLOWS:

210 IAC 3-1-5 Training and staff development
Authority: IC 11-8-2-5; IC 11-12-4-1
Affected: IC 11-12-4-1

Sec. 5. Training and Staff Development. (a) Each sheriff shall establish a written training and staff development plan for all jail employees. This plan shall be:

(1) based on the jail's manual of policies and procedures; it shall be and

(2) evaluated and revised as needed annually.

(b) Each new jail officer shall receive forty (40) hours of orientation and training at the jail prior to job assignment, and shall receive:

(1) A minimum of eighty (80) hours of orientation and training at the jail prior to job assignment, and shall receive

(2) An additional forty (40) hours certified training during the first year of employment. Each jail officer shall receive documented training each year thereafter.

The forty (40) hours of certified training during the first year of employment shall be received through the Indiana law enforcement training board. Each jail officer shall receive necessary training each subsequent year to ensure compliance with these standards.

(c) In addition to the training required in subsection (b), each jail commander shall receive a minimum of twenty-four (24) hours of documented training each calendar year. (Cost to be addressed)

(d) All personnel authorized to use firearms shall be trained in weaponry on a continuing in-service and documented firearms training course. Failure to qualify for continued firearm use shall be deemed just cause for administrative reevaluation or dismissal.

(1) No employee shall be authorized by the sheriff to use firearms unless that employee has been given training in the legal requirements of firearm use and the legal aspects of the use of deadly force.

(2) Detailed training records are required and shall be maintained on all firearms training.

(e) Each sheriff shall include training as a budget item in his jail's annual budget request to pay for this required training.

(f) A training file shall be maintained for each jail employee. (Department of Correction; 210 IAC 3-1-5; filed Jul 27, 1981, 10:30 a.m.; 4 IR 1810; readopted filed Nov 15, 2001, 10:42 a.m.; 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

SECTION 6. 210 IAC 3-1-6 IS AMENDED TO READ AS FOLLOWS:

210 IAC 3-1-6 Management information systems and inmate records
Authority: IC 11-8-2-5; IC 11-12-4-1
Affected: IC 11-12-4-1

Sec. 6. Management Information Systems and Inmate Records. (a) An intake form shall be completed for every inmate admitted to any county jail. Such the form shall contain, but is not limited to, the following information, unless otherwise prohibited by statute:

(1) Booking number.
(2) Date and time of intake.

Comment [A5]: This training is provided on the job, thus no additional cost to the county should be incurred.

Comment [A6]: Not sure how to adequately address this question. There are several ways to obtain the needed continuing education prescribed. It could be satisfied via correspondence courses, participation in regional meetings, etc.
(3) Name and aliases.
(4) Last known address.
(5) Date and time of commitment and authority therefor.
(6) Name, title, and signature of delivering officer.
(7) Specific charge or charges.
(8) Physical description, including any scars, marks, or tattoos.
(9) Mug shot and fingerprints.
(10) Sex.
(11) Age and date of birth.
(12) Place of birth.
(13) Race.
(14) Occupation.
(15) Name and address of last place of employment; employer.
(16) Health status.
(17) Name and relationship of next of kin.
(18) Address of next of kin.
(19) Court and sentence.
(20) Notation of cash and personal property. and
(21) Space for remarks to include Notation of any:
(A) open wounds; of
(B) sores requiring treatment;
(C) evidence of disease or body vermin; or tattoos.
(D) tattoos.
(22) Name of health insurance carrier.
(23) Name of primary care physician.
(24) Education level, to include the name and location of last school attended if no high school diploma.
(25) Prior commitments.
(26) Nationality or citizenship.
(27) Social Security number, and if any Social Security benefits are currently being received.

(b) Records shall be maintained on all inmates committed or assigned to any county jail. Such the records shall contain, but are not limited to, the following:
(1) Intake information.
(2) Commitment papers and court order or orders.
(3) Cash and personal property receipts.
(4) Reports of disciplinary actions or unusual occurrences.
(5) Work record.
(6) Program involvement. and
(7) Medical orders issued by the jail physician or his or her designee.

(c) Each sheriff shall do the following:
(1) Maintain on a daily basis written data concerning population movement, including but not limited to, the following:
   (A) Admission.
   (B) Processing.
   (C) Release of pretrial detainees and sentenced inmates.
(2) Each sheriff shall (2) Establish a written procedure requiring the prompt reporting of all incidents that:
   (A) result in physical harm;
   (B) threaten the safety of any person in the jail; or
   (C) threaten the security of the jail.
(3) Each sheriff shall (3) Establish written policies and procedures regarding access to and release of inmate records. Such The policies and procedures shall ensure that inmate records are current, accurate, and safeguarded from unauthorized and improper disclosure.

(d) An inmate's medical record file shall not be in any way part of the confinement record.
(e) Each sheriff shall establish a written procedure requiring that, prior to the release of any offender, the jail staff shall:

1. perform an IDACS and NCIC search; or
2. contact the department to determine whether:
   A. the offender is currently under the department’s jurisdiction; or
   B. there are any other outstanding wants or warrants for the offender.

(Department of Correction; 210 IAC 3-1-6; filed Jul 27, 1981, 10:30 a.m.; 4 IR 1810; readopted filed Nov 15, 2001, 10:42 a.m.; 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.; 20070725-IR-210070277RFA)

SECTION 7. 210 IAC 3-1-7 IS AMENDED TO READ AS FOLLOWS:

210 IAC 3-1-7 Physical plant
Authority: IC 11-8-2-5; IC 11-12-4-1
Affected: IC 11-12-4-1

Sec. 7. Physical Plant. (a) All inmate living and activity areas in each jail shall provide for the following minimum requirements:

1. Illumination shall be sufficient for reading and writing throughout the living area. Readings of at least twenty (20) foot-candles are required at desk level and in grooming areas.
2. Circulation of fresh air sufficient to remove stale air and odors from the living area. This requirement shall be satisfied if the County Board of Health certifies jail inspector documents, per ACA standards, that the air in the living area is not harmful to the inmates, provides sufficient cubic feet of air per minute per inmate.
3. A heating system sufficient to ensure healthy and comfortable living and working conditions for all inmates and staff. Temperatures shall be maintained at a comfortable level, consistent with exterior conditions, clothing and bedding issued, acceptable with ACA standards’ quality of life. Define ACA and which standards.
4. Each cell shall have direct access to the following:
   A. A toilet.
   B. A washbasin with hot and cold running water.
   C. A bunk.
5. There shall be at least one (1) toilet and one (1) shower per twelve (12) male inmates and per eight (8) female inmates. This requirement shall be satisfied as to toilet access if cells are accessible to the inmates at all the time.

(b) The reception inmate receiving area shall be located inside the security perimeter but outside inmate living quarters and have the following minimum components:

1. Weapon lockers, located outside the security area.
2. A temporary holding space which has the following:
   A. Sufficient seating capacity for all inmates assigned.
   B. Audio and visual communication.
   C. Available toilets and washbasins with hot and cold running water.
3. A booking area, with CCTV camera recording.
4. A medical examination area.
5. Shower facilities.
6. A vault or Secure area for storage of inmate’s personal property.
7. Telephone facilities.

(c) To provide security and assure compliance with fire safety regulations, Supply areas shall be separate from inmate living and activity areas and kept secured when not in use. There shall be adequate space for the following:

1. Storage and security of keys.
2. Weapons.
3. Medications.
4. Tools.

Comment [A7]: Add definition: ACA = American Correctional Association
I recommend this be changed to read “64-84 degrees” consistent with (and then add the deleted language back in).

Comment [A8]: This is no change from existing standards, thus there is no additional costs.

Comment [A9]: Change back to 1:12 ratio and there will be no additional costs to the county.

Comment [A10]: Approx cost is $500.00 to add and program a camera.
(5) Evidence.
(6) Recovered stolen property.
(7) Bedding.
(8) Housekeeping equipment and supplies.
(9) Clothing.
(10) Prisoner's property.
(11) Commissary and hygiene items. and
(12) Records.

(d) Arsenal Weapons storage shall be located outside the security perimeter of the inmate living and activity areas. Provisions shall be made for the secure storage, care, and issuance of weapons and related security equipment. The arsenal shall be equipped with an alarm system.

(e) Each jail shall have the following:
   (1) At least one (1) area suitable for inmates who must be under special medical supervision, which shall include a negative airflow system for the control of communicable disease. [cost to be addressed]

(4) Each jail shall have (2) A space available for the supervision of offenders who represent special behavioral problems including intoxication and self-destructive behavior. This area shall:
   (A) be equipped with audio-video communication; and
   (B) have access to toilet facilities and running water.

(1) There shall be (3) One (1) bed for each inmate, and the capacity of a jail shall be determined with the sheriff taking into consideration the following factors:
   (A) A bed for each inmate.
   (B) The size of the cell or sleeping area.
   (C) The size of the day room or range to which the prisoner has free access during nonsleeping hours.
   (D) Time spent in activities out of the cell and/or time spent out of range.

(f) The state jail inspector may adjust the rated capacity of any jail in the event that if there is a change in the physical plant structure, or the use of the facility indicates that such indicates a change would be appropriate. Prior to any adjustment in the physical plant standards not in effect at the time of this article, with the exception of those standards listed in subsection (h). New or revised ACA standards shall be adopted without amending this article. Counties shall not be held to physical plant standards not in effect prior to the construction of their jail except as may be ordered by the courts or statute. However, renovation of an existing jail must bring the jail into compliance with applicable ACA standards for the area under renovation. The state jail inspector shall will review the proposed adjustment with the sheriff and the County Commissioners prior to any adjustment in the facility's rated capacity.

(g) All major jail construction, renovations, or additions beginning January 1, 1982 after the effective date of this article shall comply with the most current jail construction standards established by the American Correctional Association (ACA) for Adult Local Detention Facilities, 4th Edition, and any subsequent changes in effect prior to the effective date of this article, with the exception of those standards listed in subsection (h). New or revised ACA standards shall not be adopted without amending this article. Counties shall not be held to physical plant standards not in effect prior to the construction of their jail except as may be ordered by the courts or statute. However, renovation of an existing jail must bring the jail into compliance with applicable ACA standards for the area under renovation. Incorporate by reference – use proper form. See Pages 77-78 of Rule Drafting Manual. Cost to be addressed. This just spells it out in writing.

(h) The following physical plant standards are applicable to all new construction, additions, or renovations after the effective date of this article. [Address costs]

(1) There shall be a toilet in, or adjacent to, all indoor exercise areas.
(2) All cells may be multiple occupancy, providing there is at least thirty-five (35) square feet of space per inmate. In dormitories, there shall be at least fifty (50) square feet of total space per inmate.
(3) Natural light shall be provided in any temporary holding area designed to hold inmates longer than seventy-two (72) hours.
(4) Detoxification cells shall have fixed seating elevated not less than twelve (12) inches from the floor. There shall be a water hose connection adjacent to this area accessible by staff only.
(5) All cellsblocks shall have at least one (1) floor drain.
(6) There shall be no unsecured opening greater than five (5) inches in the secured perimeter of the jail.
(7) Sight separation of male and female inmates is required except for incidental contact.
(8) Video visitation is authorized.
(9) Collapsible devices shall be used in cells to suspend clothing. Clothing hooks may not be used.
(10) CCTV cameras shall be placed in:
   (A) all inmate day rooms;
   (B) all temporary holding cells;
   (C) all booking areas;
   (D) the intoxilizer room; and
   (E) all isolation cells.

   to assist staff in the supervision and control of inmates. The privacy rights of inmates shall be observed in toilet and shower areas. CCTV equipment shall serve as a supplement to, not a substitute for, staff supervision.

   (i) Each sheriff shall have a written plan for preventive maintenance. The plan shall be reviewed annually and updated as needed. (Department of Correction; 210 IAC 3-1-7; filed Jul 27, 1981, 10:30 a.m.: 4 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

SECTION 8. 210 IAC 3-1-8 IS AMENDED TO READ AS FOLLOWS:

210 IAC 3-1-8 Commissary

Authority: IC 11-8-2-5; IC 11-12-4-1

AFFECTED: IC 11-12-4-1

Sec. 8. Commissary. (a) Each jail provides inmate commissary services, it shall be managed and operated in a manner consistent with Indiana law. (Department of Correction; 210 IAC 3-1-8; filed Jul 27, 1981, 10:30 a.m.: 4 IR 1269; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

SECTION 9. 210 IAC 3-1-9 IS AMENDED TO READ AS FOLLOWS:

210 IAC 3-1-9 Safety and sanitation

Authority: IC 11-8-2-5; IC 11-12-4-1

AFFECTED: IC 11-12-4-1

Sec. 9. Safety and Sanitation. (a) Each jail shall be maintained in a safe and sanitary condition in compliance with state and local health, sanitation, safety, and fire laws.

   (b) Inmates incarcerated in each jail shall have the responsibility for maintaining their own cells and living areas in a safe and sanitary condition. Jail officials shall make necessary cleaning equipment including mops, brooms, cleaning cleanser, soap and disinfectant, available materials shall be provided to inmates on a daily basis to assist inmates in meeting their cleaning responsibility, and as needed.

   (c) Each All areas of a jail shall be inspected by a designated jail official at least once per week. Each living area shall be inspected by designated jail officials daily. Written inspection reports shall be maintained, and steps shall be taken promptly to remedy unsafe or unsanitary conditions.

   (d) Each jail shall be inspected monthly by a licensed exterminator for evidence of insects and rodents. Licensed extermination services shall be obtained to spray or treat facilities as often as necessary to eliminate insects and rodents. Inmates shall be removed from an area if spraying or fogging is necessary and cannot properly be accomplished if inmates are present.

   (e) Faulty plumbing fixtures shall be promptly repaired or replaced as may be necessary. After receipt and confirmation of a report of malfunctioning equipment.

      (1) Exits shall be:
      (2) clearly marked;
      (3) continuously illuminated;
      (4) kept clear of obstructions; and
      (5) in usable condition.
(g) The sheriff shall do the following:
(1) Establish a written evacuation plan for use in the event of fire or major emergency. Appropriate evacuation instructions shall be posted maintained in all living and working areas of each jail, the main control room and all satellite control rooms. Staff fire drills shall be conducted as required by the state fire marshal and the results of each drill documented.

(h) The sheriff shall (2) Request that the local board of health inspect the jail at least semi-annually annually.

(i) Material safety data sheets for all caustic, toxic, or flammable materials shall be maintained in the control room; 210 IAC 3

(0) Each inmate shall be provided with items necessary to maintain personal hygiene. Shaving materials soap, toothbrush, and toothpaste. Industrial hand soap shall not be issued to inmates. Women available at least three (3) times per week unless the inmate poses a security, safety, or suicide risk. Female inmates shall be provided with choice of tampons or personal sanitary supplies. Items to maintain personal hygiene.[costs to be addressed]

(c) Inmates shall:
(1) shower and shampoo his or her hair upon admission to the jail's general population; and shall
(2) be afforded the opportunity to shower at least three (3) times per week thereafter unless an emergency or a threat to jail security exists.

(d) Each inmate shall be:
(1) allowed, upon request, to have his or her hair cut at least once every six (6) weeks at his or her own expense; and
(2) All inmates shall be provided the opportunity to wear their personal clothing when they appear in court for a jury trial.

(e) The sheriff may supervise and control the hygiene, grooming, and attire of jail inmates to the extent reasonably necessary to maintain a sanitary, safe, and secure environment. The sheriff shall reserve the right, with reasonable cause, to order an inmate's hair be cut by a licensed barber or beautician in order to maintain a sanitary and secure living and work environment. (Department of Correction; 210 IAC 3-1-10; filed Jul 27, 1981, 10:30 a.m.: 4 IR 1812; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

SECTION 10. 210 IAC 3-1-10 IS AMENDED TO READ AS FOLLOWS:

210 IAC 3-1-10 Clothing, bedding, and personal hygiene

Sec. 10. Clothing and Personal Hygiene. (a) Each jail shall provide for the issue of clean, suitable clothing, bedding and towels. Linen, a towel, and a sleeping mat to each new inmate. Each inmate shall be provided adequate material and disinfectant to cleanse his or her sleeping mat prior to transfer or release. Jail clothing bedding and towels shall be laundered at least monthly. All clothing and bedding shall be maintained in serviceable condition, and in sufficient number quantity to supply each jail's inmate population.

(b) Each inmate shall be provided with items necessary to maintain personal hygiene. Shaving materials soap, toothbrush, and toothpaste. Industrial hand soap shall not be issued to inmates. Women available at least three (3) times per week unless the inmate poses a security, safety, or suicide risk. Female inmates shall be provided with choice of tampons or personal sanitary supplies. Items to maintain personal hygiene.[costs to be addressed]

(c) Inmates shall:
(1) shower and shampoo his or her hair upon admission to the jail's general population; and shall
(2) be afforded the opportunity to shower at least three (3) times per week thereafter unless an emergency or a threat to jail security exists.

(d) Each inmate shall be:
(1) allowed, upon request, to have his or her hair cut at least once every six (6) weeks at his or her own expense; and
(2) All inmates shall be provided the opportunity to wear their personal clothing when they appear in court for a jury trial.

(e) The sheriff may supervise and control the hygiene, grooming, and attire of jail inmates to the extent reasonably necessary to maintain a sanitary, safe, and secure environment. The sheriff shall reserve the right, with reasonable cause, to order an inmate's hair be cut by a licensed barber or beautician in order to maintain a sanitary and secure living and work environment. (Department of Correction; 210 IAC 3-1-10; filed Jul 27, 1981, 10:30 a.m.: 4 IR 1812; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

SECTION 11. 210 IAC 3-1-11 IS AMENDED TO READ AS FOLLOWS:

210 IAC 3-1-11 Medical care and health services

Sec. 11. Medical Care and Health Services. (a) A duly licensed physician shall be responsible for medical services in each jail.
(b) Procedures necessary to deliver medical services to inmates shall be:

(1) in writing; and shall be
(2) approved by the responsible physician; and
(3) reviewed by the sheriff.

(c) State licensing and/or certification, or both, requirements and restrictions shall apply to all health care personnel working with jail inmates. Copies of all licensing and/or certification, or both, credentials shall be on file with the sheriff. Jail security regulations shall apply to all medical personnel.

(d) Whenever medical services are to be delivered routinely in any jail, adequate space, equipment, supplies, and materials as determined by the responsible physician shall be provided.

(e) First aid kits shall be available in each jail. The responsible physician shall approve the contents number and location of each kit and the procedure for periodic inspection of all first aid kits.

(f) Each inmate shall be medically screened upon admission to jail and before placement in the general population or living area. Screening data must be recorded on a form approved by the responsible physician and shall include, but not be limited to, the following:

(1) Current illnesses and health problems, including those specific to women.
(2) History of drug and/or alcohol, or both, use.
(3) Current medications taken.
(4) Special health requirements.
(5) Screening of other health problems designated by the responsible physician.
(6) Behavioral observations, including state of consciousness and observable mental status.
(7) Notation of the following:
   (A) Body deformities.
   (B) Trauma markings.
   (C) Bruises.
   (D) Lesions.
   (E) Jaundice. and xano
   (F) Restriction of movement.
(8) Condition of skin and visible body orifices, including rashes and infestation. and
(9) Disposition or referral of the inmate to qualified medical personnel on an emergency basis.

(g) Within fourteen (14) days following arrival at the jail, an inmate shall be given the opportunity to receive a medical examination conducted by the responsible physician or his designee, a licensed nurse.

(h) An inmate shall be informed upon admission that medical complaints shall be collected daily and responded to by medically trained personnel. Qualified medical personnel shall follow up on all complaints and allocate treatment according to priority of need. A physician shall be available at least once a week to evaluate and respond to inmate medical complaints.

(i) Each jail shall provide arrange for twenty-four (24) hour emergency medical, and dental, and psychological care availability pursuant to a written plan which includes, as a minimum, arrangements for the following:

(1) Emergency evacuation of the inmate from within the facility.
(2) Use of an emergency medical vehicle.
(3) Use of one (1) or more designated hospital emergency rooms or other appropriate health facilities.
(4) Emergency on call physicians and dentist services when the emergency health facility is not located in a nearby community. and
(5) Security procedures that provide for the immediate transfer of inmates when appropriate.

6) Emergency psychological services to prevent personal injury. [Cost to be addressed]

(j) Jail personnel shall be trained in the use of emergency care procedures and shall have current training in basic first aid equipment. At least one (1) person per shift shall have training in receiving, screening, cardiopulmonary resuscitation (CPR),
and recognition of symptoms of the common illnesses. All jail officers shall be trained regarding recognition of symptoms of mental illness and retardation and suicide screening and prevention.

(1) No jail shall accept delivery of an unconscious or critically injured person. In consultation with the responsible physician, the sheriff shall establish a blood alcohol content (BAC) level above which the jail may refuse to accept an inmate without medical screening. All medical screenings prior to booking shall be at the arrestee's expense. A copy of this policy shall be provided to local law enforcement agencies.

(2) Any inmate injured while detained in the jail shall be examined immediately by a competent medical person. A description of the injury should be recorded and photographs taken when appropriate. Any inmate's refusal of medical care shall be:

- (A) thoroughly documented;
- (B) signed by the inmate; and
- (C) witnessed by staff.

(k) Jail officials shall use their best efforts to obtain any medication prescribed by a physician. All medications shall be administered in the dosage and with the frequency prescribed. No substitutions of medications shall be made without the prescribing responsible physician's written approval.

(1) Any jail officer who administers medication shall have received documented training through the responsible physician. The jail administrator:

- (A) is accountable for administering the administration of medications according to orders; and
- (B) must record the all administration of medication in a manner and on a form approved by the responsible physician.

(2) A structured system for pharmacy storage, accountability, and distribution shall be established in accordance with recognized medical standards as determined by the responsible physician.

(3) An inmate's prescribed medication, by a responsible physician, shall accompany the inmate in the original container with the inmate's medical records upon transfer to another facility or upon release.

(l) Each The responsible physician shall be listed the jail with the Drug Enforcement Administration as a place of practice by the responsible physician. Missing controlled substances shall be reported to the Indiana board of pharmacy using DEA Form 160.

(m) Each sheriff shall do the following:

- (1) Establish policies and procedures for the development and disposition of each inmate's medical records.
- (2) Provide secure and confidential storage of such the records consistent with physician-patient privileges.

Nonmedical personnel shall have access to these records as provided by law. A sealed copy of an inmate's facility medical record shall accompany the inmate upon transfer to another facility.

(n) Each sheriff shall have a policy providing for the provision of private medical, dental, and optometry services when requested by the inmate. The services shall be at the inmate's own expense. (Department of Correction; 210 IAC 3-1-11; filed Jul 27, 1981, 10:30 a.m.; 4 IR 1812; readopted filed Nov 15, 2001, 10:42 a.m.; 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.; 20070725-IR-210070277RFA)

SECTION 12. 210 IAC 3-1-12 IS AMENDED TO READ AS FOLLOWS:

210 IAC 3-1-12 Diet and food preparation

Authority: IC 11-8-2-5; IC 11-12-4-1

Affected: IC 11-12-4-1

Sec. 12. Diet and Food Disposition. (a) Each sheriff shall establish written policies and procedures concerning the quantity and quality of food served to inmates.

(b) Food shall not be used as a reward or withheld as a disciplinary measure. All meals shall be served under the supervision of the jail administrator or his or her designee. There shall be not more than fourteen (14) hours between the evening meal and breakfast. Inmates shall be served three (3) meals each day. At least one (1) meal each day shall be served hot.

(c) Menus shall:
(1) be prepared in advance, and records of all menus and all meals served shall be retained; **Menus shall meet the approval of**
(2) be approved by a qualified dietician; and food preparation and the storage shall be in compliance with local and state health standards. Each menu shall include the recommended dietary allowance for food nutrients specified by the National Academy of Science, Food and Nutrition Board.
(3) reflect the average daily caloric intake; and
(4) be reviewed every two (2) years or after any substantial change in daily inmate physical activity.

All food service areas and equipment shall be inspected daily by administrative jail personnel. All food must be placed on racks off the floor. Food must be covered or enclosed while being transported to the inmate area.

(d) **To ensure** that the jail kitchen is maintained in a safe and sanitary condition, the following requirements shall be met:

- (1) All kitchen equipment and floors shall be cleaned daily. Walls and vents shall be cleaned regularly.
- (2) The sheriff or jail administrator shall request that the local health officer, or an otherwise qualified agency, conduct periodic inspections of the kitchen facilities **at least annually**, to ensure compliance with established health and sanitary standards.
- (3) Eating utensils shall be sanitized **after each use**. Alternatively, plastic disposal utensils may be used for each meal.
- (4) Kitchen equipment must be operational and safe for use.
- (5) Inmates working in the kitchen shall be given a preservice examination and periodic examinations **a daily visual examination** thereafter to ensure that they do not have any contagious diseases or other ailments which could facilitate food contamination. Inmates shall wear clothing approved for food handling when they are assigned to working in the kitchen **and during the delivery of food to inmates**.

(e) Medical diets approved by the responsible physician shall be honored. Religious diets shall be honored to the extent that the required food is readily accessible in the community where the jail is located. Any refusal to grant a medical or religious diet shall be reported in writing to the sheriff or jail administrator.

(1) Each sheriff shall establish in writing a control system to monitor and control food pilferage, misuse, or spoilage. **(Department of Correction; 210 IAC 3-1-12; filed Jul 27, 1981; 10:30 a.m.; 4 IR 1813; readopted filed Nov 15, 2001, 10:42 a.m.; 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.; 20070725-IR-2100702777RFA)**

SECTION 13. 210 IAC 3-1-13 IS AMENDED TO READ AS FOLLOWS:

210 IAC 3-1-13 Security and control

**Authority:** IC 11-8-2-5; IC 11-12-4-1

**Affected:** IC 11-12-4-1

Sec. 13. **Security and Control.** (a) Each sheriff shall establish a manual setting forth the jail's policies and procedures for security and control. This manual shall be distributed available to all jail personnel and shall be reviewed annually and updated as needed. Documentation of this review shall be signed by the sheriff and maintained in front of the manual. The manual shall include, but not be limited to, the following:

- (1) Supervision.
- (2) Searches and seizures.
- (3) Facility security.
- (4) Shakedowns.
- (5) Firearms and other weapons.
- (6) Maintenance of security equipment.
- (7) Key control.
- (8) **Control of the following:**
  - (A) Tools.
  - (B) Sharp culinary equipment.
  - (C) Medical instruments.
  - (D) Razors.
- (9) Records control and release of information.
- (10) Population count.
(11) Chemical agents.
(12) Post orders.
(13) Escapes.
(14) Emergency situations, including the following:
   (A) A fire.
   (B) A disturbance.
   (C) An assault.
   (D) A taking of hostages.
   (E) Natural disasters.
(15) Transportation of inmates and.
(16) The use of physical force.
(17) Responding to a suicide attempt or suicidal inmate.

Jail officers shall be trained consistent with provisions of the security and control manual. Pre training and posttraining examinations shall be administered to each jail officer and the results made part of the employee's record.

(b) Inmates shall not be permitted to handle, use, or have jail keys of any type in their possession. There shall be at least one (1) full set of keys, separate from those in use, stored in a safe place accessible only to jail personnel, for use in event of an emergency. Keys are to be color coded and classified pursuant to a key numbering and lettering system.

(c) The use of physical force by jail personnel shall be restricted to instances of justifiable self-protection, protection of inmates from self-harm, protection of others, protection of property, and prevention of escapes. Only that force shall be used only to the degree necessary and to control an inmate consistent with any statutory limitations shall be authorized. Written reports following any use of force shall be promptly submitted to the sheriff or his or her designee.

(1) Only weapons approved by the sheriff shall be used by jail personnel in emergency situations. Any jail employee who discharges a firearm in the course of his or her duty shall promptly submit a written report to the sheriff.

(2) Lethal weapons shall not be permitted beyond a designated area to which inmates have no access, except in emergency situations as approved by the sheriff.

(3) Persons designated to authorize the use of tear gas, mace, or other chemical agents or nonlethal repellants or security devices shall be:
   (A) named in writing; and
   (B) trained in the proper employment of the chemical agents these items.

(4) Each sheriff shall establish procedures for the treatment of persons injured as a result of a weapon or chemical agent the application of force.

(d) Each jail shall maintain a secure communication control center separate from other jail detention and administrative functions. Jail officers and other personnel assigned to jail duty shall be trained in security measures and the handling of special incidents such as the following:

(1) Assaults.
(2) Disturbances.
(3) Deaths.
(4) Fires and
(5) Suicide attempts.
(6) Natural disasters.

Each jail shall have an audio communication system between the communication control center and the inmate living area that can be activated from the inmate living areas in an emergency. [cost to be addressed?]

(e) Each jail shall have equipment necessary to maintain central lights, power, and communication in an emergency. Emergency equipment shall be:

(1) tested at least weekly for effectiveness; and shall be
(2) promptly repaired or replaced as necessary.

(f) Security equipment shall be:

(1) sufficient to meet facility needs; and shall be
(2) stored in a secure place, but readily accessible to staff.

There shall be a sufficient quantity of restraints, mechanical or disposable, or both, to evacuate all inmates from the jail.
in an emergency, [cost to be addressed]

(a) All:
(1) security perimeter entrances;
(2) control center doors;
(3) cellblock doors; and
(4) cell doors opening into a corridor.

shall be kept locked except when used for admission or exit of employees, inmates, or visitors and emergencies. No jail officer

of weapons, drugs, or

seized, and appropriate dispos

procedure providing for a written record concerning the seizure of contraband or prohibited property, receipts for property

possessed or used

Property that an inmate is otherwise permitted to possess may become prohibited property due to the means by which it is

items of property

responses to grievances

legal

items an inmate may

alerted and available for immedi

shall enter a high security cell area, or any other area in which a disturbance is occurring, without backup assistance being

alerted and available for immediate assistance.

(h) Jail officials may perform searches and seize contraband or prohibited property. Sheriffs may limit the personal

items an inmate may possess in their living area by both quantity and volume. However, an inmate may possess those legal papers necessary for access to the courts and legal matters pertaining to their current court case or cases and responses to grievances. Does this comport with IC 11-11-7-1? Jail officials may shall inform an inmate inmates of the items of property he is they are permitted to possess, in which event all other property not contraband is prohibited property. Property that an inmate is otherwise permitted to possess may become prohibited property due to the means by which it is possessed or used or if the quantity possessed exceeds that permitted. The sheriff or jail administrator shall establish written procedure providing for a written record concerning the seizure of contraband or prohibited property, receipts for property seized, and appropriate disposition of seized property.

(1) Notice in writing shall be given inmates and visitors as to the items not considered contraband or prohibited property.

(2) Visitors and inmates may shall be searched at jails where contact visiting is permitted. Visitors must be provided:

(A) clear notice of the possibility of a search; and

(B) the opportunity to decline their visit request upon receiving the notice.

(3) Body cavity searches of visitors may be conducted: only

(A) by medical personnel of the same sex as the person being searched. Visitors must be given clear notice of the possibility of body cavity searches and may decline their request to visit upon receiving this notice. The grounds on which body cavity searches may be conducted shall be clearly stated, only; and

(B) solely as a result of the execution of a search warrant.

(4) Inmates permitted to leave the jail temporarily, for any reason, shall be thoroughly searched prior to leaving and strip searched before reentering the jail. Doesn’t a mandatory strip search on re-entry conflict with (7), below? Searches

and seizures shall be conducted so as to avoid unnecessary force, embarrassment, or indignity to inmates.

(5) The sheriff shall establish written policies and procedures concerning the following:

(A) Contraband, prohibited property, searches and seizures of property.

(B) Searches. Personal searches may include the following:

(i) Pat down searches.

(ii) Frik searches.

(iii) Strip searches.

(iv) Body cavity searches.

(v) Metal detection scanners.

(vi) Other designated, legally approved devices.

Cell and area searches shall also be conducted routinely by staff.

(6) Incidental visual observation during clothing exchange and showering is not considered a search. However, the use of:

(A) privacy barriers;

(B) opaque partitions; and

(C) same gender observation;

are encouraged.

(7) Generally, the least invasive form of search and observation should be conducted. Strip searches shall only be conducted when a reasonable suspicion exists that an inmate may be in possession of weapons, drugs, or contraband. Here admission to a jail (arrestee) is insufficient cause alone to conduct a strip search.

(8) All strip searches and body cavity searches conducted shall be:

(A) documented on the form prescribed by the Indiana Sheriff’s Association; and

(B) maintained in the inmate’s file.
(i) Arrestee strip searches shall be conducted only when there is reasonable suspicion that the arrestee is in possession of a contraband item. Reasonable belief must be based on an individualized suspicion relevant to the following:

1. The current charge or charges or previous conviction or convictions for any of the following:
   A. Escape.
   B. Possession of drugs or weapons.
   C. Crimes of violence.
2. Fugitive or detainer for any of the above crimes.
3. Current or a history of institutional possession of contraband or prohibited property or attempted escape.
4. Refusal to submit to a frisk or pat search.
5. Weapons or drugs discovered during pat or frisk search.
6. Alerted by a metal or drug detection device.
7. Reliable information arrestee possesses drugs, weapons, or contraband.

(j) Inmate strip searches shall be conducted only when there is reasonable suspicion that the inmate is in possession of a contraband item. Reasonable belief may be based on an individualized suspicion relevant to the following:

1. Reliable information that the inmate possesses contraband.
2. The discovery of contraband in the inmate's cell or living area.
3. A serious incident in which the inmate was involved or present.
4. A refusal to submit to a frisk or pat search.
5. Contact with the public or exposure to public areas.
6. After a contact visit.
7. Returned to custody from community status, for example, weekenders, work crew, or work release.
8. Medical appointment, etc.
9. Alerted by a metal or drug detection device.
10. Court ordered detention after outside court appearance.
11. Court authorized as a condition of confinement or probation.
12. Contact with the public or exposure to public areas.
13. Inmate exposure to tools, medical instruments, or sharp culinary items.

(k) As a best practice each sheriff shall enter into a mutual aid agreement with necessary local and adjacent county law enforcement agencies for the provision of services in the event of an emergency exceeding the department's capability. Aid agreements shall also be established with local agencies for the provision of housing, material, and services in an emergency. Where is the legal authority of DOC to mandate mutual aid agreements?
the jail's suicide screening and prevention procedures.
(3) High risk inmates shall be provided more frequent supervision consistent with their classification level.

(b) The sheriff shall establish the following:
(1) A written procedure for the supervision of female inmates by male staff and the supervision of male inmates by female staff. These procedures shall take into consideration the privacy rights and needs of inmates. All reports of inappropriate sexual conduct by staff shall be investigated, and a copy of the investigation must be provided to the county prosecutor upon completion. (c) The sheriff shall establish (2) Written procedures for the segregation of inmates with serious behavioral problems, requiring protective custody, or inmates charged with disciplinary misconduct.

(1) (A) An inmate charged with disciplinary misconduct may be confined or separated from the general population of the jail. An inmate may be administratively segregated for a reasonable period of time if his or her continued presence in the general population poses a serious threat to himself or herself, others, property, or the security of the jail. Jail officials shall review the status of those administratively segregated inmates at least once every seven (7) days to determine if the reason for segregation still exists. Time spent confined or separated from the general population before a determination of guilt must be credited toward any period of disciplinary segregation imposed.

(2) (B) No inmate shall be kept in disciplinary segregation for a period in excess of thirty (30) days for any single instance of disciplined conduct without administrative review.

(3) (C) Jail officials shall maintain a permanent written record of inmate behavior and activity while in disciplinary and administrative segregation.

(d) Each area of the jail shall be visited:
(1) by the sheriff or his or her designee at least once weekly; and
(2) daily by supervisory staff.

All inspections shall be documented.

SECTION 15. 210 IAC 3-1-15 is amended to read as follows:

210 IAC 3-1-15 Inmate rights

Authority: IC 11-8-2-5; IC 11-12-4-1
Affected: IC 3-7-46-6; IC 11-12-4-1

Sec. 15. Inmate Rights. (a) The right of jail inmates to have access to the courts shall be ensured. Inmates shall have confidential access to their attorneys and the authorized representatives of their attorneys. Inmates not represented by counsel shall have reasonable access to the courts to challenge their sentences and conditions of confinement and reasonable access to an adequate law library. Inmates with an appointed public defender shall be provided the opportunity to speak to their attorney.

(b) Inmates shall not be subject to discrimination based on any of the following:
(1) Race.
(2) National origin.
(3) Color.
(4) Creed.
(5) Sex.
(6) Economic status.
(7) Political belief.

There shall be equal access to programs or services for male and female inmates.
Inmates shall have the right of access to reading materials except pornography and obscene materials as defined by Indiana law, or images depicting nudity, which seems to be directly contrary to IC 11-11-3-6: in the case of a confined adult, the department may not exclude printed matter on the grounds it is obscene or pornographic unless it is obscene under Indiana law.

and reading matter which that jail officials have reasonable grounds to believe poses an immediate and obvious danger to the safety of an individual or a serious threat to the security of the jail. A sheriff may limit the amount of reading material an inmate possesses in his or her cell or cellblock for fire and safety concerns.

An inmate is entitled to believe in the religion of his or her choice, and attendance at religious services is not required. To the greatest extent possible consistent with jail security, programs, and resources, an inmate is entitled to the following:

1. Observe the religious days of worship or holidays of his or her religion.
2. Possess and wear religious artifacts that do not compromise the safety and security of the jail.
3. Receive and possess religious literature and for his or her individual use.
4. Communicate, correspond with, and be visited by a clergyman or religious counselor of his or her choice during reasonable times, as approved by a community pastoral committee or sheriff, or both. The sheriff reserves the right to determine the pastoral status of clergy and may limit nonclergy.

An inmate shall be given a reasonable opportunity for physical exercise and recreation outside of his the immediate living quarters and out of doors whose sleeping areas, outdoors, if feasible, and consistent with the security and resources of the jail. Segregated inmates shall be offered the opportunity for at least one (1) hour of daily exercise outside of their cell.

The sheriff shall make arrangements with election officials to facilitate an inmates right to vote by absentee ballot provided that the inmate is otherwise qualified to vote. Sentenced and incarcerated, to the county clerk quarterly, as required by IC 3-7-46-6.

Each jail shall maintain a written inmate work assignment plan providing for inmate employment, subject to the:

1. number of available work opportunities; and
2. maintenance of facility security.

Unsentenced inmates may volunteer for work assignments within the jail but shall not be required to work except as may be necessary to maintain their living quarters in a safe and sanitary condition.

All inmates shall have the right to file written grievances regarding conditions in the jail with the sheriff or his or her designee. Grievances shall be promptly investigated, and a written report stating the disposition of the grievance shall be provided to the inmate. The inmate shall be provided a written response or advised of the status of the grievance within ten (10) calendar days. The sheriff shall establish in writing a grievance procedure, including at least one (1) level of appeal, which shall be made known and distributed to all inmates upon arrival and initial screening. If a grievance form is specified, inmates shall be provided the opportunity to obtain the specified form or forms at least once daily. To ensure the grievance history of a jail or inmate can be properly evaluated, there shall be a separate format used for the following:

1. Grievances.
2. Routine requests.
3. Medical requests.

Inmates may receive visitors at reasonable times during established hours of visitation. Jail officials may, for the purposes of maintaining jail security, individual safety, and administrative manageability, place reasonable restrictions on visitation. Visitations by minors within the secure perimeter of a jail may be restricted as necessary for the orderly management and security of a facility. Visitors with a prior criminal conviction may be denied visitation. At a minimum a jail’s visitation policy shall include the following. Visitors may also be denied for:

1. unacceptable attire;
2. disruptive behavior;
3. failure to control minor children; or
(4) failure to provide picture identification as established by jail policy.

A copy of this visitation policy shall be posted in the visitation area.

Each sheriff shall establish written procedures governing inmate telephone access, general visitation, special visitation, visitation for high security risk inmates, and visitation registration, including search procedures.

(3) Until further notice, the smaller jails that operate in this manner provide a time frame after which the written notice to appear to visitors. The 48 hours was derived from the consent decree involving this issue at the Indiana Boys School.

Comment [A40]: I would bounce this off of Howard. They are probably correct.

Comment [A41]: I think this does comport. It provides a time frame after which the written notice must be provided. Jails differ from prisons in many ways. Many jails have administrative staff that review and determine mail as an additional duty during normal duty hours, as opposed to having a dedicated mail clerk. This provides allowance for the smaller jails that operate in this manner.

Comment [A39]: Change “this” to “the”
request from a supervising authority of any federal, state, or county agency stating the agency has reasonable grounds to believe that a crime is being committed or has been committed by the confined person and requesting the jail monitor the confined person’s correspondence.

(g) Jail officials may open all incoming and outgoing packages to inspect for and remove funds, contraband, or prohibited property. If contraband or prohibited property is removed from a package, the inmate must be notified in writing of such removal.

(h) Jail officials may inspect all printed matter and exclude any material that is contraband or prohibited property. Following examination, printed matter may not be excluded on the grounds it is obscene or pornographic unless it is obscene under Indiana law. Printed matter may be read, rejected, censored, or copied based on the matrix in Table 1. A periodical may be excluded only on an issue by issue basis. Jail officials who withhold printed matter must promptly notify the addressee inmate of this action in writing.

Table 1: Mail Policy Matrix

<table>
<thead>
<tr>
<th>INCOMING</th>
<th>INSPECT</th>
<th>READ</th>
<th>CENSOR</th>
<th>COPY</th>
<th>REJECT</th>
<th>MISC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal</td>
<td>May, at random.</td>
<td>May, at random.</td>
<td>No</td>
<td>May, with probable cause.</td>
<td>May, with reasonable cause to believe contents are in violation of policy and procedures.</td>
<td>Books, magazines, and newspapers: “Publisher only rule” applies. Legally obscene material may be denied.</td>
</tr>
<tr>
<td>Privileged / Legal</td>
<td>Yes, in presence of inmate.</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>With reasonable cause. Author has right to protest.</td>
<td>Public and government officials mail has privileged status.</td>
</tr>
<tr>
<td>Religious</td>
<td>Yes</td>
<td>May, at random.</td>
<td>No</td>
<td>Yes, with reasonable cause.</td>
<td>Yes, if clear and present danger.</td>
<td>&quot;Publishers only rule&quot; applies.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTGOING</th>
<th>INSPECT</th>
<th>READ</th>
<th>CENSOR</th>
<th>COPY</th>
<th>REJECT</th>
<th>MISC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal</td>
<td>Yes, may at random.</td>
<td>May, at random.</td>
<td>No</td>
<td>May, with reasonable cause.</td>
<td>May, with reasonable cause.</td>
<td>Public and government officials mail has privileged status.</td>
</tr>
<tr>
<td>Privileged / Legal</td>
<td>Yes, in presence of inmate upon reasonable cause.</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes, with reasonable cause, in the presence of inmate.</td>
<td>Public and government officials mail has privileged status.</td>
</tr>
<tr>
<td>Religious</td>
<td>Yes</td>
<td>May, at random.</td>
<td>No</td>
<td>Yes, with reasonable cause.</td>
<td>Yes, if clear and present danger.</td>
<td></td>
</tr>
</tbody>
</table>

(i) Inmates shall not be permitted to mail, receive, or possess the following:

(1) Any matter tending to incite:
   (A) murder;
   (B) arson;
   (C) a riot; or
   (D) any form of violence or physical harm to any person or:
      (i) ethnic;
      (ii) gender;
      (iii) racial;
      (iv) religious; or
      (v) other;

(2) Any matter pertaining to blackmail or extortion.

Comment [A42]: TURNER v. SAFLEY, 482 U.S. 78 (1987)
Essentially First Amendment rights may be impinged upon in a correctional setting providing there is a legitimate penological interest in doing so, that there is a valid, rational connection that can be articulated, and that it is done by the least intrusive means.
(3) Sending, receiving, or possessing contraband or prohibited property.

(4) Plans to escape or assist an escape.

(5) Plans to disrupt the order or breach the security of any facility.

(6) Plans for any activity that violates the law, jail policy, or procedure.

(7) Coded messages.

(8) A description or recipe for any:

   (A) weapon;
   (B) explosive;
   (C) poison; or
   (D) destructive device.

(9) Illustrations, explanations, or descriptions of how to sabotage or disrupt:

   (A) computers;
   (B) communications; or
   (C) electronics.

(10) Recordable media.

(11) Catalogs, advertisements, brochures, and material whose primary purpose is to sell a product or products or service or services, when taken as a whole, that lack serious literary, artistic, political, educational, or scientific value. Violates IC 11-11-3-6.


(13) Any matter pertaining to gambling or a lottery;

(14) Markings on an envelope or wrapper that are obscene materials as defined by Indiana law, in this article, Statute says Indiana law.

(15) Obscene material and information concerning where, how, or from whom obscene material may be obtained.

Doesn’t this whole list violate IC 11-11-3-6: A confined person may acquire and possess printed matter on any subject, from any source. The department may inspect all printed matter and exclude any material that is contraband or prohibited property. IC 11-11-2-1

Definitions

Sec. 1. As used in this chapter:

"Contraband" means property the possession of which is in violation of an Indiana or federal statute.

"Prohibited property" means property other than contraband that the department does not permit a confined person to possess. The term includes money in a confined person’s account that was derived from inmate fraud (IC 35-43-5-20).

What does case law say on these types of first amendment restrictions? How does all of this comport with IC 11-11-3-6.5

3(i) Indigent inmates shall be furnished with free writing supplies and postage sufficient for at least two (2) letters per week.

(k) Upon mailing, indigent inmates shall be provided one (1) free copy of each legal correspondence that addresses issues involving their conditions of confinement.

(l) Inmate telephone conversations may be subject to monitoring and recording provided inmates are informed prior to or during each call, by signs posted on or near the telephones, or in the rule book provided each inmate. Conversations between an inmate and his or her legal representative may not be monitored or recorded without a court order.

(m) Inmate telephones may be turned off in those cellblocks affected prior to the transport of inmates into the community or transfer to another facility, or for security reasons. (Department of Correction; 210 IAC 3-1-16; filed Jul 27, 1981; 10:30 a.m.; 4 IR 1816; readopted filed Nov 15, 2001; 10:42 a.m.; 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.; 20070725-0R-2100701277BEA)

SECTION 17. 210 IAC 3-1-17 IS AMENDED TO READ AS FOLLOWS:

210 IAC 3-1-17 Discipline written rules
Sec. 17. Discipline. (a) Each sheriff shall establish written rules of inmate conduct for the maintenance of order and discipline among inmates. Such rules shall describe:

1. The conduct for which disciplinary action may be imposed;
2. The type of disciplinary action that may be taken; and
3. The disciplinary procedure to be followed.

Copies of these rules shall be posted in the living areas or distributed to all inmates. The disciplinary action imposed shall be proportionate to the seriousness of the rule violation. The use of physical force as a means of discipline is prohibited.

(b) All jail personnel who have regular inmate contact shall be provided training sufficient to make them thoroughly familiar with the rules of inmate conduct and the sanctions available.

c. Any of the following may be imposed as disciplinary action on jail inmates:
   (1) A report, which may be made part of the inmate’s record;
   (2) Extra work cannot be imposed on pretrial detainees or arrestees. For inmates, extra work cannot exceed:
       (A) a total of twenty (20) hours for one (1) rule violation; or
       (B) four (4) hours in any twenty-four (24) hour period.
   (3) Loss or limitation of privileges.
   (4) Change in work assignment;
   (5) Restitution;
   (6) Transfer to the Department of Correction for safekeeping;
   (7) Deprivation of earned credit time under IC 35-50-6-5.

(d) The following shall not be imposed as disciplinary action on jail inmates:
   (1) Corporal punishment.
   (2) Confinement without an opportunity for at least one-and-one-half (1.5) hour of daily exercise five (5) days each week outside of immediate living quarters, unless jail officials find and document that this opportunity will jeopardize the physical safety of the inmate or others or the security of the jail.
   (3) A substantial change in:
       (A) heating;
       (B) lighting; or
       (C) ventilation.
   (4) Restrictions on:
       (A) clothing;
       (B) bedding;
       (C) mail; and
       (D) reading and writing materials; or
       (E) the use of hygienic facilities; except for abuse of these, unless jail officials find and document that this opportunity will jeopardize the physical safety of the inmate or others or the security of the jail.
   (5) Restrictions on the following:
       (A) Medical and dental care.
       (B) Access to the following:
           (i) Courts.
           (ii) Legal counsel.
           (iii) Government officials.
           (iv) Grievance proceedings.
           (v) Personal legal papers and legal research materials.
   (6) A deviation from the diet provided to other inmates, unless approved by the responsible physician.
   (7) Extra work exceeding a total of twenty (20) hours for one (1) rule violation, or exceeding four (4) hours in any
(e) Before imposing any disciplinary action, jail officials shall afford the inmate charged with misconduct a hearing to determine his or her guilt or innocence and the disposition of the charge. The charged inmate may waive his or her right to a hearing in writing. Also, before a charge is made, the inmate and a jail official may agree to a disciplinary action in the same form of extra work or loss or limitation of privileges if no record of the conduct or disciplinary action is placed in the inmate's file. In connection with the required hearing, the inmate is entitled to the following:

1. To have not less than twenty-four (24) hours advance written notice of the date, time and place of following:
   (A) The hearing. and or
   (B) The alleged misconduct. and
   (C) The rule the misconduct is alleged to have violated.

2. To have reasonable time to prepare for the hearing.

3. To have an impartial decision maker.

4. To appear and speak in his or her own behalf.

5. To call witnesses and present evidence.

6. To confront and cross-examine witnesses, unless the decision maker finds that to do so would subject a witness to a substantial risk of harm.

7. To have advice and representation by a lay advocate in those hearings based upon a charge of institutional misconduct when the decision maker determines he or she lacks the competency to:
   (A) understand the issues involved; or
   (B) participate in the hearing.

8. To have a written statement of the following:
   (A) The findings of fact. and
   (B) The evidence relied upon. and
   (C) The reasons for the action taken.

9. To have immunity if his or her testimony or any evidence derived from his or her testimony is used in any criminal proceedings.

10. To have his or her record expunged of any reference to the charge if he or she is found not guilty or if a finding of guilt is later overturned.

Any finding of guilt must be supported by a preponderance of the evidence presented at the hearing.

(f) An inmate shall receive written notice of any formal charge against him or her within twenty-four (24) hours of knowledge or discovery or the conclusion of an investigation of the alleged offense, by jail officials, excepting weekends and holidays. The notice shall specify the following:

1. The date, time, and place of the hearing.

2. The alleged misconduct.

3. The rule the misconduct is alleged to have violated.

4. The right to a hearing. and

5. An explanation of the hearing process.

The hearing shall be held within seventy-two (72) hours, excluding weekends and holidays, of the alleged violation, unless the inmate requests additional time to prepare for the hearing.

(g) The sheriff may delegate authority in writing to one (1) or more designees to conduct hearings for alleged violations of facility rules.

(h) An inmate may appeal the disciplinary decision of a hearing authority to the sheriff. The appeal may challenge the:

1. Finding of guilt; or the

2. Type and degree of disciplinary action taken.

Any appeal shall be initiated within ten (10) days of the disciplinary decision. The sheriff may reduce but not increase any disciplinary action imposed by the hearing authority. (Department of Correction; 210 IAC 3-1-17; filed Jul 27, 1981, 10:30 a.m.: 4 IR 1817; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)
210 IAC 3-1-18 Inmate classification
Authority: IC 11-8-2-5; IC 11-12-4-1
Affected: IC 11-12-4-1

Sec. 18. (a) Each sheriff shall establish a written plan for the following:
(1) Classifying and assigning inmates according to sex.
(2) The seriousness of their alleged crimes.
(3) The degree of risk of violence to other inmates.
(4) Their status as either youths or adults and pretrial detainees or convicted persons.

When the jail is at or near capacity, the sheriff shall use the best effort to maintain proper classification and segregation. Develop and implement an objective classification system within two (2) years of the effective date of this article. This system shall include written procedures for overriding an inmate's objective classification result to accommodate local needs, for example, physical plant design, program availability, etc.

(b) Juveniles alleged to be delinquent or adjudicated delinquent shall be held:
(1) in a manner reasonably calculated to protect their personal safety; and
(2) in accordance with IC 31-6-1-21.3 and IC 31-6-4-6.5(b)(1) and all applicable law.

(c) Inmates with contagious or communicable diseases shall be segregated from other inmates upon direction of the responsible physician. Intoxicated or suicidal inmates and those inmates experiencing delirium tremens or drug withdrawal, shall also be segregated and given close observation. Allegedly insane or incompetent inmates who are held in custody:
(1) during examination of their mental condition; or
(2) while awaiting commitment to a mental institution;
shall be segregated and given close observation.

(d) Inmates shall not be segregated by:
(1) race;
(2) color;
(3) creed; or
(4) national origin;
in living area assignments. (Department of Correction; 210 IAC 3-1-18; filed Jul 27, 1981, 10:30 a.m.; 4 IR 1818; filed Jan 31, 1996, 4:00 p.m.: 19 IR 1312; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

SECTION 19. 210 IAC 3-1-19 IS AMENDED TO READ AS FOLLOWS:

210 IAC 3-1-19 New inmate admissions
Authority: IC 11-8-2-5; IC 11-12-4-1
Affected: IC 11-12-4-1

Sec. 19. Reception, Orientation, Property Control and Release. (a) Each sheriff shall establish written procedures for the following:
(1) Governing the reception and orientation of newly admitted inmates. Such The procedures shall include, but not be limited to, the following:
   (A) Verification of commitment papers.
   (B) Complete search of the individual section 13(h)(3) of this rule.
   (C) Disposition of clothing and personal property.
   (D) Medical screening, including tests for infectious diseases, as approved by the responsible physician.
   (E) Telephone calls.
   (F) Showers and hair care, if necessary.
   (G) Issue of jail clothing and supplies.
   (H) Photographing and fingerprinting, including
   (I) Notation of identifying marks or unusual characteristics.
   (J) Interview for obtaining identifying data.
(10) Classification for assignment to the living area;
(11) Assignment to the living area.

(b) Each sheriff shall establish written procedures (2) Providing for the following:
   (A) A written, itemized inventory of all personal property of newly admitted inmates.
   (B) The secure storage of such property, including money and other valuables.
   (3) For the release or transfer of inmates, to include the return or transfer of each inmate's personal property, upon release, as well as the procedures governing release of The inmate handbook shall reflect inmates are responsible for the restitution of any negative balance remaining on the inmate's trust account. If an inmate is transferred to another facility, a sheriff may request restitution from the inmate's trust account at the receiving facility, and the holding sheriff must provide a written accounting of all debits on the inmate's trust account, consistent with the provisions for inmate indigent status.

(Department of Correction; 210 IAC 3-1-19; filed Jul 27, 1981, 10:30 a.m.: 4 IR 1818; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210670277RFA)

SECTION 20. 210 IAC 3-1-20 IS ADDED TO READ AS FOLLOWS:

210 IAC 3-1-20 Suicide screening and prevention
Authority: IC 11-8-2-5; IC 11-12-4-1
Affected: IC 11-12-4-1

Sec. 20. (a) There shall be a written suicide prevention and intervention program that is reviewed and approved by a qualified medical or mental health professional:

   (b) The program shall include procedures for the following:
   (1) Screening/assessment,
   (2) Communication,
   (3) Housing,
   (4) Supervision of low-risk and high-risk suicidal inmates,
   (5) Intervention,
   (6) Reporting,
   (7) Mortality review,
   (8) More frequent observation intervals for inmates determined to be at high risk.

   (c) All staff responsible for inmate supervision shall be trained in the implementation of the suicide prevention program. (Department of Correction; 210 IAC 3-1-20)

Notice of Public Hearing

Comment [A46]: No additional cost. Six hours of mental health training is currently required by IC 11-12-4, and the initial on the job training requirement provides opportunity for jail specific training.
ARTICLE 3. COUNTY JAIL STANDARDS

Rule 1. Maintenance of County Jails

210 IAC 3-1-1 Definitions

Authority: IC 11-8-2-5; IC 11-12-4-1
Affected: IC 11-12-4-1

Sec. 1. Definitions. "Administrative Segregation" shall mean the physical separation of inmates who are determined to be mentally ill, escape prone, assaultive or violent, or likely to need protection from other inmates where such administrative segregation is determined to be necessary in order to achieve the objective of protecting the welfare of prisoners and staff.

"Chronic Care" shall mean medical service rendered to an inmate over a long period of time, i.e., treatment of diabetes, asthma or epilepsy.

"Contraband" shall mean property the possession of which is in violation of an Indiana or federal statute.

"Convalescent Care" shall mean medical service rendered to an inmate to assist in the recovery from illness or injury.

"Disciplinary Segregation" shall mean that status assigned an inmate, as a consequence or means of control resulting from a violation of jail rules, which consists of confinement in a cell, room, or other housing unit separate from inmates who are not on disciplinary segregation status.

"Emergency Care" shall mean care for an acute illness or unexpected health care need that cannot be deferred until the next scheduled sick call or physician's visit.

"Inmate" shall mean any person detained or confined in any jail governed by these rules.

"Jail" shall mean a secure county detention facility used to confine prisoners prior to appearance in court and sentenced prisoners.

"Jail Administrator", unless expressly stated otherwise, shall mean sheriff or other individual who has been assigned, designated or delegated full-time responsibility and authority for the administration and operation of the jail by the sheriff.

"Jail Officer" shall mean a sheriff's employee whose primary duties are the daily or ongoing supervision of jail inmates.

"Medical Preventive Maintenance" shall mean those health services including health education, medical services, and instruction in self-care for chronic conditions.

"Policy" shall mean a statement declaring mission, purpose and ideological position.

"Procedure" shall mean a statement establishing the action plan to accomplish policy.

"Prohibited Property" shall mean property other than contraband that the Jail Administrator does not permit an inmate to possess.

"Physician" shall mean an individual holding a license to practice medicine in Indiana, issued by the Medical Licensing Board of Indiana.

"Qualified Medical Personnel" shall mean individuals engaged in the delivery of a medical or health care service who have been licensed, certified, or otherwise properly qualified under the laws of Indiana applicable to that particular service.

"Unusual Occurrence" shall mean any significant incident or disruption of normal jail procedures, policies, routines or activities such as fire, riot, natural disaster, suicide, escape, assault, medical emergency, hostage taking, or other violation of jail rules or state laws. (Department of Correction; 210 IAC 3-1-1; filed Jul 27, 1981, 10:30 am: 4 IR 1808; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

210 IAC 3-1-2 Administration and organization

Authority: IC 11-8-2-5; IC 11-12-4-1
Affected: IC 11-12-4-1

Sec. 2. Administration and Organization. (a) Each jail shall be managed by a single Jail Administrator to whom all employees or units of management are responsible.

(b) Each Jail Administrator shall prepare annually a written report setting forth the extent and availability of services and programs to inmates. Said report shall be directed to the Circuit Court Judge and copies shall be provided to the State Jail Inspector, President of the County Council or City-County Council, and President of the County Commissioners.

(c) Each Sheriff shall develop a manual of policies and procedures which shall guide the operation of his county's jail. All policies and procedures must be in writing. The Sheriff shall encourage the participation of other community agencies in the development of policy for the jail through coordinated planning and inter-agency consultation. The advice and consultation of the
Sheriff’s staff should also be sought in the development of policies and procedures for each jail. The manual shall be reviewed and updated annually and distributed to all employees. It shall include, but not be limited to:

1. A statement of the philosophy, goals, and purposes of the jail;
2. Operations and maintenance of the jail;
3. Organizational structure of the jail, its staff and program, with grouping of similar functions, services and activities into administrative sub-units;
4. Delineation of channels of communication;
5. A procedure for the monitoring of operations and programs through required inspections and reviews;
6. A system of written reports to be directed to the sheriff or jail administrator including as a minimum: Information on major development, serious incidents, population data, staff and inmate morale, major problems and proposed plans to resolve them;
7. Staff training;
8. Employee-management relations; and
9. Staff-inmate communication.

(Facility management; 210 IAC 3-1-2; filed Jul 27, 1981, 10:30 am: 4 IR 1809; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

210 IAC 3-1-3 Fiscal management

Sec. 3. Fiscal Management. (a) Each sheriff shall establish written procedures to govern the internal handling of monies. All such procedures shall be consistent with all requirements of the State Board of Accounts.

(b) Each sheriff shall maintain fiscal records which will clearly indicate the annual costs for his county's jail. Any such records shall reflect all monies collected and disbursed during any budget period and shall be established in compliance with all requirements of the State Board of Accounts.

(c) Each sheriff shall prepare and present annually a budget request to the appropriate government funding body. The jail budget request should accurately reflect the needs and objectives of the subject facility.

(d) Each sheriff shall maintain a written inventory of county jail property. The inventory shall be reviewed and updated annually. (Facility management; 210 IAC 3-1-3; filed Jul 27, 1981, 10:30 am: 4 IR 1809; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

210 IAC 3-1-4 Personnel

Sec. 4. Personnel. (a) Each sheriff shall establish written jail personnel policies and procedures. (Facility management; 210 IAC 3-1-4; filed Jul 27, 1981, 10:30 am: 4 IR 1810; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

210 IAC 3-1-5 Training and staff development

Sec. 5. Training and Staff Development. (a) Each sheriff shall establish a written training and staff development plan for all jail employees. This plan shall be based on the jail’s manual of policies and procedures. It shall be evaluated and revised as needed annually.

(b) Each new jail officer shall receive forty (40) hours of orientation and training at the jail prior to job assignment and shall receive an additional forty (40) hours certified training during the first year of employment. Each jail officer shall receive documented training each year thereafter. The forty (40) hours of certified training during the first year of employment shall be received through the Indiana Law Enforcement Training Board.

(c) All personnel authorized to use firearms shall be trained in weaponry on a continuing in-service and documented firearms
training course. Failure to qualify for continued firearm use shall be deemed just cause for administrative re-evaluation or dismissal.

(1) No employee shall be authorized by the sheriff to use firearms unless that employee has been given training in the legal requirements of firearm use and the legal aspects of the use of deadly force.

(2) Detailed training records are required and shall be maintained on all firearms training.

(d) Each sheriff shall include training as a budget item in his jail’s annual budget request to pay for this required training.

Department of Correction; 210 IAC 3-1-5; filed Jul 27, 1981, 10:30 am; 4 IR 1810; readopted filed Nov 15, 2001, 10:42 a.m.; 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.; 20070725-IR-210070277RFA

210 IAC 3-1-6 Management information systems; inmate records

Authority: IC 11-8-2-5; IC 11-12-4-1
Affected: IC 11-12-4-1

Sec. 6. Management Information Systems and Inmate Records. (a) An intake form shall be completed for every inmate admitted to any county jail. Such form shall contain, but not limited to, the following information, unless otherwise prohibited by statute:

(1) Booking number;
(2) Date and time of intake;
(3) Name and aliases;
(4) Last known address;
(5) Date and time of commitment and authority therefor;
(6) Name, title and signature of delivering officer;
(7) Specific charge(s);
(8) Physical description;
(9) Mug shot and fingerprints;
(10) Sex;
(11) Age and date of birth;
(12) Place of birth;
(13) Race;
(14) Occupation;
(15) Last place of employment;
(16) Health status;
(17) Name and relationship of next of kin;
(18) Address of next of kin;
(19) Court and sentence;
(20) Notation of cash and personal property; and
(21) Space for remarks (to include notation of any open wounds, of sores requiring treatment, evidence of disease or body vermin, or tattoos).

(b) Records shall be maintained on all inmates committed or assigned to any county jail. Such records shall contain, but are not limited to:

(1) Intake information;
(2) Commitment papers and court order(s);
(3) Cash and personal property receipts;
(4) Reports of disciplinary actions or unusual occurrences;
(5) Work record;
(6) Program involvement; and
(7) Medical orders issued by the jail physician or his designee.

(c) Each sheriff shall maintain on a daily basis written data concerning population movement, including but not limited to:

(1) Admission;
(2) Processing; and
(3) Release of pre-trial detainees and sentenced inmates.

(d) Each sheriff shall establish a written procedure requiring the prompt reporting of all incidents that result in physical harm,
threaten the safety of any person in the jail, or threaten the security of the jail.

(e) Each sheriff shall establish written policies and procedures regarding access to and release of inmate records. Such policies and procedures shall insure that inmate records are current, accurate and safeguarded from unauthorized and improper disclosure.

(f) An inmate’s medical record file shall not be in any way part of the confinement record. (Department of Correction; 210 IAC 3-1-6; filed Jul 27, 1981, 10:30 am: 4 IR 1810; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

210 IAC 3-1-7 Physical plant

Authority: IC 11-8-2-5; IC 11-12-4-1
Affected: IC 11-12-4-1

Sec. 7. Physical Plant. (a) All inmate living and activity areas in each jail shall provide for the following minimum requirements:

1. Illumination shall be sufficient for reading and writing throughout the living area; readings of at least 20 foot candles are required at desk level.
2. Circulation of fresh air sufficient to remove stale air and orders from the living area. This requirement shall be satisfied if the County Board of Health certifies that the air in the living area is not harmful to the inmates.
3. A heating system sufficient to insure healthful and comfortable living and working conditions for all inmates and staff. Temperatures shall be maintained at a comfortable level consistent with exterior conditions, clothing and bedding issued.
4. Each cell shall have direct access to a toilet, a washbasin with running water and a bunk.
5. There shall be at least one toilet and one shower per twelve inmates in the activity area. This requirement shall be satisfied as to toilet access if cells are accessible to the inmates at all time.
(b) The reception area shall be located inside the security perimeter but outside inmate living quarters. It shall have the following minimum components:

1. Weapon lockers, located outside the security area;
2. Temporary holding space which has sufficient seating capacity for all inmates assigned, audio and visual communication, and available toilets and washbasins with running water;
3. Booking area;
4. Medical examination area;
5. Shower facilities;
6. Vault or secure area for storage of inmate's personal property; and
7. Telephone facilities.
(c) To provide security and assure compliance with fire safety regulations, supply areas shall be separate from inmate living and activity areas. There shall be adequate space for storage and security of keys, weapons, medications, tools, evidence, recovered stolen property, bedding, housekeeping equipment and supplies, clothing, prisoner's property, commissary and hygiene items, and records.
(d) Arsenals shall be located outside the security perimeter of the inmate living and activity areas. Provisions shall be made for the secure storage, care and issuance of weapons and related security equipment. The arsenal shall be equipped with an alarm system.
(e) Each jail shall have at least one area suitable for inmates who must be under special medical supervision.
(f) Each jail shall have a space available for the supervision of offenders who represent special behavioral problems including intoxication and self-destructive behavior. This area shall be equipped with audio-video communication and have access to toilet and running water.
(g) There shall be one bed for each inmate and the capacity of a jail shall be determined with the sheriff taking into consideration the following factors: (a) A bed for each inmate; (b) The size of the cell or sleeping area; (c) The size of the day room or range to which the prisoner has free access during non-sleeping hours; (d) Time spent in activities out-of-cell and/or time spent out of range.

The State Jail Inspector may adjust the rated capacity of any jail in the event that change in the structure or the use of that facility indicate that such change would be appropriate. Prior to any adjustment in rated capacity, the State Jail Inspector shall review the proposed adjustment with the sheriff and the County Commissioners.

(h) All major jail construction beginning January 1, 1982 shall comply with jail construction standards established by the
(i) Each sheriff shall have a written plan for preventive maintenance. The plan shall be reviewed and updated annually.

Sec. 8. Commissary. (a) Each jail commissary shall be managed and operated in a manner consistent with Indiana law.

Sec. 9. Safety and Sanitation. (a) Each jail shall be maintained in a safe and sanitary condition, in compliance with state and local health, sanitation, safety, and fire laws.

(b) Inmates incarcerated in each jail shall have the responsibility for maintaining their own cells and living areas in a safe and sanitary condition. Jail officials shall make cleaning equipment, including mops, brooms, scouring cleanser, soap and disinfectant, available to inmates on a daily basis to assist inmates in meeting their cleaning responsibility.

(c) Each jail shall be inspected by a designated jail official at least once per week. Each living area shall be inspected by designated jail officials daily. Written inspection reports shall be maintained, and steps shall be taken promptly to remedy unsafe or unsanitary conditions.

(d) Each jail shall be inspected weekly for evidence of insects and rodents. Licensed extermination services shall be obtained to spray or treat facilities as often as necessary to eliminate insects and rodents. Inmates shall be removed from an area if spraying or fogging is necessary and cannot properly be accomplished if inmates are present.

(e) Plumbing fixtures shall be promptly repaired or replaced as may be necessary after receipt and confirmation of a report of malfunctioning equipment.

(f) Exits shall be clearly marked, continuously illuminated, kept clear and in usable [sic.] condition.

(g) The sheriff shall establish a written evacuation plan for use in the event of fire or major emergency. Appropriate evacuation instructions shall be posted in all living and working areas of each jail.

(h) The Sheriff shall request that the local Board of Health inspect the jail at least semi-annually.

(i) The Sheriff shall establish written policies and procedures concerning safety, sanitation, and control of supplies.

Sec. 10. Clothing and Personal Hygiene. (a) Each jail shall provide for the issue of suitable clothing, bedding and towels to each new inmate. Clean clothing, bedding and towels shall be issued at least weekly. These items shall be maintained in sufficient number to supply each jail's inmate population.

(b) Each inmate shall be provided with shaving materials, bar soap, toothbrush, and toothpaste. Industrial hand soap shall not be issued to inmates. Women inmates shall be provided with choice of tampons or sanitary napkins.

(c) Inmates shall shower upon admission to the jail's general population and shall be afforded the opportunity to shower at least three times per week thereafter unless an emergency or a threat to jail security exists.

(d) Each inmate shall be allowed, upon request, to have his/her hair cut at least once every six weeks.

(e) All inmates shall be provided the opportunity to wear their personal clothing when they appear in court for trial.
(f) The Sheriff may supervise and control the hygiene, grooming, and attire of jail inmates to the extent reasonably necessary to maintain a sanitary, safe and secure environment. (Department of Correction; 210 IAC 3-1-10; filed Jul 27, 1981, 10:30 am: 4 IR 1812; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

210 IAC 3-1-11 Medical care and health services
Authority: IC 11-8-2-5; IC 11-12-4-1
Affected: IC 11-12-4-1

Sec. 11. Medical Care and Health Services. (a) A duly licensed physician shall be responsible for medical services in each jail. (b) Procedures necessary to deliver medical services to inmates shall be in writing and shall be approved by the responsible physician. (c) State licensing and/or certification requirements and restrictions shall apply to all health care personnel working with jail inmates. Copies of all licensing and/or certification credentials shall be on file with the sheriff. Jail security regulations shall apply to all medical personnel. (d) Whenever medical services are to be delivered routinely in any jail, adequate space, equipment, supplies and materials as determined by the responsible physician shall be provided. (e) First-aid kits shall be available in each jail. The responsible physician shall approve the contents, number and location of such kits and the procedure for periodic inspection of all first-aid kits. (f) Each inmate shall be medically screened upon admission to jail and before placement in the general population or living area. Screening data must be recorded on a form approved by the responsible physician and shall include, but not be limited to: (1) Current illnesses and health problems, including those specific to women; (2) History of drug and/or alcohol use; (3) Medications taken; (4) Special health requirements; (5) Screening of other health problems designated by the responsible physician; (6) Behavioral observations, including state of consciousness and mental status; (7) Notation of body deformities, trauma markings, bruises, lesions, jaundice and ease of movement; (8) Condition of skin and body orifices, including rashes and infestation; and (9) Disposition/referral of inmate to qualified medical personnel on an emergency basis. (g) Within fourteen (14) days following arrival at the jail, an inmate shall be given the opportunity to receive a medical examination conducted by the responsible physician or his designees. (h) Inmate medical complaints shall be collected daily and responded to by medically trained personnel. Qualified medical personnel shall follow up all complaints and allocate treatment according to priority of need. A physician shall be available at least once a week to evaluate and respond to inmate medical complaints. (i) Each jail shall provide 24-hour emergency medical and dental care availability pursuant to a written plan which includes as a minimum arrangements for: (1) Emergency evacuation of the inmate from within the facility; (2) Use of an emergency medical vehicle; (3) Use of one or more designated hospital emergency rooms or other appropriate health facilities; (4) Emergency on-call physicians and dentist services when the emergency health facility is not located in a nearby community; and (5) Security procedures that provide for the immediate transfer of inmates when appropriate. (j) Jail personnel shall be trained in the use of emergency care procedures and shall have current training in basic first-aid equipment. At least one person per shift shall have training in receiving screening, cardio pulmonary resuscitation (CPR) and recognition of symptoms of the illnesses most common to the facility. All jail officers shall be trained regarding recognition of symptoms of mental illness and retardation. (1) No jail shall accept delivery of an unconscious or critically injured person. (2) All injured inmates shall be examined immediately, by a competent medical person. A description of the injury should be recorded and photographs taken when appropriate. (k) Jail officials shall use their best efforts to obtain any medication prescribed by a physician. All medications shall be
COUNTY JAIL STANDARDS

administered in the dosage and with the frequency prescribed. No substitutions of medications shall be made without the prescribing physician's approval.

(1) Any jail officer who administers medication shall have received training from the responsible physician and the jail administrator, is accountable for administering medications according to orders, and must record the administration of medication in a manner and on a form approved by the responsible physician.

(2) A structured system for pharmacy storage and distribution shall be established in accordance with recognized medical standards as determined by the responsible physician.

(l) Each jail shall be listed with the Drug Enforcement Administration as a place of practice by the responsible physician.

(m) Each sheriff shall establish policies and procedures for the development and disposition of each inmate's medical records and shall provide secure and confidential storage of such records consistent with physician-patient privileges. (Department of Correction; 210 IAC 3-1-11; filed Jul 27, 1981, 10:30 am: 4 IR 1812; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

210 IAC 3-1-12 Diet and food preparation; written procedures

Authority: IC 11-8-2-5; IC 11-12-4-1
Affected: IC 11-12-4-1

Sec. 12. Diet and Food Preparation. (a) Each sheriff shall establish written policies and procedures concerning the quantity and quality of food served to inmates.

(b) Food shall not be used as a reward or withheld as a disciplinary measure. All meals shall be served under the supervision of the jail administrator or his designee. There shall be no more than fourteen (14) hours between the evening meal and breakfast. Inmates shall be served three (3) meals each day. One meal each day shall be served hot.

(c) Menus shall be prepared in advance and records of all menus and all meals served shall be retained. Menus shall meet the approval of a qualified dietician, and food preparation and the storage shall be in compliance with local and state health standards. Each menu shall include the recommended dietary allowance for food nutrients specified by the National Academy of Science, Food and Nutrition Board. All food service areas and equipment shall be inspected daily by administrative jail personnel. All food must be placed on racks off the floor. Food must be covered while being transported to the inmate area.

(d) To insure that the jail kitchen is maintained in a safe and sanitary condition, the following requirements shall be met:

(1) All kitchen equipment and floors shall be cleaned daily. Walls and vents shall be cleaned regularly.

(2) The sheriff or jail administrator shall request that the local health officer, or an otherwise qualified agency, conduct periodic inspections of the kitchen facilities to insure compliance with established health and sanitary standards.

(3) Eating utensils shall be sanitized. Alternatively, plastic disposal utensils may be used for each meal.

(4) Kitchen equipment must be operational and safe for use.

(5) Inmates working in the kitchen shall be given a pre-service examination and periodic examinations thereafter to insure that they do not have any contagious diseases or other ailments which could facilitate food contamination. Inmates shall wear clothing approved for food handling when they are assigned to the kitchen.

(e) Medical diets approved by the responsible physician shall be honored. Religious diets shall be honored to the extent that the required food is readily accessible in the community where the jail is located. Any refusal to grant a medical or religious diet shall be reported in writing to the sheriff or jail administrator.

(f) Each sheriff shall establish in writing a control system to monitor and control food pilferage, misuse or spoilage. (Department of Correction; 210 IAC 3-1-12; filed Jul 27, 1981, 10:30 am: 4 IR 1813; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

210 IAC 3-1-13 Security and control; written procedures

Authority: IC 11-8-2-5; IC 11-12-4-1
Affected: IC 11-12-4-1

Sec. 13. Security and Control. (a) Each sheriff shall establish a manual setting forth the jail's policies and procedures for security and control. This manual shall be distributed to all jail personnel and shall be reviewed annually and updated as needed. The manual shall include, but not be limited to:

(1) Supervision;
(2) Searches and seizures;
(3) Facility security;
(4) Shakedowns;
(5) Firearms and other weapons;
(6) Maintenance of security equipment;
(7) Key control;
(8) Tool control;
(9) Records control;
(10) Population count;
(11) Chemical agents;
(12) Post orders;
(13) Escapes;
(14) Emergency situations, including fire, disturbance, assault, taking hostages, natural disasters;
(15) Transportation of inmates; and
(16) Use of physical force.

Jail officers shall be trained consistent with provisions of the security and control manual. Pre and post training examinations shall be administered to each jail officer, and the results made part of the employee's record.

(b) Inmates shall not be permitted to handle, use, or have jail keys of any type in their possession. There shall be at least one full set of keys, separate from those in use, stored in a safe place accessible only to jail personnel, for use in event of an emergency. Keys are to be color coded and classified pursuant to a key numbering and lettering system.

(c) The use of physical force by jail personnel shall be restricted to instances of justifiable self-protection, protection of others, protection of property, and prevention of escapes. Force shall be used only to the degree necessary and consistent with any statutory limitations. Written reports following any use of force shall be promptly submitted to the sheriff or his designee.

(1) Only weapons approved by the sheriff shall be used by jail personnel in emergency situations. Any jail employee who discharges a firearm in the course of his duty shall promptly submit a written report to the sheriff.

(2) Weapons shall not be permitted beyond a designated area to which inmates have no access, except in emergency situations.

(3) Persons designated to authorize the use of tear gas, mace, or other chemical agents shall be named in writing and shall be trained in the proper employment of the chemical agents.

(4) Each sheriff shall establish procedures for the treatment of persons injured as a result of a weapon or chemical agent.

(d) Each jail shall maintain a secure communication control center separate from other jail detention and administrative functions. Jail officers and other personnel assigned to jail duty shall be trained in security measures and handling of special incidents such as assaults, disturbances, fires and natural disasters. Each jail shall have an audio communication system between the communication control center and the inmate living area.

(e) Each jail shall have equipment necessary to maintain central lights, power and communication in an emergency. Equipment shall be tested at least weekly for effectiveness and shall be repaired or replaced as necessary.

(f) Security equipment shall be sufficient to meet facility needs and shall be stored in a secure, readily accessible area.

(g) All security perimeter entrances, control center doors, cell block doors, and cell doors opening into a corridor shall be kept locked except when used for admission or exit of employees, inmates or visitors, and emergencies. No jail officer shall enter a high security cell area without back-up assistance.

(h) Jail officials may perform searches and seize contraband or prohibited property. Jail officials may inform an inmate of the items of property he is permitted to possess, in which event all other property not contraband is prohibited property. Property that an inmate is otherwise permitted to possess may become prohibited property due to the means by which it is possessed or used. The sheriff or jail administrator shall establish written procedure providing for a written record concerning the seizure of contraband or prohibited property, receipts for property seized, and appropriate disposition of seized property.

(1) Notice in writing shall be given inmates and visitors as to the items not considered contraband or prohibited property.

(2) Visitors and inmates may be searched at jails where contact visiting is permitted.

(3) Body cavity searches may be conducted only by medical personnel of the same sex as the person being searched. Visitors must be given clear notice of the possibility of body cavity searches may and decline their request to visit upon receiving this notice. The grounds on which body cavity searches may be conducted shall be clearly stated.

(4) Inmates permitted to leave the jail temporarily, for any reason, shall be thoroughly searched prior to leaving and before re-entering the jail. Searches and seizures shall be conducted so as to avoid unnecessary force, embarrassment, or indignity.
(5) The sheriff shall establish written policies and procedures concerning contraband, prohibited property, searches and seizures of property.

(Department of Correction; 210 IAC 3-1-13; filed Jul 27, 1981, 10:30 am: 4 IR 1814; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

210 IAC 3-1-14 Inmate supervision

Authority: IC 11-8-2-5; IC 11-12-4-1
Affected: IC 11-12-4-1

Sec. 14. Supervision of Inmates. (a) There shall be sufficient jail personnel present in the jail to provide adequate twenty-four hour supervision of inmates.

(1) A jail officer shall provide personal observation not including observation by a monitoring device, of each inmate at least once every sixty (60) minutes between the hours of 8:00 p.m. and 7:00 a.m. Such observation may be conducted on an irregular schedule but shall be documented.

(2) High risk, suicidal inmates shall be provided appropriate supervision consistent with that behavior.

(b) The sheriff shall establish written procedure for the supervision of female inmates by male staff and the supervision of male inmates by female staff. These procedures shall take into consideration the privacy rights and needs of inmates.

(c) The sheriff shall establish written procedures for the segregation of inmates with serious behavioral problems, inmates requiring protective custody, or inmates charged with disciplinary misconduct.

(1) An inmate charged with disciplinary misconduct may be confined or separated from the general population of the jail for a reasonable period of time if his continued presence in the general population poses a serious threat to himself, others, property or the security of the jail. Jail officials shall review the status of that inmate at least once every seven (7) days to determine if the reason for segregation still exists. Time spent confined or separated from the general population before a determination of guilt must be credited toward any period of disciplinary segregation imposed.

(2) No inmate shall be kept in disciplinary segregation for a period in excess of thirty (30) days for any single instance of disciplined conduct without administrative review.

(3) Jail officials shall maintain a permanent written record of activity in disciplinary and administrative segregation areas.

(d) Each area of the jail shall be visited by the Sheriff or his designee at least once weekly and daily by supervisory staff. All inspections shall be documented.

(e) Inmates shall not be authorized to supervise or exert control or assume any authority over other inmates. (Department of Correction; 210 IAC 3-1-14; filed Jul 27, 1981, 10:30 am: 4 IR 1815; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

210 IAC 3-1-15 Inmate rights

Authority: IC 11-8-2-5; IC 11-12-4-1
Affected: IC 11-12-4-1

Sec. 15. Inmate Rights. (a) The right of jail inmates to have access to the courts shall be insured. Inmates shall have confidential access to their attorneys and the authorized representatives of their attorneys. Jail inmates not represented by counsel shall have reasonable access to an adequate law library.

(b) Inmates shall not be subject to discrimination based on race, national origin, color, creed, sex, economic status, or political belief. There shall be equal access to programs or services for male and female inmates.

(c) Inmates shall have the right of access to reading material except pornography as defined by Indiana law or reading matter which jail officials have reasonable grounds to believe poses an immediate danger to the safety of an individual or a serious threat to the security of the jail.

(d) An inmate is entitled to believe in the religion of his choice, and attendance at religious services is not required. To the greatest extent possible consistent with jail security, programs and resources, an inmate is entitled to:

(1) Observe the religious days of worship or holidays of his religion;

(2) Possess and wear religious artifacts;

(3) Receive and possess religious literature; and
(4) Communicate, correspond with and be visited by a clergymen or religious counselor of his choice.
(e) An inmate shall be given a reasonable opportunity for physical exercise and recreation outside of his immediate living quarters and out of doors where feasible, consistent with the security and resources of the jail.
(f) Each sheriff shall make arrangements with election officials to facilitate an inmate's right to vote by absentee ballot provided that the inmate is otherwise qualified to vote.
(g) Each jail shall maintain a written inmate work assignment plan providing for inmate employment, subject to the number of available work opportunities and the maintenance of facility security. Unsentenced inmates shall not be required to work except as may be necessary to maintain their living quarters in a safe and sanitary condition.
(h) All inmates shall have the right to file written grievances regarding treatment of conditions in the jail with the sheriff or his designee. Grievances shall be promptly investigated, and a written report stating the disposition of the grievance shall be provided the inmate. The sheriff shall establish in writing a grievance procedure which shall be made known and distributed to all inmates upon arrival and initial screening.
(i) Inmates may receive visitors at reasonable times. Jail officials may, however, for the purposes of maintaining jail security, individual safety, and administrative manageable, place reasonable restrictions on visitation.
(1) Each sheriff shall establish written procedures providing for inmate telephone access; general visitation; special visitation; visitation for high security risk inmates; and visitor registration, including search procedures.

210 IAC 3-1-16  Mail; written procedures

Sec. 16. Mail. (a) Each sheriff shall establish a written procedure consistent with Indiana law governing inmate mail correspondence.
(b) An inmate may send and receive an unlimited amount of correspondence to or from any person outside the jail in any language. The sheriff may restrict correspondence between inmates within the jail or with inmates of any other jail or penal institution.
(c) Correspondence to or from government officials, courts, attorneys, or representatives of the public news media may not be opened, read, censored, copied or otherwise interfered with in regard to its prompt delivery or transmission. However, if jail officials have reasonable grounds to believe that a piece of correspondence may contain contraband or prohibited property, said correspondence may be opened by jail officials in the presence of the addressee for the purpose of examining the contents for contraband or prohibited property. Upon completion of the inspection, the item of correspondence must be promptly delivered or transmitted without reading, censoring, copying or further interfering with its delivery or transmission.
(d) Correspondence from a person not enumerated in paragraph (c) of this section may be opened to inspect for and remove contraband or prohibited property and to permit removal of funds for crediting the addressee's account. Such correspondence may not be read, censored, copied or otherwise interfered with unless jail officials have reasonable grounds to believe that it poses an immediate danger to the safety of an individual or a serious threat to the security of the jail. The addressee must be informed in writing of the amount of any funds removed.
(e) Correspondence to a person not enumerated in paragraph (c) of this section may be sealed by the inmate. However, if jail officials have reasonable grounds to believe that such correspondence may contain contraband or prohibited property or poses an immediate danger to the safety of an individual or serious threat to the security of the jail, it may be opened for inspection and removal of the contraband or the prohibited property, when appropriate, or reading and appropriate action.
(f) Whenever jail officials delay, censor, copy or withhold correspondence, the addressee shall be given prompt notice in writing. Jail officials shall maintain a record of each decision to withhold, copy, censor, delay or otherwise interfere with the prompt transmission of correspondence.
(g) Jail officials may open all incoming and outgoing packages to inspect for and remove funds, contraband or prohibited property. If contraband or prohibited property is removed from a package, the inmate must be notified in writing of such removal.
(h) Jail officials may inspect all printed matter and exclude any material that is contraband or prohibited property. Printed matter may not be excluded on the grounds it is obscene or pornographic unless it is obscene under Indiana law. A periodical may be excluded only on an issue by issue basis. Jail officials who withhold printed matter must promptly notify the addressee in writing.
(i) Indigent inmates shall be furnished with free writing supplies and postage sufficient for at least two letters per week.

(Department of Correction; 210 IAC 3-1-16; filed Jul 27, 1981, 10:30 am: 4 IR 1816; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

210 IAC 3-1-17 Discipline; written rules

Authority: IC 11-8-2-5; IC 11-12-4-1
Affected: IC 35-50-6-4; IC 35-50-6-5

Sec. 17. Discipline. (a) Each sheriff shall establish written rules of inmate conduct for the maintenance of order and discipline among inmates. Such rules shall describe the conduct for which disciplinary action may be imposed, the type of disciplinary action that may be taken, and the disciplinary procedure to be followed. Copies of these rules shall be distributed to all inmates. The disciplinary action imposed shall be proportionate to the seriousness of the rule violation. The use of physical force as a means of discipline is prohibited.

(b) All jail personnel who have regular inmate contact shall be provided training sufficient to make them thoroughly familiar with the rules of inmate conduct and the sanctions available.

(c) Any of the following may be imposed as disciplinary action on jail inmates:

1. A report, which may be made part of the inmate's record;
2. Extra work;
3. Loss or limitation of privileges;
4. Change in work assignment;
5. Restitution;
6. Transfer to the Department of Correction for safe-keeping;
7. Segregation from the general population for a fixed period of time;
8. Reassignment to a lower credit time class under IC 35-50-6-4;
9. Deprivation of earned credit time under IC 35-50-6-5.

(d) The following shall not be imposed as disciplinary action on jail inmates:

1. Corporal punishment;
2. Confinement without an opportunity for at least one-half hour of daily exercise outside of immediate living quarters, unless jail officials find and document that this opportunity will jeopardize the physical safety of the inmate, others, or the security of the jail;
3. A substantial change in heating, lighting or ventilation;
4. Restrictions on clothing, bedding, mail, visitation, reading, and writing materials or the use of hygienic facilities, except for abuse of these;
5. Restrictions on medical and dental care, access to courts, legal counsel, government officials or grievance proceedings, and access to personal legal papers and legal research materials;
6. A deviation from the diet provided to other inmates, unless approved by the responsible physician;
7. Extra work exceeding a total of twenty (20) hours for one (1) rule violation, or exceeding four (4) hours in any twenty-four (24) hour period.

(e) Before imposing any disciplinary action, jail officials shall afford the inmate charged with misconduct a hearing to determine his guilt or innocence and the disposition of the charge. The charged inmate may waive his right to a hearing in writing. Also, before a charge is made, the inmate and a jail official may agree to a disciplinary action in the forms of extra work or loss or limitation of privileges if no record of the conduct or disciplinary action is placed in the inmate's file. In connection with the required hearing, the inmate is entitled to:

1. Have not less than twenty-four (24) hours advance written notice of the date, time and place of the hearing, and of the alleged misconduct, and the rule the misconduct is alleged to have violated;
2. Have reasonable time to prepare for the hearing;
3. Have an impartial decisionmaker;
4. Appear and speak in his own behalf;
5. Call witnesses and present evidence;
6. Confront and cross-examine witnesses, unless the decisionmaker finds that to do so would subject a witness to a substantial risk of harm;
COUNTY JAIL STANDARDS

(7) Have advice and representation by a lay advocate in those hearings based upon a charge of institutional misconduct when the decisionmaker determines he lacks the competency to understand the issues involved or to participate in the hearing.
(8) Have a written statement of the findings of fact, the evidence relied upon, and the reasons for the action taken;
(9) Have immunity if his testimony or any evidence derived from his testimony is used in any criminal proceedings;
(10) Have his record expunged of any reference to the charge if he is found not guilty or if a finding of guilt is later overturned.

Any finding of guilt must be supported by a preponderance of the evidence presented at the hearing. An inmate shall receive written notice of any charge against him within twenty-four (24) hours of knowledge or discovery of the alleged offense by jail officials, excepting weekends and holidays. The notice shall specify the date, time and place of the hearing; the alleged misconduct; the rule the misconduct is alleged to have violated; the right to a hearing and explanation of the hearing process. The hearing shall be held within seventy-two (72) hours of the alleged violation unless the inmate requests additional time to prepare for the hearing.

(g) The sheriff may delegate authority in writing to one or more designees to conduct hearings for alleged violations of facility rules.

(h) An inmate may appeal the disciplinary decision of a hearing authority to the sheriff. The appeal may challenge the finding of guilt or the type and degree of disciplinary action taken. Any appeal shall be initiated within ten (10) days of the disciplinary decision. The sheriff may reduce but not increase any disciplinary action imposed by the hearing authority. (Department of Correction; 210 IAC 3-1-17; filed Jul 27, 1981, 10:30 am: 4 IR 1817; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

210 IAC 3-1-18 Inmate classification
Authority:  IC 11-8-2-5; IC 11-12-4-1
AFFECTED: IC 11-12-4-1

Sec. 18. (a) Each sheriff shall establish a written plan for the following:
(1) Classifying and assigning inmates according to sex.
(2) The seriousness of their alleged crimes.
(3) The degree of risk of violence to other inmates.
(4) Their status as either youth or adults and pretrial detainees or convicted persons.

When the jail is at or near capacity, the sheriff shall use the best effort to maintain proper classification and segregation.

(b) Juveniles alleged to be delinquent or adjudicated delinquent shall be held only in accordance with IC 31-6-1-21.3 [IC 31-6 was repealed by P.L.1-1997, SECTION 157, eff July 1, 1997.] and IC 31-6-4-6.5(b)(1) [IC 31-6 was repealed by P.L.1-1997, SECTION 157, eff July 1, 1997.].

(c) Inmates with contagious or communicable diseases shall be segregated from other inmates. Intoxicated inmates and those inmates experiencing delirium tremens or drug withdrawal shall also be segregated and given close observation. Allegedly insane or incompetent inmates who are held in custody during examination of their mental condition or while awaiting commitment to a mental institution shall be segregated and given close observation.

(d) Inmates shall not be segregated by race, color, creed, or national origin in living area assignments. (Department of Correction; 210 IAC 3-1-18; filed Jul 27, 1981, 10:30 a.m.: 4 IR 1818; filed Jan 31, 1996, 4:00 p.m.: 19 IR 1312; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)

210 IAC 3-1-19 Written procedures governing new inmate admissions
Authority:  IC 11-8-2-5; IC 11-12-4-1
AFFECTED: IC 11-12-4-1

Sec. 19. Reception, Orientation, Property Control and Release. (a) Each sheriff shall establish written procedures governing the reception and orientation of newly admitted inmates. Such procedures shall include, but not be limited to:
(1) Verification of commitment papers;
(2) Complete search of the individual;
(3) Disposition of clothing and personal property;
(4) Medical screening, including tests for infectious diseases;
(5) Telephone calls;
(6) Showers and hair care if necessary;
COUNTY JAIL STANDARDS

(7) Issue of jail clothing and supplies;
(8) Photographing and fingerprinting, including notation of identifying marks or unusual characteristics;
(9) Interview for obtaining identifying data;
(10) Classification for assignment to the living area;
(11) Assignment to the living area.

(b) Each sheriff shall establish written procedures providing for a written, itemized inventory of all personal property of newly admitted inmates; the secure storage of such property, including money and other valuables; and the return of each inmate's personal property upon release, as well as the procedures governing release of inmates. (Department of Correction; 210 IAC 3-1-19; filed Jul 27, 1981, 10:30 am: 4 IR 1818; readopted filed Nov 15, 2001, 10:42 a.m.: 25 IR 1269; readopted filed Jul 6, 2007, 2:54 p.m.: 20070725-IR-210070277RFA)
201—50.1(356,356A) Definitions. The following are defined terms:

“Activity area” means such area, distinct from the living unit, where prisoners may congregate for programming. This area is to be under constant staff observation.

“Alternative jail facility” means a facility designated pursuant to Iowa Code chapter 356A, and which is used as a halfway-house-type facility rather than a jail-type operation. These facilities shall be subject to inspection and accreditation by the state jail inspector utilizing applicable administrative rules for residential facilities pursuant to 201—Chapter 43 and other acceptable operational standards.

“Average daily population” means the average number of prisoners housed daily during any given time period.

“Barrier free” means no walls or other obstructions impeding contact by staff within their assigned area of operation.

“Capacity” means the number of prisoner occupants which any cell, room, unit, building, facility or combination thereof may accommodate according to the square footage and fixture requirements of the standards.

“Cell” means prisoner occupancy bedroom space with toilet and lavatory facilities.

“Cellblock” means a group of cells with an associated dayroom.

“Classification” means a system of obtaining pertinent information concerning prisoners with which to make a decision on assignment of appropriate housing, security level, and activities.

“Continuous visual observation” means uninterrupted visual contact unaided by closed circuit television (CCTV).

“Dayroom” means a common space shared by prisoners residing in a cell or group of cells, to which prisoners are admitted for activities such as dining, bathing, or passive recreation and which are situated immediately adjacent to prisoner sleeping areas.

“Detention area” means that portion of the facility used to confine prisoners.

“Direct supervision jail” means a style of jail construction designed to facilitate direct contact between officers and prisoners. The officer is stationed inside the housing unit. Evaluation and classification of prisoners are ongoing and continuous functions of a direct supervision jail and are based on close contact with prisoners.

“Disability” means a physical or mental impairment that substantially limits one or more of the major life activities of an individual; a record of such an impairment; or being regarded as having such an impairment.

“DOC” means the Iowa department of corrections.

“Dormitory” means an open area for two or more prisoners with all fixtures self-contained. There is no barrier between the sleeping area and other fixtures such as shower, table, recreation equipment, or similar items.
“Emergency situation” means any significant disruption of normal operations caused by riot, strike, escape, fire, natural disaster or other serious incident.
“Evaluation” means an ongoing process whereby judgments are made concerning a prisoner based upon the behavior of that prisoner.
“Existing facility” means any place in use as a jail or for which bids have been let for construction prior to September 12, 2001.
“Holding cell” means a secure room or cell where prisoners may be held up to 24 hours while awaiting the procedure of commitment or release or court appearances.
“Holdover” means a nonsecure area within a law enforcement facility, hospital, mental health facility or other existing public building that is intended to serve as a short-term holding facility for juveniles. A nonsecure area may be a multipurpose area which is unable to be locked.
“Housing unit” means a detention area. This area may be a single occupancy cell, multiple occupancy cell, cellblock, or dormitory.
“Inspection unit” means the state jail inspection unit.
“Jail” means any place administered by the county sheriff and designed to hold prisoners for as long as lawfully required but not to exceed one year pursuant to Iowa Code chapters 356 and 356A.
“Jail administrator” means the sheriff, sheriff’s designee, or the executive head of any agency operating a jail. The jail administrator shall be responsible for the operation of the facility according to these rules.
“Jailer” means any person who is involved in the booking or supervision of prisoners, who has direct contact with prisoners or who has control over the movement or release of prisoners within the jail. Jailers shall meet the requirements of rules 201—50.10(356,356A) and 50.11(356,356A), Iowa Administrative Code.
“Jail inspector” means the department of corrections employee responsible for inspections of jails and enforcement of these rules by authority of Iowa Code section 356.43.
“Jail supervisor” means any person who is responsible for the routine operation of a jail during assigned duty hours. While this person does not have to be on the premises at all times, the person must be readily available for consultation.
“Juvenile” means any person under the age of 18 years.
“Living unit” means an area within a housing unit and that contains individual sleeping compartments, dayrooms, all necessary personal hygiene fixtures, and sufficient tables and seats to accommodate capacity.
“Lock down” means whenever prisoners are required to be in their individual cells or locked in same.
“Mail” means anything that is sent to or by prisoners through the United States Postal Service.
“Major remodeling” means construction that changes the architectural design of an existing jail and that increases or decreases capacity.
“Medical practitioner” means a licensed physician, licensed osteopathic physician or physician’s assistant or medical resources such as a hospital or clinic.
“Mental illness” means a psychiatric illness or disease expressed primarily through abnormalities of thought, feeling, and behavior producing either distress or impaired function.
“Minister” means a trained person ordained or licensed by a bona fide religion to conduct the services of that faith.
“Monitoring” means having a reasonable degree of knowledge or awareness of what activities a prisoner is engaged in during incarceration.

“Multiple occupancy cell” means a cell designed for more than one prisoner and accessible to a dayroom.

“Nonsecure hold” means a nonsecure area within a law enforcement facility and which is intended to serve as a short-term holding facility for juveniles. A nonsecure area may be a multipurpose area which is unable to be locked.

“Person performing jail duties” means all persons directly involved in the provision of services to prisoners or the operation of a jail except:

1. Outside contractors performing specific housekeeping functions under the direct supervision of a jailer.
2. Individuals such as maintenance personnel, cooks, and janitors, if they do not have direct contact with prisoners or routine access to areas occupied by prisoners.

“Physical jeopardy” means, due to the prisoner’s physical or mental condition, the prisoner is in peril of serious physical harm.

“Pod” means a grouping of two or more housing units, usually found in large facilities, which will aid in the control of prisoners.

“Prisoner” means any individual confined in a jail.

“Residential facilities” means the facilities governed by 201—Chapter 43.

“Roving supervising officer” means an officer who provides direct supervision of prisoners by continuously moving through the housing unit, cells, and activity area of the unit.

“Segregation cell” means a single occupancy cell equipped with tamper-resistant bunks, a toilet, and a wash basin which are of the type recommended for maximum security housing.

“Unencumbered space” is floor space that is not encumbered by furnishings or fixtures. Unencumbered space is determined by subtracting the floor area encumbered by furnishings and fixtures from the total floor area. (All fixtures must be in operational position for these calculations.)

“Waiver/variance” means a waiver of a specific standard granted by the Iowa department of corrections in accordance with 201—Chapter 7.

“Weapons” means any instrument, excluding restraining devices, chemical control agents and electronic control devices, with an intended use of self-defense, protection of another, or to gain or maintain compliance from an individual.

[ARC 9578B, IAB 6/29/11, effective 8/3/11]

201—50.2(356,356A) General provisions.

50.2(1) Applicability. These rules apply to all facilities regulated by Iowa Code chapters 356 and 356A except temporary holding facilities which are covered by 201—Chapter 51.

50.2(2) Capacity. Established capacities as determined by these rules shall not be exceeded except in the event of an emergency and then only for such a period of time as is necessary to arrange for alternate housing or release of sufficient prisoners to bring the number of persons confined into compliance with the rated capacity.

50.2(3) Right to inspect and visit. The chief jail inspector or authorized representatives shall visit and inspect jails and may do so on an unannounced basis. Jail personnel and supervisors shall cooperate
in inspections and shall exhibit to the inspectors, upon request, all books, records, medical
records, data, documents and accounts pertaining to a jail or to the prisoners confined and shall
assist inspectors to perform the functions, powers and duties of their office. Provisions of the
first paragraph of Iowa Code
section 356.43 shall control to the extent of any inconsistency of the provisions of this subrule.

50.2(4) Other standards. Nothing contained in these standards shall be construed to prohibit
local officials from adopting standards and requirements governing their employees and
facilities, provided such standards and requirements exceed and do not conflict with standards
mandated in this chapter. These standards shall not be construed as authority to violate any state
fire safety standard, building standard, health and safety code, or any constitutional requirement.
No jail shall be operated without substantially meeting these rules, absent the granting of a
waiver/variance.

50.2(5) Equal opportunity. Facilities, programs, and services shall be available on an equitable
basis to both males and females even though each standard does not specify that it applies to
both males and females.

50.2(6) Nondiscriminatory treatment. Each jail administrator shall ensure that staff and prisoners
are not subject to discriminatory treatment based upon race, religion, nationality, disability, sex
or age absent compelling reason for said discriminatory treatment. Discrimination on the basis of
a disability is prohibited in the provision of services, programs, and activities.

201—50.3(356,356A) Inspection and compliance. The chief jail inspector or authorized
representatives shall visit and inspect each jail within this state at least annually to determine the
degree of compliance with these standards and within 45 days of each inspection shall report the
results to the sheriff and the governing body responsible for the facility.
If a residential facility is operated by a judicial district department of correctional services, the
regional deputy director of the department of corrections and the regional deputy director’s
personnel shall be responsible for all inspections and approvals and shall have the same powers
as the members of the jail inspection unit in carrying out these rules.

50.3(1) Notice of noncompliance with minimum standards. Whenever the determination is made
that a jail or other holding facility is not in compliance with established minimum state jail
standards, the chief administrator of the affected governmental facility will be notified by letter
posted or personal delivery of the need to bring the facility into compliance. The jail inspection
unit shall issue a notice of noncompliance to the responsible jail administrator and the governing
body of each instance in which the jail fails to comply with the minimum standards established
under these rules. The letter shall contain a listing of the statute(s) and rule(s) with which the
facility is not in compliance and a description of the deficiencies and shall specifically identify
each minimum standard with which the jail has failed to comply.

50.3(2) Enforcement of minimum standards; remedial orders. Upon receipt of a notice of
noncompliance pursuant to subrule 50.3(1), the responsible authorities shall initiate appropriate
corrective measures within the time prescribed by the jail inspection unit in its notice (which
shall not exceed 90 days) and shall complete the corrections within a reasonable time as
prescribed by the notice of noncompliance. The jail inspector may agree with the responsible
authorities to a plan of action detailing corrective steps with corresponding time frames which
will bring the facility into compliance within a reasonable time. If the responsible officials IAC receiving a notice of noncompliance fail to initiate corrective measures or to complete the corrective measures within the time prescribed, the jail inspection unit may order the jail in question or any portion thereof closed, that further confinement of prisoners or classifications of prisoners in the noncomplying jail or any portion thereof be prohibited, or that all or any number of prisoners then confined be transferred to and maintained in another jail or detention facility, or any combination of remedies.

An order for closure shall contain the following:

a. Statute(s) and rule(s) violated.
b. A brief description of the deficiencies.
c. The effective date of the order.
d. An explanation of remedies required before reopening.

This order shall be the notice of noncompliance pursuant to Iowa Code section 356.43 and 201—Chapter 12 concerning contested cases. The matter shall then proceed in accordance with 201—Chapter 12. The jail inspector may agree with the responsible authorities to a plan of action detailing corrective steps with corresponding time frames which would bring the facility into compliance within a reasonable time. The remedial order shall be in writing and shall specifically identify each minimum standard with which the jail has failed to comply. Such remedial order shall become final and effective 30 days after receipt thereof. In the event immediate closure is required, emergency action shall proceed pursuant to 201—12.24(17A).

**50.3(3) Precedent.** Because rules cannot adequately anticipate all potential specific factual situations and circumstances presented for action, determination or adjudication by the jail inspection unit, the nature of the action taken with regard to any matter or the disposition of any matter pending before the jail inspection unit is not necessarily of meaningful precedential value, and the department shall not be bound by the precedent of any previous action, determination, or adjudication in the subsequent disposition of any matter pending before it. This rule is intended to implement Iowa Code sections 17A.10, 17A.12 and 356.43.

**201—50.4(356,356A) Physical plant—general.**

**50.4(1) Building to meet existing codes.** All facilities are required to be structurally sound and to meet existing building code and health code requirements.

**50.4(2) Professional inspections.**

a. The state jail inspector may require for good reason that an agency operating a jail cause it to be examined by an architect, engineer, licensed electrician, health inspector, plumber, heating and air conditioning specialist, food establishment inspector, state fire marshal or fire inspector or any other person with expertise which may be of assistance to the state jail inspector in making an informed decision relative to the jail operation or structure. Inspection by a municipal inspector qualified in these areas may be permitted.

b. Any facility determined to be deficient following inspection may be ordered closed by the jail inspector, or specific conditions limiting its operation may be imposed in lieu of closing.

An order of closure shall contain the following:

(1) Statute(s) and rule(s) violated.

(2) A brief description of the deficiencies.
(3) The effective date of the order.
(4) An explanation of remedies required before reopening.

An order of closure shall adhere to subrules 50.3(1) and 50.3(2). This order shall be the notice of noncompliance pursuant to Iowa Code section 356.43 and 201—Chapter 12 concerning contested cases. The matter shall then proceed in accordance with 201—Chapter 12.

c. In the event that any agency fails to cooperate in an inspection, the jail inspector may arrange for an inspection and the agency operating the facility shall be financially responsible for any expense involved.

50.4(3) Heating and ventilation. All detention and living areas shall be reasonably heated and ventilated, with air flow sufficient to admit fresh air and remove disagreeable odors, to ensure healthful and comfortable living and working conditions for prisoners and staff. Fans and an adequate supply of cold liquids will be made available and utilized when indoor temperatures exceed 85° Fahrenheit.

50.4(4) Cells. Maximum security cells shall be equipped with tamper-resistant bunks, secured table(s) and seat(s), plus a toilet and washbasin recommended for jail or prison use. Cells shall have an adequate supply of both hot and cold water; mixing valves may be used. Housing areas of less secure design need not contain tamper-resistant fixtures.

50.4(5) Lighting. Lighting shall be a minimum of 20 candlepower at the table top for the purposes of reading and writing. Living areas shall be devoid of dark areas. Hallways, entrances and exits shall be sufficiently lit to observe a person entering or exiting. Light controls shall be out of the control of prisoners. Housing areas may be variably illuminated to allow sleep, but continuous observation of prisoners must be possible. All exits shall be equipped with independent emergency lighting sources.

50.4(6) Screens. If windows are opened for ventilation, screens shall be installed and maintained in good repair.

50.4(7) Electrical. Drop cords shall not be used as permanent wiring. Electrical service shall meet the requirements of the governmental body permitted by statute to adopt standards for electrical service. Appliances shall plug directly into a fixed receptacle. Emergency generator power shall be available. Emergency generator power shall be tested at regular intervals not less than monthly. A record of test dates shall be maintained.

50.4(8) Storage.

a. Storage of any type in primary detention areas is not permitted except for supplies necessary for the operation of the jail.

b. Adequate storage space for prisoners’ personal clothing and property shall be provided. Space provided shall be secure, and the prisoner’s name or identification number shall be affixed to the storage space. Property shall be inventoried and accounted for as provided in Iowa Code section 804.19. Previously addressed in 50.13(2)(c).

c. Janitorial supplies shall be stored in a manner to prevent unauthorized prisoner access. Janitorial supplies and equipment shall not be stored in prisoner living areas.

d. Areas used for storage of chemicals, paints, and cleaning supplies shall not be accessible to prisoners and such products shall be stored away from the primary detention area. Such storage shall not be in boiler or furnace rooms.

50.4(9) Mirrors. Mirrors within detention areas shall be of tamper-resistant construction and
securely fixed in place.

**50.4(10) Firearms lockers.** A place inaccessible to prisoners shall be provided where officers entering the security area can store firearms.

**50.4(11) Noise level.** Prisoner noise inside the jail shall be controlled to ensure an orderly and secure jail operation. Jail policy shall include a rule pertaining to noise level. Prisoners must be advised of the rule.

[ARC 9578B, IAB 6/29/11, effective 8/3/11]

**201—50.5(356,356A) Physical requirements for existing facilities.** This rule shall apply to all jails in existence prior to June 30, 1984. In cases where an existing jail undergoes major remodeling after September 12, 2001, rules 50.6(356,356A) and 50.7(356,356A) shall apply to the area being upgraded.

**50.5(1)** Each single occupancy cell for prisoners in normal status shall have a minimum floor area of 40 square feet provided that the prisoner is not required to spend more than 16 hours during any 24-hour period in the cell.

**50.5(2)** Each single occupancy cell must provide 50 square feet of floor space for prisoners held more than 16 hours during any 24-hour period.

**50.5(3)** Multiple occupancy cells shall provide 40 square feet of floor space for the first prisoner and an additional 20 square feet for each additional prisoner provided that no prisoner is required to spend more than 16 hours in the cell during any 24-hour period.

**50.5(4)** Prisoners held in multiple occupancy cells for more than 16 hours during any 24-hour period shall have a minimum of 50 square feet of floor space for the first prisoner and 30 additional square feet of floor space for each additional prisoner.

**50.5(5)** Except in emergency situations, no multiple occupancy cell shall house more prisoners than the rated capacity.

**50.5(6)** Dormitory units shall have a minimum of 60 square feet of floor space per prisoner.

**50.5(7)** Each single occupancy cell, multiple occupancy cell and dormitory unit shall provide the following:

- a. A minimum of 7 feet from floor to ceiling height.
- d. Access to a lavatory that furnishes both hot and cold water; mixing valves may be used.
- e. Sufficient tables and seats to accommodate the rated capacity of the unit. The tables and seats may be located in the cells or in an adjacent dayroom.
- f. A functionally operating shower which furnishes both hot and cold water; mixing valves may be used. This shower may be either in the housing unit itself or in an adjacent area.

**50.5(8)** Each dayroom shall have a minimum floor area of 30 square feet. There shall be an additional 15 square feet for each prisoner beyond one.

**201—50.6(356,356A) Physical requirements for new and remodeled facilities—after June 30, 1984.** This rule shall apply to jails which are of new construction and to all major remodeling after June 30, 1984. For jails which are of new construction and for all major remodeling after September 12, 2001, rule 50.7(356,356A) shall apply. Plans for any remodeling or new
construction shall be submitted to the jail inspection unit prior to letting any bids or commencing any construction subject to this rule. The jail inspection unit shall, within 60 days of receiving plans, review them for compliance with this rule and forward any comments to the submitting authority.

50.6(1) New housing units may be single occupancy cells, multiple occupancy cells or dormitory units. Each single occupancy cell shall have a minimum of 70 square feet of floor space. Each multiple occupancy cell shall have a minimum of 70 square feet of floor space for the first prisoner and an additional 50 square feet of floor space for each additional prisoner. Dormitory units shall provide a minimum of 60 square feet per prisoner.

50.6(2) All housing units shall provide:
- No less than 7 feet of space between the floor and ceiling.
- A bunk of adequate size for normal-sized adults for each prisoner.
- Sufficient desks/tables and chairs/seats to accommodate the capacity of the housing unit.
- A dayroom which provides a minimum floor area of 30 square feet for the first prisoner and an additional 15 square feet for each prisoner beyond one. (Dormitories excluded.)
- A functionally operating shower which produces both hot and cold water.
- A lavatory that furnishes both hot and cold water for each group of nine prisoners or portion thereof.
- A functional toilet for each group of nine prisoners or portion thereof.

50.6(3) Each maximum security cell shall have a security-type toilet/lavatory combination fixture which provides adequate hot and cold running water. These cells may rely on common toilet facilities located outside the detention room provided that the prisoner is never involuntarily locked in the room and denied access to the toilet facilities.

50.6(4) Holding cells shall provide a minimum of 20 square feet per prisoner with a total capacity per cell of eight prisoners. Holding cells need not contain any fixture other than a means whereby prisoners may sit. Drinking water and toilet facilities shall be made available under staff supervision. Dayrooms need not be available to prisoners held in holding cells. Holding cells are for detaining persons for a limited period of time, not to exceed 24 hours, except in cases of emergency, while awaiting booking, processing, transfer, court appearance or discharge. Detainees will be supplied blankets if detained overnight in the holding cell. Emergencies are defined as unexpected occurrences, requiring immediate attention, of singular incident and resolution.

50.6(5) The facility shall be designed to admit natural lighting and to give access to outside viewing by prisoners where practical.

50.6(6) The facility shall be designed and constructed so that prisoners may be segregated according to existing laws and regulations.

50.6(7) Except in emergency situations, no housing unit shall house more prisoners than its rated capacity.

50.6(8) All hinged doors serving as required exits shall swing with exit traffic.

201—50.7(356,356A) Physical requirements for new and remodeled facilities—after September 12, 2001. This rule shall apply to jails which are of new construction and all major remodeling or reconstruction after September 12, 2001. Plans for any remodeling or new
construction shall be submitted to the jail inspection unit prior to letting any bids or commencing any construction subject to this rule. The jail inspection unit shall, within 60 days of receiving plans, review them for compliance with this rule and forward any comments to the submitting authority.

50.7(1) New housing units may be single occupancy cells, multiple occupancy cells or dormitory units. Each single occupancy cell shall have a minimum of 70 square feet of floor space. Each multiple occupancy cell shall have a minimum of 35 square feet of unencumbered floor space for each prisoner. Dormitory units shall provide a minimum of 60 square feet per prisoner.

50.7(2) All housing units shall provide:

a. No less than 7 feet of space between the floor and ceiling.
b. A bunk of adequate size for normal-sized adults for each prisoner.
c. Sufficient desks/tables and chairs/seats to accommodate the capacity of the housing unit.
d. A dayroom which provides a minimum floor area of 30 square feet for the first prisoner and an additional 15 square feet for each prisoner beyond one. (Dormitories excluded.)
e. A functionally operating shower which produces both hot and cold water for each group of 12 prisoners.
f. A lavatory that furnishes both hot and cold water for each group of 9 prisoners or portion thereof.
g. A functional toilet for each group of 9 prisoners or portion thereof.

50.7(3) Each maximum security cell shall have a security-type toilet/lavatory-combination fixture which provides adequate hot and cold running water. These cells may rely on common toilet facilities located outside the detention room provided that the prisoner is never involuntarily locked in the room and denied access to the toilet facilities.

50.7(4) Holding cells shall provide a minimum of 20 square feet per prisoner with a total capacity per cell of eight prisoners. Holding cells need not contain any fixture other than a means whereby prisoners may sit. Drinking water and toilet facilities shall be made available under staff supervision. Dayrooms need not be available to prisoners held in holding cells. Holding cells are for detaining persons for a limited period of time, not to exceed 24 hours, except in cases of emergency, while awaiting booking, processing, transfer, court appearance or discharge. Detainees will be supplied blankets if detained overnight in the holding cell. Emergencies are defined as unexpected occurrences, requiring immediate attention, of singular incident and resolution.

50.7(5) Exercise areas shall be 15 square feet per prisoner for the maximum number of prisoners expected to use the space at one time in accordance with 50.18(1) “c.”

50.7(6) The facility shall be designed to admit natural light and to give access to outside viewing by prisoners where practical.

50.7(7) The facility shall be designed and constructed so that prisoners may be segregated according to existing laws and regulations.

50.7(8) Except in emergency situations, no housing unit shall house more prisoners than its rated capacity.

50.7(9) All hinged doors serving as required exits shall swing with exit traffic.
201—50.8(356,356A) Physical requirements for new and remodeled facilities—after December 28, 2005. This rule shall apply to all jails which are of new construction and to all major remodeling or reconstruction after December 28, 2005.

50.8(1) Cells and dormitory units.

a. Single occupancy cells shall provide a minimum of 35 square feet of unencumbered floor space. When confinement exceeds 10 hours per day, except during administrative segregation or emergencies, there shall be at least 70 square feet of total floor space.

b. Multiple occupancy cells shall provide a minimum of 25 square feet of unencumbered floor space for each prisoner. When confinement exceeds 10 hours per day, except during administrative segregation or emergencies, there shall be at least 35 square feet of unencumbered floor space for each occupant.

c. Dormitory units shall provide a minimum of 60 square feet of floor space for each prisoner, exclusive of lavatories, showers, and toilets.

50.8(2) All housing units shall provide:

a. No less than 7 feet of space between the floor and ceiling.

b. A bunk of adequate size for normal-sized adults for each prisoner and at least 12 inches off the floor.

c. Sufficient desks/tables and chairs/seats to accommodate the capacity of the housing unit.

d. A dayroom, which provides a minimum floor area of 35 square feet of space per prisoner (exclusive of lavatories, showers and toilets) for the maximum number of prisoners who use the dayroom at one time. No dayroom shall encompass less than 100 square feet of space, exclusive of lavatories, showers and toilets. Dayrooms shall provide sufficient seating and writing surfaces. (Dormitories excluded.)

e. A functionally operating shower which produces both hot and cold water for each group of 12 prisoners.

f. A lavatory that furnishes both hot and cold water for each group of 9 prisoners or portion thereof.

g. A functional toilet/stool for each group of 9 prisoners or portion thereof. Urinals may be substituted for up to one-third of the toilets in housing units for male prisoners.

50.8(3) Each maximum-security cell shall have a security-type toilet/lavatory-combination fixture that provides adequate hot and cold running water.

50.8(4) Holding cells/special-needs cells.

a. Holding cells shall provide a minimum of 20 square feet per prisoner with a maximum capacity per cell of eight prisoners. Holding cells need not contain any fixture other than a means whereby prisoners may sit. Drinking water and toilet facilities shall be made available under staff supervision. Dayrooms need not be available to prisoners held in holding cells. Holding cells are for detaining persons for a limited period of time not to exceed 24 hours, except in cases of emergency, while the persons are awaiting booking, processing, transfer, court appearance or discharge. Prisoners will be supplied blankets if detained overnight in the holding cell. Emergencies are defined as unexpected occurrences, requiring immediate attention, of singular incident and resolution.

b. Special-needs cells. A jail may contain one or more single occupancy cells, designated as special-needs cells, in which to temporarily contain violent persons. The cell shall have not less than 40 square feet of floor space and a ceiling height of not less than 7 feet. The cell shall be
constructed to minimize self-injury. Toilet facilities may be controlled from outside the cell and may be in the floor. Water need not be available in the cells, but water shall be accessible from staff upon request.

50.8(5) Exercise areas.

a. This paragraph shall apply to all jails constructed on or before July 1, 2008. Exercise areas may be indoor or outdoor exercise areas and shall contain 15 square feet per prisoner for the maximum number of prisoners expected to use the space at one time, but not less than 500 square feet of unencumbered space. Segregation units may have individual exercise areas containing a minimum of 180 square feet of unencumbered space. Exercise areas shall provide opportunity for adequate exercise in accordance with 50.18(1)“c.” Exercise areas shall not be the same as dayrooms.

b. This paragraph shall apply to all jails which are of new construction and to all major remodeling or reconstruction after July 1, 2008. Exercise areas may be indoor or outdoor exercise areas and shall contain 15 square feet per prisoner for the maximum number of prisoners expected to use the space at one time, but not less than 500 square feet of unencumbered space. Segregation units may have individual exercise areas containing a minimum of 180 square feet of unencumbered space. Exercise areas shall have a minimum ceiling height of 18 feet. Exercise areas shall provide opportunity for adequate exercise in accordance with 50.18(1)“c.” Exercise areas shall not be the same as dayrooms.

50.8(6) The facility shall be designed to admit natural light and to give access to outside viewing by prisoners where practical.

50.8(7) The facility shall be designed and constructed so that prisoners may be segregated according to existing laws and regulations.

50.8(8) Except in emergency situations, no housing unit shall house more prisoners than its rated capacity.

50.8(9) All hinged doors serving as required exits shall swing with exit traffic.

201—50.9(356,356A) Fire safety and emergency evacuation.

50.9(1) Approval of building plans. All new construction or major remodeling plans shall be approved by the state fire marshal prior to commencement of construction.

50.9(2) Compliance with fire marshal rules. No jail shall be occupied by a prisoner unless the state fire marshal or qualified local fire prevention authority has issued a certificate of inspection within the last 24 calendar months documenting that the jail complies with the fire safety standards for jails included in administrative rules promulgated by the state fire marshal. Jails may be inspected by the fire marshal, or by personnel of local fire departments deemed by the fire marshal qualified to conduct inspections, on a schedule determined by the fire marshal. The state jail inspection unit of the department of corrections, a jail administrator, or the chief executive of an agency that administers a jail may request that the state fire marshal inspect a jail for compliance with fire safety standards. If the state fire marshal finds that a jail is not in substantial compliance with fire safety standards based on such an inspection, the state fire marshal may require the jail administrator to submit to the fire marshal a plan of correction of violations of these standards. The director of the Iowa department of corrections may initiate proceedings to close the jail if the jail does not comply with the plan of correction.
50.9(3) Evacuation plan. The administrator of each jail shall prepare a written plan for emergency evacuation of the facility in the event of fire or other disaster. This plan shall include security arrangements and one or more alternate housing arrangements for displaced prisoners. All personnel employed in the facility shall be thoroughly familiar with this plan and relevant portions thereof shall be conspicuously posted. Evacuation drills shall be practiced or simulated by all staff on at least an annual basis and a record thereof shall be maintained according to subrule 50.22(10), Iowa Administrative Code.

50.9(4) Release of prisoners.

a. There shall be a reasonable expectation of the prompt removal of prisoners in the event of a life-threatening situation. Keys for all locks necessary for emergency exit shall be readily accessible and clearly identifiable with cell and door locks.

b. There shall be at least one full set of jail keys, other than those regularly used, stored in a safe place accessible only to appropriate persons, for use in the event of an emergency.

50.9(5) Fire extinguishers. All jails shall be equipped with fire extinguishing equipment approved and located in accordance with standards established by the state fire marshal by administrative rule. Fire extinguishers shall be tested at least annually to ensure they remain in operative condition. A record of such checks shall be maintained.

50.9(6) Emergency lighting. All exits shall be equipped with independent emergency lighting sources. All corridors and passage aisles shall be illuminated by independent emergency lighting sources. Lighting shall be arranged to ensure no area will be left in darkness.

50.9(7) Required exits. Where exits are not immediately accessible from an open floor area, safe and continuous passage aisles or corridors leading directly to every exit shall be maintained and shall be so arranged as to provide access for each prisoner to at least two separate and distinct exits from each floor. Passage aisles or corridors shall be kept clear. A locked exit may be classified as an emergency exit only if necessary keys to locked doors are readily available. Elevators shall not be counted as required exits.

50.9(8) Fire alarms. A means of fire detection utilizing equipment of a type meeting requirements established by the state fire marshal shall be installed and maintained. These alarms shall be ceiling-mounted if possible and shall be located and protected from prisoner access. The detection equipment shall be battery-operated or constructed as to continue operating during a power failure. Battery-operated systems shall be tested monthly. Electronic systems shall be tested at least annually. A record of test dates and results shall be maintained according to subrule 50.22(10), Iowa Administrative Code.

50.9(9) Heating appliances. Heating appliances and water heaters shall not be located along the path of required exits.

50.9(10) Hinged doors. All hinged doors serving as required exits from an area designed for an occupancy in excess of 50 persons, or as part of a major remodeling project or as part of new construction, shall swing with exit traffic.

50.9(11) Mattresses. Only fire-resistant mattresses of a type that will not sustain a flame and certified by an independent testing laboratory and that meet the standards established by the state fire marshal shall be used in jails. Mattresses that are ripped, excessively cracked or which contain large holes shall be replaced. Pillows shall be replaced when torn or excessively cracked.
50.9(12) Sprinkler heads. If installed, sprinkler heads accessible to prisoners not under direct supervision must be of the weight-sensitive type, be protected with a sleeve that would hamper the tying of material on the sprinkler head, or be recessed into the wall or ceiling.

201—50.10(356,356A) Minimum standards for jail personnel.
50.10(1) Requirements for employment. No person shall be recruited, selected or appointed to serve as a jail administrator or jailer unless the person:
   a. Is 18 years of age or older.
   b. Is able to read and write in English.
   c. Is of good moral character as determined by a thorough background investigation including a fingerprint search conducted of local, state and national fingerprint files.
   d. Is not by reason of conscience or belief opposed to the use of force, when appropriate or necessary to fulfill the person’s duties.
   e. Has the ability to perform the essential elements of the position as defined in department job specifications.
   f. Is an appropriate candidate for employment as demonstrated by qualified psychological screening.
   g. Rescinded IAB 11/23/05, effective 12/28/05.
50.10(2) Minimum standard for retention. No employee shall be retained who has demonstrated inappropriate action beyond a reasonable degree, who is not psychologically fit for jail employment, or who has repeatedly failed to observe these rules.
50.10(3) Conflict of interest. No person working in a jail shall transact any business with any prisoner nor shall any person working in a jail arrange through another party any business transaction with a prisoner. The jail shall have a written code of ethics that the jail provides to all employees. At a minimum, the code shall:
   a. Prohibit staff from using their official positions to secure privileges for themselves or others.
   b. Prohibit staff from engaging in activities that constitute a conflict of interest.

201—50.11(356,356A) Training for jail personnel.
50.11(1) Initial orientation. Except in an emergency situation, all persons performing jail duties and dispatchers subject to performing jail duties within the confines of the jail shall meet the following requirements, and the provision of this information and training shall be documented:
   a. The individual shall be fully knowledgeable of the administrative rules referring to jail standards.
   b. The individual shall be fully knowledgeable of jail rules, written policies and procedures as adopted by the jail administrator.
   c. The individual shall have been given specific orientation with respect to a prisoner’s rights during confinement and procedures adopted to ensure those rights.
   d. If the individual is to have access to a firearm at any time, the individual shall hold a valid permit to carry weapons issued under the authority of Iowa Code chapter 724. The individual shall be professionally trained and qualified in the use of any firearm, electric restraint control device, and chemical control agents prior to use in connection with the individual’s duties at the jail.
The jail administrator shall record by log sheet the signature(s) of all jailers and jail supervisors attesting that they have full knowledge of the administrative rules referring to jail standards and the written policies and procedures governing the jail’s operation.

The individual shall have been instructed in the use of required firefighting equipment and the fire and emergency evacuation plan.

All staff who administer medication shall be trained in accordance with the Iowa State Sheriffs and Deputies Association medication training program or other recognized medication administration course.

**50.11(2) Training documented.** All jailers and jail administrators shall meet and document the completion of all training requirements as specified by the Iowa law enforcement academy training standards as found in 501—9.1(80B) and 501—9.2(80B), Iowa Administrative Code. The jail administrator shall record by log sheet the signature(s) of all persons attending the training.

**50.11(3) First aid.** At least one staff member on duty at the facility shall be currently trained in first aid (or the equivalent) and CPR. This rule is intended to implement Iowa Code section 80B.11A.

**201—50.12(356,356A) Standard operating procedures manual.** Pursuant to the authority of Iowa Code sections 356.5 and 356.36, each jail shall establish and the jail administrator shall ensure compliance with a standard operating procedures manual to include the following administrative rules: subrules 50.2(5), 50.2(6), 50.4(11), 50.9(3), 50.9(4), 50.10(1), 50.10(2), 50.10(3), 50.11(1) and rules 50.13(356,356A) to 50.22(356,356A) as noted. The following standards do not require written policy: 50.13(2) “c”(3), 50.15(4), 50.16(4), and 50.16(8).

**201—50.13(356,356A) Admission/classification and security.**

**50.13(1) Admission and classification.**

a. No person shall be confined or released from confinement without appropriate process or order of court.

b. With the exception of incidental contact under staff supervision, the following classes of prisoners shall be kept separate by architectural design barring conversational and visual contact from each other:

1. Juveniles and adults (pursuant to Iowa Code section 356.3).
2. Females from males (exception—alternative jail facilities) (pursuant to Iowa Code section 356.4).

b. The following shall be kept separate whenever possible:

1. Felons from misdemeanants.
2. Pretrial prisoners from sentenced prisoners.
3. Witnesses from prisoners charged with crimes.

b. The following shall be kept physically separated:

1. Prisoners of whom violence is reasonably anticipated.
2. Prisoners who are a health risk to others.
3. Prisoners of whom sexually deviant behavior is reasonably anticipated.
4. Prisoners likely to be exploited or victimized by others.

e. Detention of juveniles shall be pursuant to Iowa Code section 232.22.
f. All staff involved in the booking process or the supervision of prisoners shall be trained in
suicide prevention. At the time of booking, an attempt shall be made (either by observation for
marks or scars or direct questioning of the prisoner) to determine if the prisoner is suicidal. The
following questions, or others of equal meaning, shall be incorporated into the booking process
with appropriate documentation to aid in suicide prevention:
(1) Does the prisoner show signs of depression?
(2) Does the prisoner appear overly anxious, afraid, or angry?
(3) Does the prisoner appear unusually embarrassed or ashamed?
(4) Is the prisoner acting or talking in a strange manner?
(5) Does the prisoner appear to be under the influence of alcohol or drugs?
(6) Does the prisoner have any scars or marks which indicate a previous suicide attempt?
In all cases, the following questions will be asked of the prisoner:
Have you ever tried to hurt yourself?
Have you ever attempted to kill yourself?
Are you thinking about hurting yourself?
g. Housing for prisoners with disabilities shall be designed for their use, or reasonable
accommodations shall be provided for the prisoners’ safety and security.
h. Jail personnel shall ask each prisoner within 24 hours of the prisoner’s incarceration if the
prisoner is a military veteran. If so, jail personnel shall advise the prisoner that the prisoner may
be entitled to a visit from a veteran service officer to determine if veteran services are required or
available and, within 72 hours, shall provide the prisoner with contact information for the county
commission of veteran affairs and provide the prisoner the opportunity to contact the county
commission of veteran affairs to schedule a visit from a veteran service officer.
50.13(2) Security and control. The jail administrator shall develop and implement written
policies and procedures for the jail which provide for the control of prisoners and for the safety
of the public and the jail staff. The policy and procedures shall include:
a. Supervision of prisoners.
(1) Twenty-four-hour supervision of all prisoners shall be provided pursuant to Iowa Code
section 356.5(6).
(2) When staff is not within the confinement area of the jail, a staff person shall be in a position
to hear prisoners in a life-threatening or emergency situation; or a calling device to summon help
will be provided. By policy and practice there shall be a means of ensuring that appropriate
personnel will be available on a 24-hour basis to respond to an emergency including, but not
limited to, fire, assaults, suicide attempts, serious illness, and to preserve order, within a
reasonable time period.
(3) At least hourly, personal observation of individual prisoners shall be made and documented.
Prisoners considered to be in physical jeopardy because of physical or mental condition,
including apparently intoxicated persons, as indicated by the medical history intake process and
by personal observation, shall be checked personally at least every 30 minutes until the condition
is alleviated. A CCTV-audio monitoring system may supplement but shall not replace personal
observations. In order to use a CCTV-audio monitoring system, the following requirements must
be met: CCTV and audio must be operational at all times. Visual and audio must be clear and
distinct. Observation of shower and restroom activities shall be at the discretion of the jail
administrator.
(4) No employee or visitor of one sex shall enter a housing unit occupied by the other sex unless advance notice has been provided except in case of an emergency (does not apply to alternative jail facilities). Advance notice may be provided at the time of orientation.

(5) When females are housed in the jail, at least one female staff member shall be on duty in the jail at all times, in accordance with Iowa Code section 356.5(6) (does not apply to alternative jail facilities).

(6) All juveniles arrested for intoxication due to substance abuse shall be personally observed on a continuous basis throughout the period of detention. The activities of juveniles arrested for crimes other than the above shall be monitored at all times, and the juvenile shall be observed by means of personal supervisory checks at no more than 30-minute intervals.

b. Weapons. Except in an emergency situation, no weapons shall be allowed in an area occupied by prisoners.

c. Searches.

(1) All prisoners and property entering or leaving the jail shall be thoroughly searched; searches of persons charged with a simple misdemeanor shall follow provisions of Iowa Code section 804.30. The prisoner’s name or identification number shall be affixed to the property or storage space. Receipts shall be made for property taken from prisoners at the time of admission and returned to prisoners at the time of release.

(2) All persons entering a jail may be searched for contraband. Persons may be denied admission if they refuse to consent to a required search.

(3) A search notice shall be posted in a conspicuous place (no policy required).

(4) Prisoner rules shall contain a clear definition of each item permitted in the jail. All other items shall be considered contraband.

(5) Random, unannounced, and irregular searches of areas accessible to prisoners shall be conducted for contraband and weapons.

d. Key control. Jail keys shall be stored in a secure area when not in use. There shall be at least one full set of jail keys, separate from those in use, stored in a safe place accessible only to designated jail personnel for use in the event of an emergency. The jail administrator will identify those persons who may have access to keys.

e. Facility security.

(1) All areas of the jail shall be inspected regularly and frequently and kept clear of large posters, pictures and articles of clothing that obstruct the view of prisoners by jail staff.

(2) All jail locks, doors, bars, windows, screens, grilles and fencing shall be inspected on at least a monthly basis. Any damaged or nonfunctioning equipment or fixtures shall be reported to the jail administrator in writing. The jail administrator shall ensure prompt repair of any damaged or nonfunctioning equipment or fixture.

(3) The jail administrator shall develop written policy and procedures for the movement and transportation of prisoners outside the secure area of the jail. The policy shall require procedures that will ensure the safety of the jail staff and the public and prevent prisoner escape. The policy shall provide procedures for movement of prisoners for medical treatment and to and from the courts and other facilities. The classification and security risk of the prisoner to be moved will determine the number of staff required and the type of restraints to be used, if any.

(4) The jail administrator shall have written plans for situations that threaten facility security.
Such situations include but are not limited to: bomb threats, riots, hunger strikes, disturbances, hostage situations, escape attempts, medical emergencies, natural disasters and staff work stoppage. The plans shall be made available to all applicable personnel and reviewed by jail staff at least annually and updated as needed.

f. Restraint devices. The jail administrator shall have a written policy on restraint devices. Restraint devices shall not be applied as punishment. Restraint devices shall be used only when a prisoner is a threat to self or others or jeopardizes jail security. There shall be defined circumstances under which supervisory approval is needed prior to application of restraints. Restraint devices shall not be applied for more time than is necessary to alleviate the condition requiring the use of the restraint device. While restrained, prisoners shall be either clothed or covered in a manner that maximizes prisoner privacy. Four/five-point restraints shall be used only when other types of restraints have proven ineffective. If prisoners are restrained in a four/five-point position, the following minimum procedures shall be followed:

(1) Observation by staff shall be continuous. (A CCTV system may be used.)
(2) Personal visual (non-CCTV) observation of the prisoner and the restraint device application shall be made at least every 15 minutes.
(3) Restraint guidelines shall include consideration of an individual’s physical and health condition, such as body weight.
(4) All decisions and actions shall be documented.

[ARC 9578B, IAB 6/29/11, effective 8/3/11]

201—50.14(356,356A) Cleanliness and hygiene.

50.14(1) Housekeeping.

a. The jail shall be kept clean and sanitary. Toilets, wash basins, showers and other equipment throughout the facility shall be maintained in good working order. Walls, floors and ceilings shall be well maintained.

(1) Unless cleaning is done by staff, necessary cleaning equipment shall be provided to prisoners. Cleaning equipment shall be removed from the cell and dayroom areas when cleaning is completed.
(2) The jail shall be maintained in a pest-free condition. Persons spraying chemicals shall be certified by the Iowa department of agriculture and land stewardship. Prisoners and staff shall not be directly exposed to the chemicals being used.

b. The jail shall have a sharps disposal container for razors and needles. The facility shall be equipped to handle disposal of contaminated or hazardous waste according to universal health precautions.

50.14(2) Clothing, bedding, and hygiene items. Prisoners held in excess of 24 hours shall be provided sanitary bedding and linens sufficient to ensure comfort under existing temperature conditions. These items may be withheld by the jail administrator if deemed necessary pursuant to subrule 50.21(5). A standard issue shall include:

a. Toilet articles necessary for daily personal hygiene.

b. Institutional clothing may be issued.

c. If, upon admission to a jail with an average daily population exceeding ten persons, it is determined that the prisoner will be held longer than 24 hours, facility-provided clothing shall be issued.
d. The laundry means and schedule shall be adequate to meet the daily needs of the prisoners. Prisoners shall receive clean linens and clothing no less than weekly.

50.14(3) Personal hygiene.
a. For sanitation and health reasons, prisoners shall be required to keep themselves clean at all times.
b. Unless medically exempted, all prisoners to be held over 24 hours shall be required to shower or bathe.
c. Prisoners may be required to shave or cut their hair only for sanitation.
d. Jail personnel shall establish procedures for prisoner hair care.
e. The sharing of instruments which are subject to blood contamination, such as non-electric razors and toothbrushes, is prohibited. Electric razors properly sterilized under medically approved conditions may be shared.

[ARC 9578B, IAB 6/29/11, effective 8/3/11]

201—50.15(356,356A) Medical services. The jail administrator shall establish a written policy and procedure to ensure that prisoners have the opportunity to receive necessary medical attention for the prisoners’ objectively serious medical and dental needs which are known to the jail staff. A serious medical need is one that has been diagnosed by a physician as requiring treatment or is one that is so obvious that even a lay person would easily recognize the necessity for a physician’s attention. The plan shall include a procedure for emergency care. Responsibility for the costs of medical services and products remains that of the prisoner. However, no prisoner will be denied necessary medical services, dental service, medicine or prostheses because of a lack of ability to pay. Medical and dental prostheses shall be provided only for the serious medical needs of the prisoner, as determined by a licensed health care professional. Cosmetic or elective procedures need not be provided.

50.15(1) Medical resources. Each jail shall have a designated licensed physician, licensed osteopathic physician or medical resource, such as a hospital or clinic staffed by licensed physicians or licensed osteopathic physicians, designated for the medical supervision, care and treatment of prisoners as deemed necessary and appropriate. Medical resources shall be available on a 24-hour basis.

50.15(2) Trained staff.
a. All staff who administer medication shall be trained in accordance with the Iowa State Sheriffs and Deputies Association medication training program or other recognized medication administration course.
b. At least one staff member on duty at the jail shall be currently trained in first aid (or the equivalent) and CPR.

50.15(3) Prisoner involvement. No prisoner shall be involved in any phase of delivery of medical services.

50.15(4) First-aid kits. A first-aid kit approved by qualified medical personnel shall be available to staff (no policy required).

50.15(5) Chemical control agents. A prisoner affected by a chemical control agent shall be offered a medical examination and appropriate treatment as soon as reasonable.

50.15(6) Screening upon admission.
a. Any person who is obviously injured, ill or unconscious shall be examined by qualified medical personnel before being admitted to a jail.

b. Prisoners suspected of having a contagious or communicable disease shall be separated from other prisoners until examined by qualified medical personnel.

c. As a part of the admission procedure, a medical history intake form shall be completed for each person admitted to the jail. The intake procedure shall include screening for potential self-injury or potential suicide. Jail staff with actual knowledge that there is a substantial risk that a prisoner intends to commit suicide shall take reasonable measures to abate that risk. The jail shall have a written suicide prevention plan. Essential elements of the plan shall include annual training to recognize the potential for suicide, communication between staff, appropriate housing and intervention procedures.

d. During times when there is no means of immediate access to the district court, a person arrested on a charge constituting a simple misdemeanor and believed by the arresting officer/agency to be mentally ill, and because of that illness is likely to physically injure the person’s self or others, shall be admitted to the jail only after the arresting officer/agency has demonstrated a reasonable effort to comply with the emergency hospitalization procedure, as provided in Iowa Code section 229.22. The jail shall have a written plan to provide prisoners access to services for the detection, diagnosis and treatment of mental illness. The plan shall include a mental health screening process at admission.

e. Prisoners shall be provided with information on how they can obtain necessary medical attention, and the agency’s policy and procedure shall also reflect this.

50.15(7) Medication procedures.

a. Written policies and procedures pertaining to providing medication shall be established.

b. All prescription medicine shall be securely stored and inventory control practiced. Inventory control shall include documentation of all medication coming into the jail and the amount returned or destroyed when a prisoner is released.

c. A written procedure for recording the taking or administering of all medications shall be established.

d. Prescription medication, as ordered by a licensed physician, licensed osteopathic physician or licensed dentist, shall be provided in accordance with the directions of the prescribing physician or dentist. Prisoners with medication from a personal physician, osteopathic physician or dentist may be evaluated by a physician, osteopathic physician or dentist selected by the jail administrator to determine if the present medication is appropriate.

50.15(8) Medical records. A separate medical record shall be maintained for each prisoner receiving medical care. The record shall include the illness being treated, medication administered, special diets required, medical isolations and the name of the attending health professional or institution. The record may be kept in the prisoner’s file jacket but must be labeled confidential.

50.15(9) Medication storage.

a. Prisoners’ medications shall be stored at the proper temperature, as defined by the following terms:

(1) Room temperature: temperature maintained between 15 degrees centigrade (59 degrees Fahrenheit) and 30 degrees centigrade (85 degrees Fahrenheit).

(2) Cool: temperature between 8 degrees centigrade (46 degrees Fahrenheit) and 15 degrees
centigrade (59 degrees Fahrenheit).

(3) Refrigerate: temperature that is thermostatically maintained between 2 degrees centigrade (36 degrees Fahrenheit) and 8 degrees centigrade (46 degrees Fahrenheit).

(4) All medication required to be “cool” or “refrigerated” shall be stored in a separate refrigerator or in a separate locked container within a refrigerator that is used for other purposes.

b. Any medications bearing an expiration date may not be administered beyond the expiration date.

c. Expired drugs or drugs not in unit dose packaging, whose administration had been discontinued by the attending physician, shall be destroyed by the jail administrator or designee in the presence of a witness. A record of drug destruction shall be made in each prisoner’s medical record. The record shall include the name, the strength and the quantity of the drug destroyed, and the record shall be signed by the jail administrator or designee and by the witness.

d. Medications dispensed by a pharmacy in unit dose packaging may be returned to the dispensing pharmacy pursuant to board of pharmacy examiners rule 657—23.15(124,155A).

e. Jails utilizing unit dose packaging shall have written policies and procedures providing for the return of drugs so packed to the issuing pharmacy. Policy shall include proper record keeping of disposal.

201—50.16(356,356A) General food service requirements.

50.16(1) Prisoner being held. If a prisoner is held over a meal period, a meal of adequate nutrition shall be provided.

50.16(2) Daily meals. The three meals provided for each 24-hour duration shall be served at reasonable and proper intervals; at least one meal shall be a hot meal. Food must be served at the proper temperature; hot foods shall be reasonably hot and cold foods reasonably cold.

50.16(3) Time of serving. Meals shall be served at approximately the same time every day.

50.16(4) Documentation. The facility shall document that its food service meets or exceeds nationally recommended minimum dietary allowances for basic nutrition for appropriate age groups. Dietary guidelines meeting the above requirements shall be certified by a qualified nutritionist or dietitian (no policy required).

50.16(5) Medical diets. Special diets as prescribed by a physician shall be followed and documented. The physician who prescribes the special diet shall specify a date on which the diet will be reviewed for renewal or discontinuation. Unless specified by the prescribing physician, a certified dietitian shall develop the menu.

50.16(6) Religious requests. When a special diet is requested by a prisoner as part of the prisoner’s religious beliefs, the facility shall meet that need, unless the facility can demonstrate that its refusal does not impose a substantial burden on the exercise of the prisoner’s religion or that its refusal furthers some compelling interest and is the least restrictive means of furthering that interest.

50.16(7) Punishment. Deviation from normal feeding procedures shall not be used as punishment.

50.16(8) Inspection of facilities of outside food service providers. If food service is provided by outside sources, only a facility with a food establishment license or those required to undergo inspection by other statutes shall be utilized to provide these services. The transfer of food shall be done under sanitary conditions (no policy required).
201—50.17(356,356A) In-house food services.

50.17(1) Food preparation areas shall be clean and sanitary in accordance with state health standards regulating institutional or food establishment operations.

50.17(2) All food products shall be stored or refrigerated in compliance with state health standards governing institutional or food establishment operations.

50.17(3) Dishes, utensils, pans and trays shall be sanitized after use in accordance with state health standards for food establishments or institutions.

50.17(4) Staff shall serve or supervise the serving of all meals. Food handlers must be clean and free of illness or disease.

201—50.18(356,356A) Prisoner activities.

50.18(1) Exercise. Prisoners held beyond seven days and not leaving the jail pursuant to Iowa Code section 356.26 shall be offered exercise time.

a. A minimum of two one-hour exercise sessions shall be offered during each full calendar week. Playing board games or cards or reading is recreation and is not considered exercise. A record of exercise sessions shall be maintained according to subrule 50.22(15).

b. Restrictions. Exercise requirements may be restricted by disciplinary action.

c. Exercise areas. An exercise area outside the cell shall be available. Such area must provide opportunity for adequate exercise. Corridors and hallways must remain clear of equipment or material and must provide unimpeded access to exits.

d. Suspension of outdoor exercise. Outdoor exercise may be suspended during inclement weather. Appropriate clothing shall be provided for exercise during winter months.

50.18(2) Religion. All prisoners shall be afforded a reasonable opportunity to pursue their religious faith. Any infringement upon the opportunity to pursue one’s faith must further some compelling interest and must be the least restrictive means of furthering that interest. The jail administrator or designee may plan, direct and supervise all aspects of a religious program, including approval and training of both laypersons and clergy persons ministering faiths represented in the prisoner population.

50.18(3) Reading material. A reasonable quantity and variety of reading material shall be made available to prisoners.

a. Access to reading material from an outside source may be restricted to unused material sent directly from the publishing source.

b. Material deemed to be a threat to security or safety within the jail may be denied distribution.

c. Obscene material, as described in Iowa Code section 728.1, may be prohibited.

d. When a prisoner is denied access to a publication, the jail administrator shall inform the prisoner of that denial in writing and shall explain, in writing, the reason(s) for denial.

50.18(4) Discrimination. Prisoner activities, programs and services shall be available to prisoners with disabilities.

201—50.19(356,356A) Communication.

50.19(1) Prisoner mail.

a. Prisoners held beyond 24 hours shall be furnished a reasonable amount of writing materials upon request. Jail officials may prohibit a prisoner from corresponding with a person who states in writing that the person does not want to correspond with the prisoner. This does not include a
“prior approval” list.
b. A reasonable amount of postage shall be provided to indigent prisoners held beyond 24 hours for communication with the courts and for at least two letters per week of a personal nature when other means of communication are not available.
c. General correspondence may be opened and inspected; it may be read for security reasons if the prisoner is notified of this procedure.
d. Privileged correspondence if so marked may be opened only in the presence of the prisoner and then only to detect the presence of contraband; it may not be read except by the prisoner. Privileged correspondence is defined as incoming and outgoing mail to or from:
(1) An attorney;
(2) A judge;
(3) The governor of Iowa;
(4) The citizen’s aide office;
(5) A member of the state or federal legislature.
e. Written policy, procedure, and practice require that, excluding weekends and holidays, incoming and outgoing letters be held for no more than 24 hours and packages be held for no more than 48 hours for inspection before delivery to the prisoner or post office.

50.19(2) Telephone calls upon arrest.
a. Prisoners shall be permitted telephone access to their family or an attorney, or both, without unnecessary delay after arrest at no charge if made within the local calling area as required by Iowa Code section 804.20.
b. Policy and procedures shall be developed to govern prisoner telephone calls. The procedure shall provide for the handling of emergency calls.
c. Prisoners not in segregation status for discipline shall have reasonable access to telephones beyond the requirements of Iowa Code section 804.20.

50.19(3) Attorneys and ministers. Attorneys and ministers shall be permitted to visit prisoners upon the request of the prisoner at reasonable hours if security and daily routine are not unduly interrupted.

50.19(4) General visitation.
a. All prisoners in normal status shall be allowed reasonable visitation.
b. Rules shall specify who is allowed to visit and when and how often visitors are allowed.
c. Jail staff shall document the date and time of visit, name and address of each person visiting, and name of prisoner visited. Computerized logs are acceptable.
d. A visit may be denied if reasonable suspicion exists that the visit might endanger the security of the facility. A record shall be made of such denial and the reason(s) therefor.

50.19(5) Detaining non-U.S. citizens. When non-U.S. citizens are detained, they shall be advised of the right to have their consular officials notified or the nearest consular officials shall be notified of the detention, whichever is required by the Vienna Convention. Consular officials shall be given access to non-U.S. citizens in jail and shall be allowed to provide consular assistance. When a jail administrator becomes aware of the death of a non-U.S. citizen, consular officials shall be notified.

201—50.20(356,356A) Access to the courts. Prisoners who do not have an attorney shall have access to the legal materials the jail decides to provide, in order to facilitate the preparation of
legal documents that directly or collaterally attack the prisoner’s sentence or that challenge the conditions of the prisoner’s confinement.

201—50.21(356,356A) Discipline and grievance procedures.
50.21(1) No prisoner shall be allowed to have authority or disciplinary control over another prisoner.
50.21(2) The use of physical force by staff shall be restricted to instances of justifiable self-protection, the protection of others or property, the prevention of escapes or the suppression of disorder, and then only to the degree necessary to overcome resistance. Corporal punishment is forbidden.
50.21(3) The following information shall be made available to all prisoners and explained to any prisoner unable to read English:
   a. A set of rules (including sanctions) and regulations pertaining to the conduct of persons in custody.
   b. What services are available to them.
   c. A prisoner grievance procedure which includes at least one level of appeal. A jail may limit the use of the grievance process in order to make sure that it is not abused.
50.21(4) Prisoners who have allegedly violated jail rules shall be provided information pertaining to the handling of disciplinary hearings consistent with the due process rights of the accused. This information shall include the following:
   a. Notice of charges and hearing.
   b. A description of the hearing process. The jail policy and procedures manual shall contain the following:
      (1) Written guidelines for resolving minor prisoner infractions which include a written statement of the rule violated and a hearing and decision within seven days, excluding weekends and holidays, by a person not involved in the rule violation. The prisoner may waive the hearing.
      (2) A procedure to refer violations of criminal law to the appropriate criminal justice agency.
      (3) A policy which requires staff members to prepare a disciplinary report and forward it to a designated staff person. Disciplinary reports shall include the following information:
         1. Specific rule(s) violated;
         2. A statement of the charge;
         3. Any unusual prisoner behavior;
         4. Any staff witnesses;
         5. An explanation of the event that includes who was involved, what transpired, and the time and location of the occurrence;
         6. Any physical evidence and its disposition;
         7. Any immediate action taken, including the use of force.
      (4) A policy that requires an impartial investigation to begin within 24 hours of the time the violation is reported and be completed without unreasonable delay, unless there are exceptional circumstances for delaying the investigation.
      (5) A policy and procedure that provides for prehearing detention of prisoners who are charged with a rule violation. The facility administrator or designee shall review the prisoner’s prehearing status within 72 hours.
(6) A policy that prisoners charged with a rule violation receive a written statement of the charge(s), including a description of the incident and specific rule(s) violated. The prisoner shall be given the information at least 24 hours prior to the disciplinary hearing. The hearing may be held in less than 24 hours with the written consent of the prisoner.
(7) A policy and procedure that allows the prisoner to be present at the hearing, unless the prisoner waives that right in writing or is a threat to the security and safety of the facility. Prisoners may be excluded during testimony. Any prisoner’s absence shall be documented.
(8) A policy that provides for the disciplinary hearing to be conducted no later than seven days, excluding weekends and holidays, following the report of the alleged rule violation.
(9) A policy that provides for postponement or continuance of the disciplinary hearing for a reasonable period and for good cause. Reasons for postponement or continuance shall be documented.
(10) A policy and procedure that provides for an impartial person or panel of persons to conduct the disciplinary hearing. A record of the proceedings shall be made and maintained for at least two years.
(11) A policy and procedure that allows prisoners an opportunity to make a statement and present documentary evidence at the hearing and to call witnesses on their behalf unless calling witnesses creates a threat to the security or safety of the facility. The reasons for denying such a request shall be documented.
(12) A policy and procedure that allows a staff member or agency representative to assist prisoners at disciplinary hearings. A representative shall be appointed when it is apparent that a prisoner is not capable of collecting and presenting evidence on the prisoner’s own behalf.
(13) A policy that disciplinary committee decisions are based solely on information obtained in the hearing process.
(14) A policy and procedure to ensure that a written report is made of the decision and the supporting reasons and that a copy is given to the prisoner. The hearing record and documents shall be kept in the prisoner’s file.
(15) A policy that requires the jail administrator or designee to review all disciplinary hearings and dispositions to ensure conformity with the jail policy and procedures.
c. An explanation of the appeal process. The jail policy and procedure manual shall contain a policy and procedure to advise the prisoner that the prisoner may appeal the decision to the jail administrator or designee within 24 hours. The administrator or designee shall affirm or reverse the decision of the disciplinary committee as soon as possible but within 15 days, excluding weekends and holidays.
50.21(5) Deprivation of clothing, bedding, or hygienic supplies shall not be used as discipline or punishment. These items may be withheld from any prisoner who the staff reasonably believes would destroy such items or use them as weapons, for self-injury or to aid in escape.

50.22(356,356A) Records. The following records shall be maintained by the jail administrator for two years unless a different period is specified:
50.22(1) Jail calendar. This record shall contain information as required by Iowa Code section 356.6.
50.22(2) Visitor registration. This record shall contain the name and address of the person visiting; name of prisoner visited; and the date, time and duration of the visit.
50.22(3) Jail inspection records. Jail inspection records shall contain the following and be maintained for a minimum period of two years:
   a. Fire marshal’s certificates.
   b. Written reports received from all persons doing official inspections of the jail.

50.22(4) Medical history intake form. Notation of injury upon admission shall be included.

50.22(5) Records of medical care.

50.22(6) Injury reports. Copies of all reports of investigations relating to injuries within the facility shall be maintained by the jail administrator in a separate injury file or referenced in the prisoner file by log for a period of five years.

50.22(7) Disciplinary records.

50.22(8) Property receipts. Property receipts as required by Iowa Code section 804.19 shall be completed and distributed as required.

50.22(9) Menu records. This record shall include letters of documentation issued by a qualified dietitian.

50.22(10) Fire and disaster evacuation plan and record(s) of required fire drills.

50.22(11) Records of staff training.

50.22(12) Disposition of medication. A record shall be kept of the disposition of prescribed medication not taken by a prisoner.

50.22(13) Supervisory checks. A record shall be made to document all required supervisory checks of prisoners.

50.22(14) Incident reports. Records shall be made to document the following:
   a. Use of force;
   b. Suicide/suicide attempts;
   c. Threats to staff, staff assaults, escapes, fires, prisoner abnormal behavior, any verbal or nonverbal references to suicide and self-mutilation.
   d. The state jail inspection unit of the department of corrections shall be notified within 24 hours of any death, attempted suicide, fire, escape, injury to staff or prisoners from assaults, or use of force and prisoner self-injuries. A copy of the investigative reports and other records shall be given to the state jail inspector upon request.

50.22(15) Exercise documentation. A record shall be kept relative to date, time and length of exercise periods offered to specific prisoners, cell blocks, tiers, or any other type of cell grouping or housing unit.

201—50.23(356,356A) Alternative jail facilities. County detention facilities qualifying as alternative jail facilities developed and operated under the auspices of Iowa Code section 356A.1 and not under the charge of the sheriff of the county are subject to the rules for residential treatment centers operated by judicial district departments of correctional services as prescribed by 201—Chapter 43.

201—50.24(356,356A) Nonsecure holds for juveniles.

50.24(1) Standards for nonsecure hold areas. The area to be used to detain the juvenile must be an unlocked area such as a lobby, office or other open room. Additionally, the following minimum procedures must be followed:
   a. The juvenile is not physically secured to any stationary object.
b. The juvenile is under continuous visual supervision.
c. The juvenile has access to bathroom facilities.
d. A meal or meals shall be provided at usual meal times.

50.24(2) Supervision of juveniles in nonsecure hold. Juveniles in nonsecure hold status (see Iowa Code sections 232.19(2) and 232.222(2)) shall have continuous visual supervision by a qualified adult. The jail administrator may contract with an outside agency to perform supervisory functions. Persons performing juvenile supervisory functions must:

a. Be at least 18 years of age.
b. Have received a physical prior to employment.
c. Perform at a staff-to-prisoner ratio that will ensure a safe environment for both the juvenile(s) and the staff.
d. Report any knowledge of child abuse to mandatory child abuse reporters.
e. Have successfully completed a child abuse and criminal background check.

50.24(3) Prohibited acts. Each nonsecure site must develop a policy of posted orders which protects juveniles against neglect; exploitation; degrading punishment such as corporal punishment, verbal abuse, threats, or derogatory remarks about the juvenile or the juvenile’s family; binding or tying to restrict movement; enclosing the juvenile in a confined space such as a closet, locked room, or similar cubicle; and deprivation of meals.

50.24(4) Attendant nonsecure area operating procedures.

a. Attendant shall make certain the juvenile is aware of the policies of the nonsecure holding area.
b. The personal effects of the juvenile shall be placed in a safe, secure place. A property receipt shall be issued to the juvenile.
c. All items given to the juvenile are subject to being searched.
d. Attendant shall pat search juvenile.

50.24(5) Care and treatment.

a. Medical.

(1) No juvenile shall be held who is obviously injured, is obviously physically or mentally ill, or in the judgment of the arresting officer is under the influence of drugs or intoxicated from the use of alcohol to the point of needing medical attention without first being examined by a medical practitioner.

(2) In an emergency situation or when the juvenile is suffering severe pain or is in danger of loss of life or permanent injury, medical treatment may be administered without parental consent. When none of the above situations exist, parental consent or judicial concurrence must be made before providing medical treatment.

(3) Juveniles suspected of having a contagious or communicable disease shall be isolated from other juveniles.

(4) There shall be at least one person on duty in the jail supervising the nonsecure hold area who is trained in multimedia first aid and CPR.

(5) First-aid kits shall be immediately available.

(6) Any person providing medication shall be trained in the procedure of providing medication.

(7) As part of the admission procedure, a medical history intake form shall be completed. As part of this procedure, an attempt will be made to determine if the juvenile is suicidal by observing behavior and looking for marks or scars which would indicate previous suicide attempts.
(8) There shall be written policies or procedures pertaining to providing medication.
(9) All medication shall be stored according to state pharmaceutical standards and written
inventory control maintained. The inventory shall include the starting number of pills, when pills
were provided and by whom, the remaining number of pills at the time the juvenile left the jail,
the disposition of the remaining pills, and a staff witness to the disposition of the pills.
(10) Special diets as prescribed by a physician shall be followed and documented.
(11) When a special diet is required for an individual due to a bona fide religious belief, the jail
shall meet that need.

b. Communications.
(1) Juveniles shall be permitted, at no charge, telephone access to their family or an attorney,
or both, without unnecessary delay after being taken into custody. Once family or attorney has
been contacted, the number of additional calls, if any, will be determined by attendant.
(2) Attorneys and ministers shall be permitted to visit upon request when such visiting will not
disrupt security or daily routines of the jail. Determination of additional visits shall be made by
attendant.

c. Safety and sanitation.
(1) Walls, floors, and ceiling shall be well maintained.
(2) Facility shall be maintained in a pest-free condition.
(3) Clean bedding, including sheets, blankets, and pillowcases, shall be issued to each juvenile
who wishes to sleep between the hours of 9 p.m. and 7 a.m.
(4) Soiled clothing which may affect the health of the juvenile shall be exchanged for clean,
jail-provided clothing.
(5) An emergency evacuation plan must be conspicuously posted.
(6) There shall not be less than one AA-ABC fire extinguisher in operable condition for each
3,000 square feet of facility on any given floor of the building.
(7) All exits shall be equipped with independent emergency lighting.
(8) Where exits are not immediately accessible from an open floor area, safe and continuous
passage aisles or corridors leading directly to every exit shall be maintained and shall be so
arranged as to provide access for each juvenile to at least two separate and distinct exits from
each floor. A locked exit may be classified as an emergency exit only if necessary keys to locked
doors are on the person of the attendant. Elevators shall not be counted as required exits.
(9) A means of fire detection utilizing equipment of a type tested and approved by Underwriters
Laboratories shall be installed and maintained in operational condition according to the factory
manual. These alarms shall be ceiling-mounted and of such construction to continue in operation
during power failure. Alarms shall be tested on at least a monthly basis. Such test shall be
documented.
(10) Only fire-resistant mattresses and pillows approved by the state fire marshal’s office shall be
used.

d. Staff training requirements.
(1) Attendants shall be knowledgeable of jail policies and procedures pertaining to juvenile
nonsecure holds, and acknowledgment of this shall be made by attendant’s dated signature.
(2) Nonsecure hold attendants shall have received instruction in the following areas prior to
supervising juveniles in a nonsecure holding area:
   1. Role of nonsecure hold attendant.
2. Confidentiality issues.
3. Intake procedures—medical and suicide screening.
4. Communication and listening skills.
5. Dealing with a depressed or suicidal juvenile.
6. Overview of state and federal law.
7. Provision of medication.

**e. Juvenile supervision.**

(1) An attendant shall be in the presence of all juveniles held at all times. Same-sex attendant or staff shall be present when juveniles perform bodily functions/shower.

(2) A log shall be maintained at half-hour intervals reflecting the juvenile’s activities and behavior.

**f. Records.** The following records shall be maintained by the jail for a period of at least two years:

(1) Medical history intake form.
(2) Records of medical care.
(3) Injury reports.
(4) Food served.
(5) Records of staff training.
(6) Disposition of medication.
(7) Individual log.
(8) Any use of force reports.
(9) Any suicide or suicide attempts reports.

**g. Incident reports.** Reports of the following incidents shall be sent to the state jail inspection unit, department of corrections, within 24 hours of incident:

(1) Any injury to juvenile or staff that requires medical attention.
(2) Any use of force by staff.
(3) Any attempted suicide.

The state jail inspection unit, department of corrections, shall be notified within five hours of any successful juvenile suicide that occurred in a nonsecure hold area.

**50.24(6) Exemption from nonsecure hold standards.** Any requests for exemption from nonsecure hold standards shall be submitted according to the waiver and variance provisions under 201—Chapter 7, Iowa Administrative Code.

**201—50.25(356,356A) Direct supervision jails.** Direct supervision jails, in addition to the preceding rules, are subject to the following rules:

**50.25(1)** There may be contact of different classifications of prisoners in a common activity area only while the prisoners are under continuous direct supervision with the exception of:

a. Persons of whom violence is reasonably anticipated. (50.13(1) “d”(1))

b. Persons who are a health risk. (50.13(1) “d”(2))

c. Persons of whom sexually deviant behavior is reasonably anticipated. (50.13(1) “d”(3))

d. Persons under the age of 18 (Iowa Code section 356.3). Persons charged in adult court with a forcible felony are to be separated whenever possible.
50.25(2) There shall be separate and distinct staff persons in the jail at all times to perform the following duties:
   a. Provide central control or lock doors into or out of the housing unit.
   b. Provide direct supervision of prisoners in the housing unit. During hours of lockdown, prisoner checks may be done hourly and documented. Prisoners must be physically observed during these checks.
   c. Provide emergency backup to the supervision officer as a priority of assigned duties.
50.25(3) Prisoners classified as maximum security may not be allowed into areas occupied by other prisoners at any time. Maximum security prisoners may be required to exercise or perform other activities in a group with other maximum security prisoners only. Facility staff must weigh the potential for violence prior to admitting any maximum security prisoner into a group.
50.25(4) The housing unit shall not exceed its rated capacity.
50.25(5) Whenever prisoners are not locked down, there shall be sufficient lighting in all areas of living units and activity areas to allow full observation by staff.
50.25(6) Prisoners assigned to one living unit shall not be allowed to enter a different living unit except when permitted to share activities.
50.25(7) Any agency utilizing a direct supervision mode of prisoner management shall ensure that, before accepting prisoners, jail staff shall receive appropriate training in the following areas:
   a. Philosophy of direct supervision.
   b. Techniques of effective supervision and leadership.
   c. Decision-making techniques.
   d. Crisis intervention techniques.
   e. Effective communication techniques.
   f. Classification and evaluation techniques for direct supervision jails.
The training mandated by this chapter is required in addition to the above-listed training requisites.
50.25(8) There shall be a classification system developed which shall include an initial classification determination and an ongoing evaluation of the classification status. This system shall include, but not be limited to, the following considerations:
   a. Individual’s criminal history.
   b. Individual’s present behavior.
   c. Individual’s present charge.
   d. Health.
   e. Potential for violence.
   f. Sexual deviation.
   g. Self-harm or suicide potential.
   h. Mental and physical maturity relative to personnel safety.
   i. Previous behavior in other institutional settings.
   j. Noticeable changes in attitude.
50.25(9) Programming (books, television, work, treatment) shall be available to reduce prisoner idleness. Subjects referred to within the parentheses are illustrative and not inclusive.
50.25(10) Each officer assigned to a housing unit shall have a mechanical or electronic means on the officer’s person to summon assistance in times of emergency.
50.25(11) Supervision checks as required by paragraph 50.13(2) “a” will continue to be required and documented. CCTV shall not be used for supervision checks. During those periods when prisoners are out of their cells and in full view of staff, supervisory checks need not be conducted. Supervisory checks will be made when prisoners are allowed in their individual cells.

50.25(12) All incoming prisoners must be thoroughly oriented to expectations, rules, and routines of the jail. All such orientation must be documented.

50.25(13) Policies and procedures shall be developed by the sheriff or designee for the operation of the jail. These policies and procedures shall reflect the rules for direct supervision jails as delineated in this chapter. All staff shall be knowledgeable of and have access to the policy manual and shall receive training in the implementation of said policies and procedures prior to being assigned as a housing unit officer. The sole remedy for breach of these rules is by a proceeding for compliance initiated by request from the department of corrections. The violation of any rule shall not be construed to permit any civil action to recover damages against the state of Iowa, its departments, agents or employees or any county, its agencies or employees.

These rules are intended to implement Iowa Code sections 80B.11A, 356.36, and 356.43 and chapter 356A.
APPENDIX VI

IOWA
How and why Jail Standards

*1978 Scott County $5M Lawsuit
*DSS Inspection
*Code of Iowa
*ISSDA, ISAC, COP, IDOC
*IDOC
*Have Statutory Authority

Chapter 201-50 Jail inspection

Chapter 201-51 Holding facilities
59.2 (b) Equal Opportunity

59.2 (c) Nondiscriminatory treatment
50.11 (1) Training
a. Staff reacquainted with unit standards
b. Staff reacquainted with unit procedures

c. Employee orientation regarding tenant rights
d. Emergency training used in jail

e. Administrative log of training
f. Fire equipment training documented. Date

g. Medication management.

50.12 (2) Basic Training
1. Name and contact, Date
2. CPN certified, Date
3. 40 hour basic
4. 24 hour notification, Date

50.13 (2) Security and Control Procedures
a. Identification of personnel in areas
b. Emergency calling system

c. Fire equipment available in reasonable time

d. Fire drills

e. Credentialed personnel
f. Observation, checkers, and monitors optional

g. Non-emergency intra-agency communications

h. Administration of property

i. Patient rights
j. Patient safety policies
k. Staff qualifications
l. Staff training
m. Alarms

50.13 (3) Security and Control Procedures
a. Identification of personnel in areas
b. Emergency calling system

c. Fire equipment available in reasonable time

d. Fire drills

e. Credentialed personnel
f. Observation, checkers, and monitors optional

g. Non-emergency intra-agency communications

h. Administration of property

i. Patient rights
j. Patient safety policies
k. Staff qualifications
l. Staff training
m. Alarms

50.13 (4) Security and Control Procedures
a. Identification of personnel in areas
b. Emergency calling system

c. Fire equipment available in reasonable time

d. Fire drills

e. Credentialed personnel
f. Observation, checkers, and monitors optional

g. Non-emergency intra-agency communications

h. Administration of property

i. Patient rights
j. Patient safety policies
k. Staff qualifications
l. Staff training
m. Alarms

50.13 (5) Security and Control Procedures
a. Identification of personnel in areas
b. Emergency calling system

c. Fire equipment available in reasonable time

d. Fire drills

e. Credentialed personnel
f. Observation, checkers, and monitors optional

g. Non-emergency intra-agency communications

h. Administration of property

i. Patient rights
j. Patient safety policies
k. Staff qualifications
l. Staff training
m. Alarms
### 50.14 (1) Housekeeping
- Neat and sanitary
- All rooms to be made up daily
- Neat and orderly environment
- Housekeeping performed
- Dusting performed

### 50.14 (2) Clothing, bedding and hygiene items
- Neat and clean after 24 hours
- Comfortable
- Neat and clean
- Bedding changed
- Clothing cleaned
- Towels changed after 24 hours
- Towels changed

### 50.14 (3) Personal hygiene
- Personal hygiene maintained
- Personal cleanliness
- Bathing performed
- Personal hygiene maintained
- Shaving performed
- Hygiene practices

### 50.15 Food service
- Food provided at least one meal period
- Food service maintained
- Food served at appropriate time
- Food served on trays
- Food handled at one serving time
- Food temperature maintained
- Food free from contamination
- Food served in appropriate containers

### 50.16 (1) Exercise
- Two activity sessions per week documented
- Exercise equipment
- Exercise area
- Exercise attire
- Exercise documentation

### 50.16 (2) Religious opportunities

### 50.16 (3) Reading material available/policy

### 50.16 (4) Activities available for disabled
50.24 Non-secure holds for juveniles (Policy)

50.28 Direct supervision jails:
1a. Central control staff
1b. Direct supervision staff
1c. Direct supervision officers
1d. Staff training documented
1e. Classification system procedures
1f. Policy and procedures

JAIL CAPACITY:
General Population
Temporary Holding
TOTAL

TODAY:
General Population
Temporary Holding
TOTAL

50.35 Existing Facilities (prior to 87/86):
50.35(1) Forty (40) square feet of bed space for each inmate housed less than 15 hours
50.35(2) Single cells - fifty (50) square feet of floor space for inmates held more than 15 hours
50.35(3) Multiple Occupancy Cells - Forty (40) square feet of floor space for fixed inmates. 20 square feet for each additional inmate held less than 15 hours
50.35(4) Multiple occupancy cells - Fifty (50) square feet for fixed inmates. Thirty square feet additional space per inmate in multiple occupancy cells held over 15 hours
50.35(5) Design capacity not exceeded
50.35(6) Dormitory - Forty (40) square feet for each inmate
50.35(7) a. Sleep (7) feet of ceiling height
   b. Bank of adequate size
   c. Access to functional toilet
   d. Adequate storage
   e. Sufficient tables and seats for rated capacity
   f. Functional chairs
50.35(8) Thirty (30) square feet for dayrooms facilities. Twenty (20) square feet for each additional inmate
Section 5.4: New Construction (after 01/01/69)
- Single-family dwelling: 1,500 sq ft per occupant
- Multiple-family: 1,000 sq ft per occupant
- Bathroom: 60 sq ft
- Kitchen: 400 sq ft
- Bedroom: 200 sq ft
- Garage: 400 sq ft
- Deck: 100 sq ft
- Yard: 1,500 sq ft

Section 5.7: New Construction (after 01/01/69)
- Single-family dwelling: 1,500 sq ft per occupant
- Multiple-family: 1,000 sq ft per occupant

Section 5.8: New Construction (after 12/23/69)
- Single-family dwelling: 1,500 sq ft per occupant
- Multiple-family: 1,000 sq ft per occupant
- Bathroom: 60 sq ft
- Kitchen: 400 sq ft
- Bedroom: 200 sq ft
- Garage: 400 sq ft
- Deck: 100 sq ft
- Yard: 1,500 sq ft

Section 5.9: Existing Construction
- Single-family dwelling: 1,500 sq ft per occupant
- Multiple-family: 1,000 sq ft per occupant
- Bathroom: 60 sq ft
- Kitchen: 400 sq ft
- Bedroom: 200 sq ft
- Garage: 400 sq ft
- Deck: 100 sq ft
- Yard: 1,500 sq ft

Section 5.10: New Construction (after 01/01/69)
- Single-family dwelling: 1,500 sq ft per occupant
- Multiple-family: 1,000 sq ft per occupant

Section 5.11: Existing Construction
- Single-family dwelling: 1,500 sq ft per occupant
- Multiple-family: 1,000 sq ft per occupant

Section 5.12: New Construction (after 01/01/69)
- Single-family dwelling: 1,500 sq ft per occupant
- Multiple-family: 1,000 sq ft per occupant

Section 5.13: Existing Construction
- Single-family dwelling: 1,500 sq ft per occupant
- Multiple-family: 1,000 sq ft per occupant
Inspections are based upon information provided by the temporary holding facility staff and the personal observation of the jail inspector. The below signed agrees that the statements made to the jail inspector are true to the best of his/her knowledge.

Signature

Title

Use of Verification Code

Numbers and Lettering

Verification numbers and letters will be used to indicate two facts regarding the inspection process. The number will designate either compliance or noncompliance. The letter corresponds to the way in which the numbered response was selected.

Code:

1. **Compliance**
   a. Policy statement reviewed
   b. Observed
   c. Verbal assurance of practice
   d. Documentation reviewed
   e. Documentation verbally assured
   f. Measure
   g. Detainee rules

2. **Non-compliance**
50.2 (5) Equal Opportunity

50.2 (6) Nondiscriminatory treatment

50.4 (2) Physical Plant inspection(s) needed:

50.4 (3) Heating and ventilation
   a) Reasonable heated and ventilated
   b) Fresh air supply
   c) Fans/Cold liquids available over 85º

50.4 (4) Maximum-security cells
   a) Tamper resistant bunks
   b) Table/seat
   c) Toilet/wash basin
   d) Adequate hot and cold water supply

50.4 (5) Lighting
   a) Housing areas - 20 ft. candlepower
   b) Exits-Independent lighting source

50.4 (6) Screens

50.4 (7) Electrical Facilities
   a) No drop cords
   b) Emergency power
   c) Test log of emergency power

50.4 (8) Storage
   a) Storage in detention area
   b) Inmate storage secure identified-receipted
   c) Janitor supplies storage
   d) Chemical storage

50.4 (9) Mirrors tamper resistant

50.4 (10) Firearm locker

50.4 (11) Noise level
   Policy and Prisoners advised

50.9 (2) Fire Inspection-Date: ______
   a) State ____  b) Local ____  c) Approved ______

50.9 (3) Emergency Evacuation
   Evacuation plan
   Evacuation routes posted
   Annual fire drill training documented, Date: ______________

50.9 (4) Release of prisoners
   a) Prompt release in emergency
   b) Two full sets of jail keys

50.9 (5) Fire extinguishers, Date: _____________

50.9 (6) Emergency lighting
   Corridors, passages, exits

---

Revised 06/2008
50.9 (7) Required exits
Two exits each floor/exits clear/keys available

50.9 (8) Fire alarms tested and documented as required
Prisoner inaccessible
Battery type tested monthly
Electronic type tested yearly, Date

50.9 (9) No heating appliances along path of exit

50.9 (10) Doors to swing with traffic

50.9 (11) Pillows and mattresses approved

50.9 (12) Sprinkler Heads, inaccessible, suicide resistant

50.10 (1) Requirements for employment

50.10 (2) Minimum standard for retention

50.10 (3) Conflict of interest policy
Business transactions with prisoners

50.11 (1) Training
a) Staff knowledgeable of jail standards
b) Staff knowledgeable of policy/procedures manual
c) Employee orientation regarding inmate rights
d) Weapons training if used in jail
e) Administrative log of training
f) Fire equipment training documented, Date:
g) Medication management

50.11 (2), 50.11 (3) Basic Training
1) First aid certified, Date
2) CPR certified, Date
3) 40 hour basic
4) 20 hour recertification, Date

50.12 Standard operating procedures manual

50.13 (1) Admission/Classification
a) Appropriate order/confinement and release
b) Inmate architectural separation
1) Juveniles (la. Code 356.3)
2) Males/females (Iowa Code 356.4)
c) Separation when possible
1) Felons/misdemeanants
2) Pretrial/sentenced
3) Witnesses
d) Physical separation required
1) Violent prisoners
2) Prisoners who may be a health risk
3) Sexual deviant prisoners
4) Prisoners likely to be exploited or victimized
e) Juveniles (Iowa Code 232.22)
1) Fourteen (14) years or older
2) Committed listed crime
3) Six (6) hours/less
4) Court order over six (6) hours
f) Suicide prevention
Booking personnel trained
Documentation of suicidal determination
g) Housing for prisoners with disabilities
h) Veterans notification
50.13 (2) Security and Control Procedures

a) Supervision of prisoners
   1) Staff on premises at all times
      Emergency calling device
      Emergency response staff available in reasonable time
   2) Supervision - documented
      Hourly checks
      30 minute checks
      CCTV/audio clear-distinct
      Observation, showers and restrooms optional
   3) Entering housing of opposite sex
   4) Female staff on duty
   5) Required observation of juveniles

b) Prohibited weapons

c) Prisoner searches (IC 804.30)(Strip search)
   1) Prisoners/property, upon entry/leaving
   2) All persons entering the jail searched
   3) Search notice posted
   4) Prisoner rules contain items permitted
   5) Cell search policy

d) Key control policy

e) Facility security policy
   1) All areas clear of viewing obstructions
   2) Security inspection of equipment/fixtures
   3) Policy on prisoner movement
   4) Policy on incidents that threaten security
      Riots/Disturbances
      Hunger strikes
      Hostage situations
      Escape attempts
      Medical emergencies
      Natural disasters
      Staff shortage
      Bomb Threats

f) Policy and documentation on the use of restraints

50.14 (1) Housekeeping

a) Jail clean and sanitary
   1) Cleaning equipment provided
   2) Jail to be maintained pest free
   Dept of Ag approved, Name

b) Sharps/hazardous material container

50.14 (2) Clothing, bedding and hygiene items

Items provided after 24 hours: bedding-linen

a) Toilet articles
b) Clothing issued
c) Clothing provided after 24 hours
d) Laundry schedule weekly

50.14 (3) Personal hygiene

a) Prisoners maintain personal cleanliness
b) Shower/bath (if held over 24 hours)
c) Hair sanitation
d) Hair procedures
e) Sharing razor/toothbrush prohibited

50.15 Written medical services procedures

50.15 (1) Medical resources designated

50.15 (3) Prisoners not involved in medical delivery

50.15 (4) First aid kit-approved
50.15 (5) Prisoners affected by chemical agents to be offered appropriate treatment

50.15 (6) Prisoner Admission
a) Injured prisoner examined before admission
b) Suspected communicable disease inmate isolated
c) Medical history form
   • Suicide screening at intake
   • Written suicide prevention plan
   • Annual suicide prevention training Date:
d) Mentally ill admissions policy and procedures
e) Prisoner informed how to obtain medical attention

50.15 (7) Medication procedures
a) Written policy/procedure on providing medication
b) Medication inventory and storage
c) Provided medication documented
d) Prescription followed

50.15 (8) Medical records maintained

50.15 (9) Medication storage
a) Medication stored at proper temperature
b) Medication not administered beyond expiration date
c) Documented drug destruction-witness included
d) Policies and procedures direct return of drugs to pharmacy/documentation of disposal

50.16 Food service
a) Meal provided if detained over meal period
b) Three meals for each 24 hours served at reasonable intervals; at least one (1) hot meal. Hot meals hot, cold meals cold
c) Meal served at approximately same time daily
d) Food service documentation/Date:

50.17 In-house food service
Health inspection-date: ________________

50.18 (1) Exercise
a) Two/one hour sessions per week/documented
b) Exercise restriction
c) Exercise area
d) Suspension of outdoor exercise/appropriate clothing

50.18 (2) Religious opportunities

50.18 (3) Reading material available/policy

50.18 (4) Activities available for disabled

50.19 (1) Prisoner mail
a) Writing materials provided
b) Prisoners (without funds) provided postage to communicate with court plus two letters per week for personal communication
c) Opening of general correspondence
d) Privileged communications not opened outside presence of prisoner
1) Attorney
2) Judge
3) Governor
4) Citizen's Aid Office
5) State/Federal Legislature
e) Mail distribution policy/documentation

50.19 (2) Telephone
a) Telephone calls upon arrest (804.20)
b) Prisoner telephone policy

50.19 (3) Visitation/Attorney
Visitation/Minister

50.19 (4) General visitation
a) Normal status visitation
b) Rules
c) Registration
d) Denial

50.19(5) Non-US citizen notification policy

50.20 Access to the courts
a) Postage provided to indigent prisoners
b) Access to law library material or be represented by counsel in civil actions
c) Prisoner copy arrangements
d) Writing supplies available
e) Prisoner notified of facility procedures regarding access to courts

50.21 Discipline and grievance procedures
a) No prisoner authority over another prisoner
b) Use of physical force
c) Information provided prisoners:
   1) Facility rules
   2) Available services
   3) Grievances procedures
d) Due process procedures:
   1) Written notice charges and hearing
   2) Description of hearing process

Procedures required:
1) Resolving minor infractions
2) Referring criminal violations
3) Staff prepares a disciplinary report
4) Impartial investigation of the incident
5) Pre-hearing detention
6) Written notice to prisoner 24 hrs prior to hearing
7) Prisoner allowed to be present
8) Hearing conducted within 7 days of violation
9) Postponement procedure and documentation
10) Impartial hearing/record maintained for 2 years
11) Prisoner allowed to make statement, present evidence
12) Denial is documented
13) Staff member assist at hearing if requested/needed
14) Decisions based on information obtained at hearing
15) Written decision and reasons given to prisoner/placed in prisoners file
16) Jail Administrator reviews dispositions
17) Explanation of appeal process with time frames
18) Clothing, bedding, or hygienic supplies may be withheld only for prisoner self-protection

50.22 Records
1) Jail calendar (356.6)
2) Visitor registration as required by 50.19(4) c
3) Persons performing facility inspections
   a) Fire Marshal or designee
   b) 
   c) 
4) Medical intake screening as required by 50.15(6)c
5) Medical care as required by:
   50.15(7)c medication .................................................................
   50.15(8) med records .................................................................
   50.16(5) med diet ......................................................................

6) Separate injury file or log (5 yrs.) ....................................................

7) Disciplinary records required by 50.21 ..............................................

8) Property receipt as required by 50.3(2)e ...........................................

9) Menu records ...........................................................................

10) Fire and disaster plans & Required fire drills ..................................

11) Records of staff training .............................................................

12) Disposition of medication required by 50.15(9)c ...........................

13) Documentation of supervisory checks as required by: 50.13(2)a3 & 50.13(2)a4 .............................................................

14) Incident reports
   a) Use of force as require by 50.21(2) ............................................
   b) Suicide/suicide attempts/self injury ............................................
   c) Inmate/inmate or Inmate/staff assaults ....................................
   d) Escapes/Fires/unusual incidents ............................................
   e) Jail inspector notified within 24 hours ....................................

15) Exercise documentation .............................................................

50.24 Non-secure holds for juveniles (Policy) ........................................

50.25 Direct supervision jails.
   2)a. Central control staff ............................................................
   2)b. Direct supervision staff ......................................................
   2)c. Backup for supervision staff ..............................................

7) Staff training documented .........................................................

8) Classification system procedures ................................................

13) Policy and procedures .............................................................

JAIL CAPACITY:
General Population
Temporary Holding
TOTAL

TODAY:
General Population
Temporary Holding
TOTAL

Juveniles
COMMENTS AND RECOMMENDATIONS

Facility Name: ________________________________ Date: __________
50.5 Existing Facilities (prior to 07/84)

50.6(1) Forty (40) square feet for single cell used less than 16 hours

50.6(2) Single cells – fifty (50) square feet floor space for inmates held more than 16 hours

50.6(3) Multiple Occupancy Cells - Forty (40) square feet floor space for first inmate, 20 square feet for each additional held less than 16 hours

50.6(4) Multiple occupancy cells - Fifty (50) square feet for first inmate. Thirty square feet additional space per inmate in multiple occupancy cells held over 16 hours

50.6(5) Designed capacity not exceeded

50.6(6) Dormitory - Sixty (60) square feet for each inmate

50.7(2) Non-Maximum

50.7(3) Maximum Security type toilet/lavatory

50.7(4) Holding area – twenty (20) square feet per inmate not to exceed eight inmates

50.7(5) Natural lighting when practical

50.7(6) Ability to segregate according to law

50.7(7) No unit is to exceed rated capacity

50.8 New Construction (after 09/01)

50.8 (1)

50.8 (2) Single cell 70 sq. ft.

50.8 (3) Toilet/lavatory accessible at all times

50.8 (4) Holding cells – twenty (20) square feet per inmate, not to exceed eight (8) inmates

50.8 (5) Adequate exercise area. Minimum fifteen (15) square feet per inmate expected to use
50.8 (6) Natural lighting where practical

50.8 (7) Segregation according to law/regulations

50.8 (8) No unit to exceed rated capacity

50.8 New Construction (after 12/28/05)
- Single cell 35 sq. ft. unencumbered
- Single cell more than 10 hrs. per day 70 sq. ft.
- Multiple occupancy. 25 sq. ft. unencumbered per occupant
- Multiple occupancy. More than 10 hrs. per day 35 sq. ft unencumbered per occupant
- Dormitory cell 35 sq. ft. unencumbered per occupant

Housing units provide:
- a) seven (7) ft. of ceiling height
- b) bunk for each occupant 12 in. off floor
- c) Desk/table/seats/chairs for each occupant
- d) Dayroom 35 sq. ft. unencumbered per occupant. No less than 100 sq. ft. exclusive of showers and toilets.
  Seating and writing surfaces. (Dormitories excluded.)
- e) Shower for each 12 occupants
- f) Lavatory for each 9 occupants
- g) Toilet for each 9 occupants (Urinals may be substituted for 1/3 of toilets in male housing)

Maximum security - Has security type fixtures

Holding cells - 20 sq. ft. of floor space. Place for setting. Maximum capacity of 8 prisoners

Special needs cells - 40 sq. ft. floor space

Exercise area - 15 sq. ft. per person using the area. Not less than 500 sq. ft.

Natural Lighting

Ability to segregate according to existing laws

Capacity is not exceeded

All door swing with exit traffic

Recreation area ceiling height 18ft. (New and renovations as of July 1, 2008 and after)

Does the jail utilize direct supervision

Above requirements verified by measurement previously and there have been no significant changes.

Revised 06/2008

IOWA DEPARTMENT OF CORRECTIONS - JUVENILE DETENTION MONITORING REPORT

Facility Name: ___________________________ Date: __________________

Administrator: ___________________________ Phone: __________________

A. ☒ This facility can adequately separate juvenile prisoners from adult prisoners when both are held in custody by placing only juveniles in cells, (identified in the statement of facts), which are separated from other cells or areas by solid doors and walls or are of sufficient distance to prohibit all but haphazard/incidental conversational and visual contact with adult prisoners or juveniles are under staff supervision. Pursuant to I.C. 356 and IAC 201-50.13, or IAC 201-51.11 this facility is found to be in substantial compliance with the above codes and is therefore certified to hold juveniles waived to the adult court.

B. ☐ This facility is not in compliance with I.C. 356 and IAC 201-50.13 and therefore may not hold juveniles.

Note to what extent separation of juvenile and adult offenders exists in the areas listed below.

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6 Y or N (Comments)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intake</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dining</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Recreation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vocation/Work</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visiting</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transportation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical/Dental</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Designated Non-secure Hold Area</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Use the following code in describing the extent of separation:
1. Adult prisoners and juveniles can have physical contact with each other (no separation).
2. Adult prisoners and juveniles can see or hear each other (physical separation).
3. Conversation is possible although they cannot see each other (sight separation).
4. Adult prisoners and juveniles can see each other but no conversation is possible (sound separation).
5. Adult prisoners and juveniles cannot see or talk to each other (sight and sound separation).
6. Policy and procedures ensure compliance with the above code sections. (Yes or No) (Comment)

STATEMENT OF FACTS

______________________________________________________________

______________________________________________________________

Delbert G. Longley, Jail Inspector
<table>
<thead>
<tr>
<th>Item</th>
<th>OK</th>
<th>N/A</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Search Notice</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Firearms Locker</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>First Aid Kits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sharps Box</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hazard Waste Container</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire Extinguishers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire Smoke Alarms</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff Schedule</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sprinklers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Exits/Posted</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Lighting</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generator Log</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tables/Chairs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bunks</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mattresses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Call Box</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heating/Cooling</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cell Size</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Water Supply</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inmate Storage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemical Storage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitor/Audio Quality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Exercise Area/Log</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visitation Area/Log</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food Preparation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menu/Dietitian</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Storage</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication Log</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Females – Sight/Sound</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Juveniles – Sight/Sound</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intake Documents</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Training</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fire Inspection</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Keys</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Comments: _____

Hourly Check Log: _____

Housekeeping: _____

Hygiene Supplies: _____
## County Jail Inspection Information

<table>
<thead>
<tr>
<th>Sheriff:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Jail Administrator:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Jail address:</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Chairperson BOS:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>County Attorney:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Type of jail staff:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Jailer/Dispatchers</td>
<td></td>
</tr>
<tr>
<td>Combination Civilian/Deputy</td>
<td></td>
</tr>
<tr>
<td>Fulltime Deputy</td>
<td></td>
</tr>
<tr>
<td>Fulltime Civilian</td>
<td></td>
</tr>
<tr>
<td>Part time Civilian</td>
<td></td>
</tr>
<tr>
<td>Part time Deputy</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Staff Schedules:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of staff:</td>
<td></td>
</tr>
<tr>
<td>Enter number of staff</td>
<td></td>
</tr>
<tr>
<td>working on each shift</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date facility constructed</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Renovation dates:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Permanent beds or general population capacity:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary holding cells:</td>
<td></td>
</tr>
<tr>
<td>Total capacity:</td>
<td></td>
</tr>
</tbody>
</table>

**The jail charges a daily rate of:** $____ Room/Board fees from sentenced prisoners. $____ Work accommodated fees from sentenced prisoners. $____ Other Counties.
APPENDIX VII
FEDERAL AGENCY UPDATE
U.S. MARSHAL’S OFFICE
Detention Facility Training
Conditions of Confinement Program
Core Detention Standards

They apply to all U.S. Marshals Service (USMS), facilities that are not owned and operated by the Department of Justice.

Core standards should not be considered to supersede what is afforded other prisoners under state law, or in circumstances where safety and security would otherwise dictate. Our detainees will be treated the same as any other prisoner housed at your facility.

Based upon ACA Standards to some degree.

USMS Core Detention Standards

This information is coordinated through the USMS-POD Contract & Agreements along with OFDT E-IGA program (Replaced the USM-243/242 process).

State and Local Government refer to the E-IGA User Handbook & E-IGA Brochure

*This section A data also coincides with section C and D data to follow*
USMS Core Detention Standards

Core Detention Standards – Section G – Visual review example

The USMS walk through

Remember! Note: 2011 POD Memo to IGA's on dissemination of the USM218. The USM-218 is a document shared with local governments or other federal agencies. It is also discoverable in court for Criminal or Civil Law Suits.
### Core Detention Standards – Section H – Confinement Conditions

<table>
<thead>
<tr>
<th>A.1</th>
<th>Policy Development and Monitoring</th>
<th>The Facility Director ensures staff has the necessary information to operate and maintain the facility and its programs.</th>
<th>Compliant</th>
<th>Partially Compliant</th>
<th>Non-Compliant</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.2</td>
<td>Internal Inspections and Reviews</td>
<td>The Facility Director ensures internal operational inspections and reviews are conducted regularly and, where practicable, follow-up is provided.</td>
<td>Compliant</td>
<td>Partially Compliant</td>
<td>Non-Compliant</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>A.3</td>
<td>Detainee Records</td>
<td>The Facility Director ensures that all detainee records (including medical and mental health) are maintained accurately and confidentially.</td>
<td>Compliant</td>
<td>Partially Compliant</td>
<td>Non-Compliant</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>A.4</td>
<td>Administration and Documentation</td>
<td>The Facility Director ensures that all administrative and operational documents are maintained accurately and systematically.</td>
<td>Partially Compliant</td>
<td>Non-Compliant</td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>A.5</td>
<td>Personal Property and Mailing</td>
<td>The Facility Director ensures that all personal property is stored, processed, and returned to detainees in a timely manner.</td>
<td>Partially Compliant</td>
<td>Non-Compliant</td>
<td>Not Applicable</td>
<td></td>
</tr>
<tr>
<td>A.6</td>
<td>Detainee Release</td>
<td>The Facility Director ensures that detainees are released only with proper orders, identification verification, and notice to appropriate entities.</td>
<td>Partially Compliant</td>
<td>Non-Compliant</td>
<td>Not Applicable</td>
<td></td>
</tr>
</tbody>
</table>

### Core Detention Standards – Section B – Health Care

<table>
<thead>
<tr>
<th>B.1</th>
<th>Intake Health Screening</th>
<th>The Facility Director ensures that all detainees are screened for medical and mental health concerns.</th>
<th>Partially Compliant</th>
<th>Non-Compliant</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>B.2</td>
<td>Medical, Dental, and Mental Health Appraisals</td>
<td>The Facility Director ensures that all medical, dental, and mental health appraisals are conducted for each detainee in a timely manner, including treatment or diagnostic records.</td>
<td>Compliant</td>
<td>Partially Compliant</td>
<td>Non-Compliant</td>
</tr>
<tr>
<td>B.3</td>
<td>Access to Resources, Services, and Emergency Health Services</td>
<td>The Facility Director ensures that detainees have access to resources, services, and emergency health services.</td>
<td>Partially Compliant</td>
<td>Non-Compliant</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>

### Core Detention Standards – Section C – Security & Control

<table>
<thead>
<tr>
<th>C.1</th>
<th>Post Orders</th>
<th>The Facility Director ensures that post orders are clear and understood by all staff.</th>
<th>Partially Compliant</th>
<th>Non-Compliant</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>C.2</td>
<td>Permanent Logs</td>
<td>The Facility Director ensures that permanent records are maintained and updated regularly.</td>
<td>Partially Compliant</td>
<td>Non-Compliant</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>C.3</td>
<td>Security Features</td>
<td>The Facility Director ensures that all security features are maintained and updated regularly.</td>
<td>Partially Compliant</td>
<td>Non-Compliant</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>C.4</td>
<td>Security Inspections</td>
<td>The Facility Director ensures that security inspections are conducted regularly and documented.</td>
<td>Partially Compliant</td>
<td>Non-Compliant</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>C.5</td>
<td>Control of Contraband</td>
<td>The Facility Director ensures that contraband is controlled and disposed of properly.</td>
<td>Partially Compliant</td>
<td>Non-Compliant</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>C.6</td>
<td>Searchfavorite</td>
<td>The Facility Director ensures that all detainees are searched for contraband in a systematic manner.</td>
<td>Partially Compliant</td>
<td>Non-Compliant</td>
<td>Not Applicable</td>
</tr>
</tbody>
</table>
Core Detention Standards – Section C – Security & Control Cont’d

- Use of Force
  - The Facility Director ensures that force is used only when necessary and only as necessary. The Facility Director also ensures that where force is used in is properly documented and complies with all applicable requirements.

- Non-violent Use of Restraints
  - The Facility Director ensures that non-violent restraint is used only when necessary.

Core Detention Standards – Section D – Food Service

D.1 Sanitation Requirements:
  - The Facility Director ensures that the facility meets all applicable food service standards regarding sanitation procedures for preparing, serving, and storing food. The facility also ensures that temperature requirements for food preparation and storage are met.

D.2 Adequate and Varied Meals:
  - The Facility Director ensures that nutritionally adequate and varied meals are provided.

D.3 Special Diets
  - The Facility Director provides special diets when prescribed by appropriate medical or dental personnel.

Core Detention Standards – Section E – Staff / Detainee Communication

E.1 Staff-Detainee Communication
  - The Facility Director ensures that communication aids are provided, including translations, transcriptions, and hearing-impaired aids.

E.2 Diversity Training
  - The Facility Director provides staff with appropriate diversity and sensitivity training.

E.3 Detainee Grievances
  - The Facility Director ensures that detainee grievances are addressed in a timely manner through a formal process.

Core Detention Standards – Section F – Safety & Sanitation

F.1 Fire Safety
  - The Facility Director ensures an adequate fire safety program, which conforms to local, state, and federal regulations.

F.2 Non-Hazardous Furnishings
  - The Facility Director ensures that furnishings (e.g., mattresses, bedding, etc.) are fire-resistant, non-toxic, and non-flammable.

F.3 Control of Dangerous Materials
  - The Facility Director controls the storage, use, and disposal of all hazardous materials.

F.4 Environmental Control
  - The Facility Director provides reasonable living and working conditions for the detainees.

F.5 Clothing and Bedding
  - The Facility Director provides all detainees with adequate clothing and bedding.

F.6 Personal Hygiene/Well-being
  - The Facility Director ensures that detainees have reasonable access to personal hygiene and personal care items.

F.7 Physical Facility and Equipment
  - The Facility Director ensures that the physical facility and equipment do not present a hazard to detainees.
Detention Facility Training  
Conditions of Confinement Program  
Online Reports USM-218 / 218A / 210

Course Goals

During the next 45 minutes or so we will be discussing detention facility reporting required to effectively monitor and inspect IGA or Contract Facilities.

- Understand the Policy and POD memoranda which guides your operations as a (DMI/DFI) Detention Inspector.
- Understand How to Gain Access Rights, Log Into the system, and also understand the different User Roles utilized in the system.
- Identify the components of a detention facility’s resources and how to document them
  - Annual review of a facility utilizing the USM-218 document. Also understand the different User Roles utilized in the system.
  - Document the results of the special review of a facility in connection to Limited Use Agreements (LUA) utilizing the USM-218 document.
  - Document the results of the OFDT lead Quality Assurance Review (QAR) of Private Contracts on a USM-210 document and when these occur.
- How to coordinate with POD to ensure the Online Facility Inspection system is accurate for addition of new facilities or to make changes to the status of an existing facility.

Goal #1 Understanding the “Jail Inspection” Mission

The Detention Facility Inspector (DFI)  
The Detention Management Inspector (DMI)

Legal Guidelines: Office of General Counsel

- Under 18 U.S.C 4086 the USMS has a duty to provide for the safekeeping of any person arrested, or held under its authority for any enactment of Congress pending commitment to an institution.
- Under 18 U.S.C 4002 and 4013 the USMS has the discretionary authority to contract with state and local jail facilities to house federal Prisoners. These agreements/contracts are further explained under 28 C.F.R 0.111(o) where the responsibility of the day-to-day prisoner operations at the facility is the sole preview of the contracted facility management.
- Be cautious that your documentation doesn’t violate our 3rd Party Protection. Case Law: S/FL 95-1913-CIV-GOLD  
  - Minerva De Los Santos VS USA et al.
  - USA / USMS was shielded from liability by the FTCA exception
  - OGC stated to POD on 01/06/2012 that the USMS cannot mandate operational standards of any specific operational direction to state and local IGAs. The USMS Inspection is solely monitoring and overview to allow for proper decision making.
Online Reporting System (USM-218 / 218A / 210)

Goal #2: User Access

- Follow current Online instructions as ITD executes user access issues on behalf of POD.
- The SDUSM or other authorized management official must assign these duties to you on a USM-222 then submit an electronic UARTES to the ITS Help Desk by email or via the IT Help Desk Web Request Form.
- Note that the UAR form has several Lotus Notes applications to choose from but the USM-218 form is not listed. Please write in the memo section “Requesting access to USM-218 Data base” and include the user level requested. User ID Web registered before UAR.

Goal #2: USMS DSS User Access Page

NOTE: access problems? ITS Helpdesk or (1-202-307-5200)
• the ITS Helpdesk Manager is Felicia Price FPrice@usms.doj.gov
Examples of other WEB based USMS Online databases are Motor Pool Mileage Report, Office of Preference (OPREF), or the USM-535 JSD Special Assignments.

Goal #2: District User Roles

- Collateral Duty – Detention Facility Inspectors (LV 1)
  - Users of GS-082 or GS-1811 who conduct inspections/reviews
  - WebPSD218DFIEAST or WebPSD218DFIWEST
  - Districts East or West of the Mississippi River
  - DFI's who relocate or become SDUSM must request changes on UAR-169 to be switched from the DFI role to the reviewer role or change Districts.
- District Managers - Supervisory GS-13/14/15 (LV 2)
  - and above who approve Jail Inspection Reports
  - User Group: WebPSD218DisRevs
  - Detention Management Investigators (DMI) must be either an inspector or reviewer user role but cannot be both.

Goal #2: POD-HQ User Roles

- Office of Contracts and Agreements
  - Review Inspections from District and verify IGA/Contracts/LUA
  - WebPSD218Readers
- Office of Detention Management
  - Coordinate Inspection and After Action Reports
  - Change inspection status / Add new facilities
  - Can make certain limited report fixes for Quality Assurance
  - WebPSD218HQStaff
- Office of Detention Oversight
  - Conditions of Confinement Administrators / WebPSD218HQAdmin
  - Super User role with enhanced Quality Assurance capability to fix errors from 2010 Database transition.
The Detention Facility Monitoring Reports
USM-218 / 218A Reports

Goal #3

- USM 218 series Detention Facility Inspection Database User Manual version 2.0
- Review how to:
  - Entering a USM 218 Annual Report (item 2.3 – pg. 9)
  - Entering a USM 218 LUA Report (item 2.4 - pg. 15)
  - Entering a QAR210 report (item 2.5 – pg. 18)
  - Entering a Field 210 report for inactive facilities (item 2.6 – pg. 21)
  - Understand the completion / District Reviewer process (item 3.0 – pg 29)

Goal #3

- We must ensure the Online Facility Inspection system is accurate for addition of New facilities or to make changes to the status of an existing facility.
- Office of Contracts and Agreements coordinates addition of New Contracts & IGA or any LUA.
- Office of Detention Management coordinates data in the 218 system to include additions, deactivations, or other revisions such as LUA & QAR inspection status.

Thank You & Welcome to the team!
APPENDIX VIII

SUICIDE PREVENTION
Jail Suicide Prevention: Current Research, Policy & Procedures, and Legal Trends

presented by
Lindsay M. Hayes
National Center on Institutions and Alternatives

Copyright 2012, National Center on Institutions and Alternatives

Major Findings

• The study identified 696 jail suicides in 2005 and 2006, with 612 deaths occurring in detention facilities and 84 in holding facilities. Data collected on 464 of those deaths.

• In 1986, rate of suicide in county jails was approx. 107 deaths per 100,000 inmates or an approx. rate of 9 times greater than the community (Hayes, 1988).

• In this study, rate of suicide in county jails during 2006 dropped dramatically and was 35 deaths per 100,000 inmates or slightly more than 3 times greater than the community (Hayes, 2010).

Major Findings

• 43% of victims were detained on violent/personal charges

• The charges of Sexual Assault of Child/Murder of a Child accounted for 7% of all suicides

• 38% of victims had a history of mental illness

Major Findings

• 34% had a history of suicidal behavior

• 23% of suicides occurred within the first 24 hours of confinement, 27% occurred between 2 and 14 days, and 20% between 1 and 4 months

• 20% were intoxicated at time of death

• 32% occurred between 3:01pm and 9:00pm
**Major Findings**

- 93% of suicides were by hanging -- 66% used their bedding
- 30% used bed/bunk as the anchoring device
- 51% found dead over 1 hour from last observation
- 8% on suicide watch at time of death (and inadequately observed and/or placed in dangerous cell)

**Major Findings**

- 35% occurred in close proximity to a court hearing, with 69% of those occurring in less than 2 days
- 22% occurred within close proximity to a telephone call or visit, with 67% of those occurring in less than 1 day
- 15% of victims had agreed to "no-harm" contracts
- Deaths evenly distributed throughout year, certain seasons and/or holidays did not account for more suicides

**Major Findings**

- 85% of facilities maintained a written suicide prevention policy, but few had comprehensive suicide prevention programming. For example...
- 77% of facilities provided intake screening, but only 27% verified suicide risk during prior confinement, and only 31% verified whether arresting/transporting officer believed victim was suicide risk.

**Major Findings**

- 63% of facilities did not provide suicide prevention training (38%) or did not provide it on an annual basis (25%).
- 93% of facilities had a suicide watch protocol, but less than 2% offered option for constant observation (most utilized 15-minute observation level).
Major Findings

- 80% of facilities provided CPR certification to staff, but CPR was administered in only 63% of cases.
- 32% of facilities maintained safe housing for suicidal inmates.
- 35% of facilities maintained a mortality review process.

Major Findings

See Table 43

Toward a Better Understanding of Suicide Prevention

- We do an admirable job of managing inmates identified as suicidal and placed on precautions.
- Very few inmates successfully commit suicide while on suicide watch.
- PRIMARY CHALLENGE: How do we prevent the suicide of an inmate who is not easily identifiable as being at risk for self harm?

The full 68-page National Study of Jail Suicide: 20 Years Later can be found at:

http://nicic.gov/Library/024308
“If suicidal individuals were either willing or able to articulate the severity of their suicidal thoughts and plans, little risk would exist.”

Kay Redfield Jamison, a prominent psychologist and author of *Night Falls Fast: Understanding Suicide* (1999)

---

**Guiding Principles for Suicide Prevention**

1. The assessment of suicide risk should not be viewed as a single event, but as an ongoing process.
2. Intake screening should be viewed as something similar to taking one’s temperature – it can identify a current fever, but not a future cold.

3. Prior risk of suicide is strongly related to future risk.
4. In addition to early stages of confinement, many suicides occur in close proximity to a court hearing. We must begin to devise ways in which our housing unit staff is more attentive to this risk period.

5. A disproportionate numbers of suicides take place in “special housing units.” We must create more interaction between inmates and correctional, medical, and mental health staff in these units, including more frequent rounds by staff and admission screening into these units.
6. We should not rely exclusively on the direct statements of an inmate who deny...
Example 1

A man was arrested for various theft charges at a local hotel. Officers noticed several fresh self-inflicted cuts on both wrists. The man admitted being suicidal following the recent break-up with his girlfriend. He was transported to the hospital where an ER doctor assessed him as anxious, depressed, and suicidal. For security reasons, the man could not be held at the hospital and was released to officers with instructions for suicide precautions at the county jail.

At the county jail, the man was initially placed on suicide watch but, after a few hours, complained of being cold in his safety smock and cold with the cell lights on. He now denied being suicidal. Jail staff, without consulting with medical/mental health personnel, discontinued the suicide watch, returned his clothing, and placed the inmate in a cell where the only illumination was from the officer’s flashlight during rounds. He committed suicide a few days later.

Example 2

Police were called to the home of a man who accidentally shot and killed a friend during a domestic dispute with his estranged wife. Upon arrival, the suspect placed a handgun to his head and clicked the trigger several times. He also encouraged the officers to shoot him. Following five hours of negotiations, the suspect surrendered without incident. He was transported to the county jail and denied being suicidal during the intake screening process. The inmate was not referred to mental health staff, nor placed on suicide watch. He committed suicide the following day.

Example 3

In any facility throughout the country, the inmate is on suicide precautions for attempting suicide the previous day. He is naked except for a suicide smock, given finger foods, and on lockdown status. The mental health clinician approaches the cell and asks the inmate (within hearing distance of others on the cellblock): “How are you feeling today? Still feeling suicide? Can you contract for safety?”

Will the inmate’s response be influenced by his current predicament?

How would you respond?
Guiding Principles for Suicide Prevention

7. We must provide meaningful suicide prevention training to our staff. Training should not be scheduled simply to comply with an accreditation standard. A workshop limited to an antiquated videotape, or web-based question/answer format, or recitation of the current policy might demonstrate compliance with accreditation, but it is not meaningful.

Guiding Principles for Suicide Prevention

8. Many preventable suicides result from poor communication amongst corrections, medical and mental health staff. Facilities that maintain a multidisciplinary approach to suicide prevention avoid preventable suicides.

Guiding Principles for Suicide Prevention

9. One size does not fit all and basic decisions regarding the management of a suicidal inmate should be based upon their individual needs, not simply on the resources that are said to be available.

Example

If an acutely suicidal inmate requires continuous, uninterrupted observation from staff, they should not be monitored via CCTV simply because that is the only option the system chooses to offer.
Guiding Principles for Suicide Prevention

10. By far the most important decision in the area of suicide precaution is the determination to discharge an inmate from suicide precautions. That determination must always be made by a qualified mental health professional following a comprehensive suicide risk assessment. Decisions by non-QMHPs that result in bad outcomes incurs unnecessary liability.

Guiding Principles for Suicide Prevention

11. We must avoid creating barriers that discourage inmates from accessing mental health staff should they feel suicidal. If an inmate believes suicide precautions are “punitive,” i.e., automatic removal of clothing/issuance of a safety smock, limited movement (for showers, visiting, recreation, telephone, etc.), loss of desired cell placement and/or job, they may be reluctant to seek out mental health staff.

Guiding Principles for Suicide Prevention

12. Few issues challenge us more than inmates who threaten suicide for a perceived secondary gain. Yet we should not assume that inmates who appear manipulative are not also suicidal. The critical issue is not how we label the behavior, but how we react to it. The reaction must include a multidisciplinary approach.

Guiding Principles for Suicide Prevention

13. Lack of inmates on suicide precautions should not be interpreted to mean that there are no currently suicidal inmates in your facility, nor a barometer of sound suicide prevention practices. You can’t make the argument that your facility is housing more mentally ill and/or other high-risk individuals and then state there are not any suicidal inmates in your facility today.
Guiding Principles for Suicide Prevention

14. We must avoid using the terms “WATCH CLOSELY” or “KEEP AN EYE ON HIM!” when describing an inmate we are concerned about, but have not placed on suicide precautions. If we are concerned about them, then they should be on suicide precautions.

A lack (or small number) of inmates on suicide precautions, can be the result of inadequate identification practices.

Example

1) If someone really wants to kill themselves, there’s generally nothing you can do about it.

2) There’s no way you can prevent suicides unless you have someone sitting watching the prisoner all the time, and no one can afford to be a baby sitter.

3) Suicide prevention is a medical problem...it’s a mental health problem...it’s not our problem.

Guiding Principles for Suicide Prevention

15. We must avoid Obstacles to Prevention. Such obstacles are negative attitudes implying that inmate suicides cannot be prevented.
Guiding Principles for Suicide Prevention

16. Create and maintain a comprehensive suicide prevention program that includes the following essential components:

- Staff Training
- Intake Screening/Assessment
- Communication
- Housing
- Levels of Observation/Management
- Intervention
- Reporting
- Follow-up/Morbidity-Mortality Review

Standards of Care

1. National Commission on Correctional Health Care (contains "Guide to Developing and Revising Suicide Prevention Protocols")

2. American Correctional Association


Training

1. Initial Training (8 hours) includes:
   a) Inmate suicide research
   b) Staff attitudes about suicide (avoiding obstacles to prevention)
   c) Why facility environments are conducive to suicidal behavior, potential pre-disposing factors, high-risk periods, warning signs and symptoms
   d) Identifying suicidal inmates despite their denial of risk
   e) Components of the facility's suicide prevention policy
   f) Liability issues

2. Annual Training (2 hours) includes:
   a) Review of initial training highlights
   b) Review of suicides/serious suicide attempts during the year
   c) Review of changes in the department policy
Intake Screening/Assessment

The Intake Screening Form is completed by a trained correctional officer or nurse and includes inquiry regarding:

1) Past suicidal ideation and/or attempts
2) Current suicidal ideation, threats or plans
3) Prior mental health treatment, including hospitalization
4) Recent significant loss (job, relationship, death of a family member/close friend, etc.)
5) Expresses a feeling there is nothing to look forward to in the immediate future (e.g., helplessness and/or hopelessness)
6) Family or significant other history of suicidal behavior
7) Suicide risk during prior department confinement and/or at most recent sending facility — gathered by nursing or classification staff
8) Transporting officer believes that inmate may be a medical, mental health, and/or suicide risk

Communication

Level 1:
Sending agency/transporting officer or others and the suicidal inmate

Level 2:
Among correctional, medical, and mental health staff regarding the suicidal inmate

Level 3:
All staff and the suicidal inmate

Housing

- Housing assignments should be based on the ability to maximize staff interaction with the inmate, not on decisions that heighten depersonalizing aspects of confinement.
- Avoid isolation — a disproportionate number of suicides occur in segregation.
Housing

- To every extent possible, a suicidal inmate should be housed in the general population, mental health unit, or medical infirmary, located close to staff.

Housing

- All cells designated to house suicidal inmates should be suicide-resistant, free of all obvious protrusions (e.g., door and window bars; door handles/hinges; towel racks; clothing hooks; and large gauge mesh screening over light fixtures, radiators, sprinkler heads, smoke detectors and ceiling/wall air vents, etc.) Cell door windows should allow for clear and unobstructed visibility to all areas of the cell interior.

Two (2) Recommended Levels of Supervision

Close Observation is reserved for the inmate who is not actively suicidal, but expresses suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) and/or has a recent prior history of self-destructive behavior.

Staff should observe such an inmate at staggered intervals not to exceed 10 minutes (e.g., 5, 10, 7 minutes, etc.).

Two (2) Recommended Levels of Supervision

Because an inmate can successfully commit suicide in less than 10 minutes, Close Observation status will only be effective if checks are made on a staggered basis and the cell is suicide-resistant.
Two (2) Recommended Levels of Supervision

**Constant Observation** is reserved for the inmate who is actively suicidal, either threatening or engaging in suicidal behavior.

CCTV, inmate companions, etc. can be utilized as a supplement to, but never as a substitute for, **Constant Observation** or **Close Observation**.

Upgrading, Downgrading, and Discontinuing Suicide Precautions

- Any designated staff may place an inmate on suicide precautions or upgrade those precautions, but only a "qualified mental health professional" should downgrade and/or discontinue suicide precautions;
- If available full-time, mental health staff should assess and interact with (not just observe) suicidal inmates on a daily basis.

Intervention

1) All staff who come into contact with inmates should be trained in standard first aid and cardiopulmonary resuscitation (CPR), as well as participate in annual "mock drill" training to ensure as prompt emergency response to all suicide attempts.
Intervention

2) All housing units should contain an emergency response bag that includes a first aid kit, pocket mask or Ambu bag, latex gloves, and emergency rescue tool (to quickly cut through fibrous material.) At least one Automated External Defibrillator (AED) should be centrally located in the facility.

Intervention

3) Non-medical staff should never wait for medical personnel to arrive before entering cell or before initiating full life-saving measures (e.g., first aid and CPR).

Reporting

1) In the event of a suicide attempt or suicide, all appropriate officials should be notified through the chain of command.

2) Following the incident, the victim’s family should be immediately notified, as well as appropriate outside authorities.

Reporting

3) All staff who come into contact with the victim prior to the incident should be required to submit a statement that includes their full knowledge of the inmate and incident. Their reports should be brief, accurate, and specific to personal knowledge of the incident – and not what they assumed or thought happened.
The primary purpose of a Morbidity-Mortality review is straightforward:

What happened in the case under review and what can be learned to reduce the likelihood of future incidents?

1. The morbidity-mortality review team must be multidisciplinary and include correctional, mental health, and medical personnel. Exclusion of one or more disciplines will severely jeopardize the integrity of the review.

2. The review, separate and apart from other formal investigations that may be required to determine the cause of death, should include critical review of:
   a) Circumstances surrounding the incident;
   b) Facility procedures relevant to the incident;
   c) Relevant training received by involved staff;
   d) Medical and mental health services/reports involving the victim;
   e) Possible precipitating factors (i.e., circumstances which may have caused the victim to commit suicide); and
   f) Recommendations, if any, for change in policy, training, physical plant, medical or mental health services, and operational procedures.
Jail & Prison Suicide Litigation:
Cases of Interest

1. *Heflin v. Stewart County*, 958 F.2d 709 (6th Cir. 1992); *Tlamka v. Serrell*, 244 F.3d 628 (8th Cir. 2001); and *Bradich v. City of Chicago*, 413 F.3d 693 (7th Cir. 2005)

2. *Cunningham v. Tkadletz*, 97 C. 1109, United States District Court for the Northern District of Illinois, 1998; *Conn v. City of Reno*, 591 F.3d 1081 (9th Cir. 2010)

3. *Jacobs v. West Feliciana Sheriff’s Dept.*, 228 F.3d 388 (5th Cir. 2000)

4. *Sanville v. McCaughtry*, 266 F.3d 724 (7th Cir. 2001)


6. *Clouthier v. County of Contra Costa*, 501 F.3d 1232 (9th Cir. 2010)


Jail Suicide Prevention Resources

Lindsay M. Hayes
Project Director
National Center on Institutions and Alternatives
40 Lantern Lane, Mansfield, Massachusetts 02048
(508) 337-8805-office, (508) 337-3083-fax
e-mail: Lhayesta@msn.com
http://www.ncianet.org/services suicide-prevention-in-custody
JAIL SUICIDE PREVENTION:
Current Research, Policy and Procedures, and Legal Trends

Presented by

Lindsay M. Hayes
Project Director
National Center on Institutions and Alternatives
40 Lantern Lane, Mansfield, Massachusetts 02048
(508) 337-8806
Lhayestal@msn.com
http://www.ncianet.org/services/suicide-prevention-in-custody/

for the

National Institute of Corrections, Jails Division
Chief Jail Inspectors' Network
Aurora, Colorado

July 18, 2012

HANDOUTS
NATIONAL STUDY OF JAIL SUICIDE:
20 YEARS LATER

by
Lindsay M. Hayes
Project Director
National Center on Institutions and Alternatives

April 2010
Executive Summary

Suicide continues to be a leading cause of death in jails across the country and the rate of suicide in county jails is estimated to be several times greater than that of the general population. In September, 2006, the National Center on Institutions and Alternatives (NCIA) entered into a cooperative agreement with the U.S. Justice Department’s National Institute of Corrections to conduct a national study on jail suicides that would determine the extent and distribution of inmate suicides in local jails (i.e., city, county, and police department facilities), as well as gather descriptive data on demographic characteristics of each victim, characteristics of the incident, and characteristics of the jail facility which sustained the suicide. The study, a follow-up to a similar national survey conducted by NCIA 20 years earlier in 1986, would result in a report of the findings to be utilized as a resource tool for both jail personnel in expanding their knowledge base, and correctional (as well as mental health and medical) administrators in creating and/or revising policies and training curricula on suicide prevention.

The study resulted in the identification of 696 jail suicides during the 2005 and 2006, with 612 deaths occurring in detention facilities and 84 in holding facilities. Demographic data was subsequently analyzed on 464 of the suicides.

Among the findings regarding Characteristics of the Suicide Victims:

- 67% were white;
- 93% were male;
- Average age was 35;
- 42% were single;
- 43% were held on a violent/personal charge;
- 47% had a history of substance abuse;
- 28% had a history of medical problems;
- 38% had a history of mental illness;
- 20% had a history of taking psychotropic medication; and
- 34% had a history of suicidal behavior.

Among the findings regarding Characteristics of the Suicides:

- Deaths were evenly distributed throughout the year, certain seasons and/or holidays did not account for more suicides;
- 32% occurred between 3:01pm and 9:00pm;
- 23% occurred within first 24 hours, 27% occurred between 2 and 14 days, 20% between 1 and 4 months;
- 20% were intoxicated at time of death;
- 93% used hanging as the method;
- 66% used bedding as the instrument;
- 30% used bed/bunk as the anchoring device;
• 31% found dead over 1 hour from last observation;
• CPR administered in 63% of incidents;
• 38% held in isolation;
• 8% on suicide watch at time of death;
• No-harm contracts used in 13% of cases;
• 37% assessed by qualified mental health professionals, with 47% of those assessed within three days of death;
• 35% occurred within close proximity to a court hearing, with 69% of those occurring in less than 2 days; and
• 22% occurred within close proximity to a telephone call or visit, with 67% of those occurring in less than 1 day.

Among the findings regarding Characteristics of the Jail Facilities:

• 84% administered by county, 13% by municipal, 2% private, and less than 2% by state or regional agencies;
• 77% provided intake screening to identify suicide risk, but only 27% verified suicide risk of victim during prior confinement and only 31% verified whether arresting/transporting officer believed victim was suicide risk;
• 62% provided suicide prevention training, but 63% either did not provide training or did not provide it on an annual basis;
• 69% of training provided was for two hours or less, and only 6% was 8 hours in length;
• 80% provided CPR certification;
• 93% provided suicide watch protocol, less than 2% had the option for constant observation most (87%) utilized 15-minute observation level;
• 51% allowed only mental health personnel with discharge from suicide watch responsibilities;
• 32% maintained safe housing for suicidal inmates;
• 35% maintained a mortality review process; and
• 85% maintained a written suicide prevention policy, but suicide prevention programming was not comprehensive.

Twenty years after the previous study in 1986, this national study of jail suicides found substantial changes in the demographic characteristics of inmates committing suicide. Some of these changes were stark. For example, suicide victims once characterized as being confined on “minor other” offenses, were most recently found in the 2005-2006 data to be held on violent/personal charges. Intoxication was previously viewed as a leading precipitant to inmate suicide, yet recent data indicates that it is now found in only a minority of cases. Whereas over half of all jail suicide victims were previously dead within the first 24 hours of confinement, current data suggests that less than a quarter of all victims commit suicide during this time period, with an equal number of deaths occurring between 2 and 14 days of confinement. In addition, inmates that committed suicide appeared to be far less likely to be housed in isolation than previously reported
and, for unknown reasons, were less likely to be found within 15 minutes of the last observation by staff. Finally, more jail facilities that experienced inmate suicides had both written suicide prevention policies and an intake screening process to identify suicide risk than in years past, although the comprehensiveness of programming remains questionable.

Finally, the suicide rate in detention facilities during 2006 was calculated to be 38 deaths per 100,000 inmates, a rate approximately three times greater than that of the general population. This rate, however, represents a dramatic decrease in the rate of suicide in detention facilities during the past 20 years. The almost three-fold decrease from a previously reported 107 suicides in 1986 is extraordinary. Absent in-depth scientific inquiry, there may be several explanations for the reduced suicide rate. During the past several years, prior national studies of jail suicide have given a face to this long-standing and often ignored public health issue within our nation’s jails. Findings from the studies have been widely distributed throughout the country and eventually incorporated into suicide prevention training curricula. The increased awareness to inmate suicide is also reflected in national correctional standards that now require comprehensive suicide prevention programming, better training of jail staff, and more in-depth inquiry of suicide risk factors during the intake process. Finally, jail suicide litigation has persuaded (or forced) jurisdictions and facility administrators to take corrective actions in reducing the opportunity for future deaths. Therefore, the antiquated mindset that “inmate suicides cannot be prevented” should forever be put to rest.

Recommendations in the areas of comprehensive suicide prevention programming, staff training, and future research efforts are offered.

In conclusion, findings from this study create a formidable challenge for both correctional and health care officials, as well as their respective staffs. While our knowledge base continues to increase, which has seemingly corresponded to a dramatic reduction in the rate of inmate suicide in detention facilities, much work lies ahead. The data indicates that inmate suicide is no longer centralized to the first 24 hours of confinement and can occur at any time during an inmate’s confinement. As such, because roughly the same number of deaths occurred within the first several hours of custody as in more than a few months of confinement, intake screening for the identification of suicide risk upon entry into a facility should be viewed as time-limited. Instead, because inmates can be at risk for suicide at any point during confinement, the biggest challenge for those who work in the corrections system will be to conceptualize the issue as requiring a continuum of comprehensive suicide prevention services aimed at the collaborative identification, continued assessment, and safe management of inmates at risk for self-harm.
### Table 43: Changing Faces of Jail Suicide Victims

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Type</td>
<td>70% Detention</td>
<td>88% Detention</td>
</tr>
<tr>
<td>Race</td>
<td>72% White</td>
<td>67% White</td>
</tr>
<tr>
<td>Sex</td>
<td>94% Male</td>
<td>93% Male</td>
</tr>
<tr>
<td>Age</td>
<td>30</td>
<td>35</td>
</tr>
<tr>
<td>Marital Status</td>
<td>52% Single</td>
<td>42% Single</td>
</tr>
<tr>
<td>Most Serious Charge</td>
<td>29% Minor Other</td>
<td>43% Violent/Personal</td>
</tr>
<tr>
<td>Jail Status</td>
<td>89% Detained</td>
<td>91% Detained</td>
</tr>
<tr>
<td>Intoxication at Death</td>
<td>60%</td>
<td>20%</td>
</tr>
<tr>
<td>Time of Suicide</td>
<td>30% between 12:00am and 6:00am</td>
<td>32% between 3:01pm and 9:00pm</td>
</tr>
<tr>
<td>Length of Confinement</td>
<td>51% within 1st 24 hours</td>
<td>23% within 1st 24 hours</td>
</tr>
<tr>
<td>Method</td>
<td>94% Hanging</td>
<td>93% Hanging</td>
</tr>
<tr>
<td>Instrument</td>
<td>48% Bedding</td>
<td>66% Bedding</td>
</tr>
<tr>
<td>Time Span (between last observation and finding victim)</td>
<td>42% found within 15 minutes</td>
<td>21% found within 15 minutes</td>
</tr>
<tr>
<td>Isolation</td>
<td>67%</td>
<td>38%</td>
</tr>
<tr>
<td>Known History of Suicidal Behavior</td>
<td>16%</td>
<td>34%</td>
</tr>
<tr>
<td>Known History of Mental Illness</td>
<td>19%</td>
<td>38%</td>
</tr>
<tr>
<td>Intake Screening for Suicide Risk</td>
<td>30%</td>
<td>77%</td>
</tr>
<tr>
<td>Written Suicide Prevention Policy</td>
<td>51%</td>
<td>83%</td>
</tr>
</tbody>
</table>

The full 68-page *National Study of Jail Suicide: 20 Years Later* can be viewed at:

http://static.nicic.gov/Library/024308.pdf
Toward a Better Understanding of Suicide Prevention in Correctional Facilities

More times than not, we do an admirable job of safely managing inmates identified as suicidal and placed on precautions. After all, very few inmates successfully commit suicide on suicide watch.

What we continue to struggle with is the ability to prevent the suicide of an inmate who is not easily identifiable as being at risk for self-harm.

Kay Redfield Jamison, a prominent psychologist and author of Night Falls Fast - Understanding Suicide (1999), has better articulated the point by stating in her book that:

"If suicidal individuals were either willing or able to articulate the severity of their suicidal thoughts and plans, little risk would exist."

With this mind, the following GUIDING PRINCIPLES FOR SUICIDE PREVENTION are offered:

1) The assessment of suicide risk should not be viewed as a single event, but as an ongoing process. Because an inmate may become suicidal at any point during confinement, suicide prevention should begin at the point of arrest and continue until the inmate is released from the facility. In addition, once an inmate has been successfully managed on, and discharged from, suicide precautions, they should remain on a mental health caseload and assessed periodically until released from the facility.

2) Screening for suicide during the initial booking and intake process should be viewed as something similar to taking one's temperature – it can identify a current fever, but not a future cold. The shelf life of behavior that is observed and/or self-reported during intake screening is time-limited, and we often place too much weight upon this initial data collection stage. Following an inmate suicide, it is not unusual for the mortality review process to focus exclusively upon whether the victim threatened suicide during the booking and intake stage, a time period that could be far removed from the date of suicide. If the victim had answered in the negative to suicide risk during the booking stage, there is often a sense of relief expressed by participants of the mortality review, as well as a misguided conclusion that the death was preventable. Although the intake screening form remains a valuable prevention tool, the more important determination of suicide risk is the current behavior expressed and/or displayed by the inmate.

3) Prior risk of suicide is strongly related to future risk. At a minimum, if an inmate had been placed on suicide precautions during a previous confinement in the facility or agency, such information should be accessible to both direct care and health care personnel when determining whether the inmate might be at risk during their current confinement.

4) In addition to the heightened risk for suicide during the first 24 to 48 hours of confinement, many suicides occur in close proximity to a court proceeding. We must begin to devise ways in which our housing unit staff is more attentive to this risk period. In some jurisdictions, a brief mental status exam is given to select inmates (e.g., those on a mental health caseload, those identified as having a prior history of suicidal behavior, etc.) each time they return from a court proceeding.

5) A disproportionate number of inmate suicides take place in “special housing units” (e.g., disciplinary/administrative segregation) of the facility. One effective prevention strategy is to
create more interaction between inmates and correctional, medical and mental health personnel in these housing areas by: increasing rounds of medical and/or mental health staff, requiring regular follow-up of all inmates released from suicide precautions, increasing rounds of correctional staff, providing additional mental health screening to inmates admitted to disciplinary/administrative segregation, and avoiding lockdown due to staff shortages (and the resulting limited access of medical and mental health personnel to the units).

6) We should not rely exclusively on the direct statements of an inmate who denies that they are suicidal and/or have a prior history of suicidal behavior, particularly when their behavior, actions and/or history suggest otherwise. Often, despite an inmate's denial of suicidal ideation, their behavior, actions, and/or history speak louder than their words. For example:

In any facility, the inmate is on suicide precautions for attempting suicide the previous day. He is now naked except for a suicide smock, given finger foods, and on lockdown status. The mental health clinician approaches the cell and asks the inmate through the food slot (within hearing distance of others on the cellblock): “How are you feeling today? Still feeling suicide? Can you contact for safety?”

Will this inmate’s response be influenced by his current predicament?

How would we respond?

7) We must provide meaningful suicide prevention training to our staff, i.e., timely, long-lasting information that is reflective of our current knowledge base of the problem. Training should not be scheduled to simply comply with an accreditation standard. A workshop that is limited to an antiquated videotape, or web-based question-answer format, or recitation of the current policies and procedures, might demonstrate compliance (albeit wrongly) with an accreditation standard, but is not meaningful, nor helpful, to the goal of reducing inmate suicides. Without regular suicide prevention training, staff often make wrong and/or ill-informed decisions, demonstrate inaction, or react contrary to standard correctional practice, thereby incurring unnecessary liability.

8) Many preventable suicides result from poor communication amongst direct care, medical and mental health staff. Other problem areas for communication include outside law enforcement agencies and concern expressed from family members. Communication problems are often caused by lack of respect, personality conflicts, and other boundary issues. Simply stated, facilities that maintain a multidisciplinary approach avoid preventable suicides.

9) One size does not fit all and basic decisions regarding the management of a suicidal inmate should be based upon their individual clinical needs, not simply on the resources that are said to be available. For example, if an acutely suicidal inmate requires continuous, uninterrupted observation from staff, they should not be monitored via CCTV simply because that is the only option the system chooses to offer. A clinician should never feel pressured, however subtle that pressure may be, to downward and/or discharge an inmate from suicide precautions because additional staff resources (e.g., overtime, post transfer, etc.) are required to maintain the desired level of observation. Although they would rarely admit it, clinicians have prematurely downgraded, discharged, and/or changed the management plan for a suicidal inmate based upon pressure from facility officials.
10) By far the most difficult decision in the area of suicide precaution is the determination to discharge an inmate from suicide precautions. That determination must always be made by a qualified mental health professional (QMHIP) following a comprehensive suicide risk assessment. These decisions must be respected by non-QMHIP staff. Decisions by non-QMHIPs that result in bad outcomes incur unnecessary liability.

11) We must avoid creating barriers that discourage an inmate from accessing mental health services. Often, certain management conditions of a facility's policy on suicide precautions appear punitive to an inmate (e.g., automatic clothing removal/issuance of safety garment, lockdown, limited visiting, telephone, and shower access, etc), as well as excessive and unrelated to their level of suicide risk. As a result, an inmate who becomes suicidal and/or despondent during confinement may be reluctant to seek out mental health services, and even deny there is a problem, if they know that loss of these and other basic amenities are an automatic outcome. As such, these barriers should be avoided whenever possible and decisions regarding the management of a suicidal inmate should be based solely upon the individual's level of risk.

12) Few issues challenge us more than that of inmates we perceive to be manipulative. It is not unusual for inmates to call attention to themselves by threatening suicide or even feigning an attempt in order to gain a housing relocation, transfer to the local hospital, receive preferential staff treatment, or seek compassion from a previously unsympathetic family member. Some inmates simply use manipulation as a survival technique. Although there are no perfect solutions to the management of manipulative inmates who threaten suicide or engage in self-injurious behavior for a perceived secondary gain, the critical issue is not how we label the behavior, but how we react to it. The reaction must include a multidisciplinary treatment plan.

13) A lack of inmates on suicide precautions should not be interpreted as meaning that there are no currently suicidal inmates in the facility, nor a barometer of sound suicide prevention practices. We cannot make the argument that our correctional facilities are increasingly housing more mentally ill and/or other high risk inmates and then state there are not any suicidal inmates in our facility today. Correctional facilities contain suicidal inmates every day; the challenge is to find them. The goal should not be "zero" number of inmates on suicide precautions; rather the goal should be to identify, manage and stabilize suicidal inmates in our custody.

14) We must avoid using the terms "WATCH CLOSELY" or "KEEP AN EYE ON HIM" when describing an inmate we are concerned about, but have not placed on suicide precautions. If we are concerned about them, then they should be on suicide precautions.

15) We must avoid the obstacles to prevention. Experience has shown that negative attitudes often impede meaningful suicide prevention efforts. These obstacles to prevention often embody a state of mind (before any inquiry begins) that inmate suicides cannot be prevented.

16) We must create and maintain a comprehensive suicide prevention program that includes the following essential components: staff training, intake screening/assessment, communication, housing, levels of observation management, intervention, reporting, follow-up/morbidity-mortality review.
Suicide Prevention Policy
Lindsay M. Hayes
©National Center on Institutions and Alternatives, 2012

All correctional facilities, regardless of size, should have a detailed written suicide prevention policy that addresses each of the following critical components:

1) TRAINING: All correctional, medical, and mental health staff should receive eight (8) hours of initial suicide prevention training, followed by two (2) hours of annual training. Training should include inmate suicide research, staff attitudes about suicide (avoiding obstacles to prevention), why facility environments are conducive to suicidal behavior, predisposing factors, high-risk suicide periods, warning signs and symptoms, identifying suicidal inmates despite the denial of risk, components of the facility's suicide prevention policy, and liability issues.

2) IDENTIFICATION/SCREENING: Intake screening for suicide risk must take place immediately upon confinement and prior to housing assignment, and must include inquiry regarding: current and past suicidal behavior; prior mental health treatment; recent significant loss; suicidal behavior by family member/close friend; suicide risk during prior contact/confinement with agency, and arresting/transporting officer(s) believes inmate is currently at risk. Process must include procedures for referral to mental health and/or medical personnel. Inmates housed in special housing units should receive brief mental status screening upon entry.

3) COMMUNICATION: Procedures that enhance communication at three levels: 1) between the arresting/transporting officer(s) and jail staff; 2) between and among jail staff (including medical and mental health personnel); and 3) between jail staff and the suicidal inmate.

4) HOUSING: Isolation should be avoided; whenever possible, house in general population, mental health unit, or infirmary, in close proximity to staff. Inmates should be housed in suicide-resistant, self-immolation-free cells. Removal of clothing (excluding belts and shoelaces), as well as use of physical restraints should be avoided whenever possible, and only utilized as a last resort for periods in which the inmate is engaging in self-destructive behavior.

5) LEVELS OF SUPERVISION/MANAGEMENT: Two levels are recommended for suicidal inmates: Close observation, reserved for the inmate who is not actively suicidal, but expresses suicidal ideation and/or has a recent prior history of suicidal behavior, requires supervision at staggered intervals not to exceed every 10 minutes. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed under close observation. Constant Observation, reserved for the inmate who is actively suicidal (threatening/engaging in the act) requires supervision on a continuous/interrupted basis. CCTV, inmate companions, etc., can be utilized as a supplement to, but never as a substitute for, these observation levels. Mental health staff should assess the inmate daily, provide follow-up assessments, and treatment planning.

6) INTERVENTION: A facility's policy regarding intervention should be threefold: 1) all staff should be trained in standard first aid and CPR; 2) any staff who discovers an inmate attempting suicide should immediately respond, survey the scene to ensure the emergency is genuine, alert other staff to call for medical personnel, and begin life-saving measures; and 3) staff should never presume that the inmate is dead, but rather initiate and continue appropriate life-saving measures until relieved by medical personnel. All housing units should contain a first aid kit, CPR mask or Ambu bag, and rescue tool (to quickly cut through fibrous material).

7) REPORTING: In the event of a suicide attempt or suicide, all appropriate jail officials should be notified through the chain of command. All staff who came into contact with the victim prior to the incident should be required to submit a statement as to their full knowledge of the inmate and incident.

8) FOLLOW-UP/MORBIDITY-MORTALITY REVIEW: Every completed suicide, and serious suicide attempt (i.e., requiring hospitalization), should be examined by a morbidity-mortality review. The review, separate and apart from other formal investigations required to determine cause of serious injury or death, should include: 1) review circumstances surrounding incident; 2) review procedures relevant to incident; 3) review relevant training received by staff; 4) review pertinent health care services/reports of victim; 5) review possible precipitating factors (i.e., circumstances which may have caused victim to attempt/commit suicide); and 6) recommendations, if any, for change in policy, training, physical plant, health care services, and operational procedures.
Jail and Prison Suicide Litigation: Case Law Review

1) Jail Officers’ Failure to Conduct CPR
   - Hoffin v. Stewart County, 958 F.2d 709 (6th Cir. 1992)
   - Tlamka v. Serrell, 244 F.3d 628 (8th Cir. 2001)
   - Bradich v. City of Chicago, 413 F.3d 688 (7th Cir. 2005)

2) Nurse’s Failure to Make a Mental Health Referral
   - Arresting Officer’s Failure to Alert Jail Staff to Risk
   - Cunningham v. Tkadletz, 97 C. 1109, United States District Court for the Northern District of Illinois, 1998
   - Coun v. City of Reno, 591 F.3d 1081 (2010)

3) Sheriff and Jail Staff Deliberately Indifferent For Placing Suicidal Inmate in Unsafe Cell and Not Providing Observation
   - Jacobs v. West Feliciana Sheriff’s Dept, 228 F.3d 388 (5th Cir. 2000)

4) Correctional Officers’ Failure to Conduct Cell Checks
   - Mental Health Staff (Psychologist and Psychiatrist) Failure to Provide Adequate Assessment and Treatment
   - Sanville v. McCaughtry, 266 F.3d 724 (7th Cir. 2001)

5) County/Sheriff Failure to Implement Adequate Suicide Prevention Policy and Train Staff
   - Wever v. Lincoln County, 388 F.3d 601 (8th Cir. 2004)

6) Mental Health Clinician Failure to Provide Adequate Assessment and Treatment
   - Clauthier v. County of Contra Costa, 591 F.3d 1232 (9th Cir. 2010)

7) County/Sheriff/Health Care Contractor Failure to Implement Adequate Suicide Prevention Policy Consistent With Jail Standards
Jail and Prison Suicide Litigation: Case Law Review

Listed below are case summaries of significant jail and prison suicide litigation compiled by Lindsay M. Hayes. This listing is not intended to be all inclusive.

1) Heflin v. Stewart County [958 F.2d 709 (6th Cir. 1992)]. A deputy went to the decedent's cell on September 3, 1987 and saw a sheet tied to the cell bars. The deputy immediately went to the dispatcher's office, told the dispatcher to call the sheriff and ambulance service, picked up the cell block keys, and returned to open the cell. When the deputy entered the cell, he observed the decedent "hanging by the neck on the far side of the shower stall." The decedent's hands and feet were tied together, a rag was stuffed in his mouth, and his feet were touching the floor. With the body still hanging, the deputy checked for a pulse and signs of respiration, but found none though the body was still warm. He also opened the decedent's eyes and found the pupils were dilated. From these observations the deputy concluded that the decedent was dead. While the deputy was still alone in the cell with the hanging body, a jail trusty arrived with a knife he had picked up in the kitchen. Rather than utilize the knife to cut the decedent down, the deputy ordered the trusty out of the area. The sheriff arrived shortly thereafter and directed the deputy to take pictures of the decedent before he was taken down.

At trial, the plaintiffs introduced evidence that the county maintained a policy of leaving victims as discovered, despite the ability to resuscitate victims. They ultimately prevailed and a jury awarded damages to the decedent's family based upon proof that the defendants' acted with deliberate indifference after discovering the decedent hanging. The defendants appealed and argued that the decedent was already dead and their action or inaction could not have been the proximate cause of his death. The appeals court ruled that "there clearly was evidence from which the jury could find that Heflin died as the proximate result of the failure of Sheriff Hicks and Deputy Cratcher to take steps to save his life. They left Heflin hanging for 20 minutes or more after discovering him even though the body was warm and his feet were touching the floor. The unlawfulness of doing nothing to attempt to save Heflin's life would have been apparent to a reasonable official in Cratcher or Hick's position in 'light of pre-existing law'."

The court also affirmed the award of damages in the amount of $154,000 as well as approximately $103,999.00 in attorney fees.

See also Thamka v. Serrell [244 F.3d 628 (8th Cir. 2001)], in which the court ruled that third correctional officers could be sued for allegedly ordering inmates to stop giving CPR to an inmate who collapsed in a prison yard following a heart attack. The court stated that "any reasonable officer would have known that delaying Thamka's emergency medical treatment for 10 minutes, with no good or apparent explanation for the delay, would have risen to an Eighth Amendment violation."

See also Bradich v. City of Chicago [413 F.3d 688 (7th Cir. 2005)], in which the court ruled that deliberate indifference could occur if jail staff unnecessarily delayed (up to 10 minutes) the emergency medical response, including CPR — "protecting one's employment interests while an inmate chokes to death would exemplify deliberate indifference to serious medical needs."

2) Cunningham v. Tkadletz [97 C 1109, United States District Court for the Northern District of Illinois, 1998]. Natiera Cunningham, 18-years-old, was arrested for misdemeanor offenses arising out of an alleged shoplifting incident. She was subsequently transferred to, and incarcerated in, the Gurnee, Illinois police lock-up. Natiera was held on the misdemeanor charges, as well as on an outstanding felony warrant from Waukegan, Illinois. Shortly before midnight the same day she was arrested, Natiera attempted to commit suicide in the Gurnee lock-up by preparing to hang herself with an article of clothing. Gurnee police, who maintained video surveillance of prisoners in their lockup, observed her and immediately intervened, preventing the suicide. Natiera was transported to a nearby hospital, briefly examined, and returned to the custody of the Gurnee police. Hospital discharge instructions directed that Natiera be placed on a "suicide watch," which was maintained by the Gurnee police for the duration of the night.

Waukegan Police Department Detective Mark Tkadletz spoke by telephone with a Gurnee police commander the next morning. After being apprised of Natiera's suicide attempt some 9 hours earlier, he drove to Gurnee to take custody of Cunningham for the purpose of interrogating her regarding the outstanding felony charge. Two Gurnee police commanders later testified at trial that Detective Tkadletz was informed in detail of Natiera's earlier attempted suicide...
and was apprised that her mother was concerned that she would attempt suicide again. The commanders advised Detective Tkadlecz that they considered Naticra to be at continued risk of attempting to commit suicide.

Detective Tkadlecz took custody of Naticra and transported her to the Wautegan Police Department. While at the police station, he interrogated the young woman regarding the pending felony charge for approximately 30 minutes during which, by his own report, she became increasingly upset, and ultimately stopped answering his questions. Detective Tkadlecz subsequently took Naticra to court for a bond hearing. He never relayed any of the information he received concerning Naticra’s suicide attempt or her continuing risk of suicide to court deputies, or to anyone else.

Naticra was remanded to the Lake County Jail in Waukegan. Laurel Dens, a nurse for Correctional Medical Services (CMS), a private contractor providing medical and mental health services at the facility, administered a suicide risk screening form on Naticra. The form consisted of a series of questions and observations. The answers given were recorded on a form and totaled to provide a numerical score. CMS regulations provided that a score of eight or higher required an immediate psychiatric referral. Although Naticra scored an “eight” on the form, Nurse Dens failed to make a psychiatric referral or otherwise notify the jail authorities that the inmate might be suicidal. In a subsequent affidavit, the nurse stated she failed to make a psychiatric referral because she did not believe the truthfulness of some of Naticra’s answers, i.e., her score was not a “legitimate eight.” Accordingly, Naticra was not afforded any psychiatric treatment and was placed in the general jail population, without benefit of any type of suicide watch, or other precautions.

During her confinement, Naticra became increasingly frustrated and agitated over the inability of her family to raise money to bond her out of jail. For the next two days, she made repeated calls home, to no avail. At approximately 9:00 am on the morning of June 6, Naticra was told she was not scheduled to go to court or to be released that day. She became “disruptive” and was placed on a 23-hour lock down by Erica Sandahl, a Lake County correctional officer working on the housing tier to which Naticra was assigned. Officer Sandahl returned to the housing tier from lunch at approximately 12:15 pm. Former inmates who testified at trial stated that Naticra had refused to eat her lunch that day, and had been pleading from her cell for someone to speak to. Other plaintiff witnesses testified that, while Naticra was calling out for help, Officer Sandahl remained in the day room watching a soap opera with inmates who were not on lock down. There was, however, no testimony offered at trial to suggest that Officer Sandahl had been told anything about Naticra having attempted suicide or expressing any desire to harm herself. At the end of the television program, the officer went to Naticra’s cell and found her hanging from an overhead sprinkler. Emergency medical assistance was called. Shortly thereafter, Naticra Cunningham was pronounced dead at a nearby hospital.

In his trial testimony, Detective Tkadlecz admitted he was informed of Naticra’s earlier suicide attempt, but adamantly denied he was told that there was any continuing concern that the young woman remained at risk of suicide. The detective further maintained that since Naticra had been “treated and released” at a hospital, he was fully justified in concluding there was no reason to believe that she was at continued risk of committing suicide. He maintained, therefore, there was no need for him to have informed the sheriff’s deputies of Naticra’s suicide attempt the previous night. Detective Tkadlecz also stated that Naticra did not “appear suicidal” or “depressed,” and testified that her demeanor was similar to that of other arrestees with pending felony charges.

A settlement of all claims against Correctional Medical Services and Nurse Dens was arrived at in advance of trial. The claim against Officer Sandahl was dismissed by the trial judge at the conclusion of the plaintiff’s evidence. On October 28, 1998, an eight-person jury returned a verdict in favor of the plaintiff against Detective Tkadlecz, totaling $1,350,000, including $750,000 in punitive damages.

See also *Conn v. City of Renton* [391 F.3d 1081 (2010)], in which police officers transporting a woman to a county jail for protective custody witnessed her attempting to choke herself by wrapping a seatbelt around her neck, screaming that they should kill her or she would take her own life. They failed to either take her to a hospital or report the incident to county jail personnel. She was released, detained again 48 hours later, and hung herself in the county jail. Overturning summary judgment for the police officers, the federal appeals court found that a reasonable juror could decide that the officers acted with deliberate indifference to the decedent’s serious medical needs so that they were not entitled to qualified immunity.

3) *Jacobs v. West Feliciana Sheriff’s Department* [228 F.3d 388 (5th Cir. 2000)]. On August 21, 1996, Sheila Jacobs was arrested for the attempted, second-degree murder, by shooting, of her uncle. Jacobs had become enraged at her uncle when she learned that he had allegedly sexually molested one of her sons years before. The arresting
state troopers informed an investigator for the West Feliciana Sheriff's Department that Jacobs told them shortly after her arrest that, after shooting her uncle, she had tried to kill herself by placing a loaded gun in her mouth and pulling the trigger, but the gun had jammed. The investigator conveyed this information to Sheriff Bill Daniel and Deputies Earl Reech and Wayne Rabalais.

After processing Jacobs, the officers at the West Feliciana Parish Prison placed Jacobs in a "detox" cell. According to Deputy Rabalais, when Jacobs was placed in the detox cell, the officers had her on suicide watch and had placed a note to that effect in the control center. Although a portion of the detox cell could be observed from the jail's control room through a window, a substantial amount of the cell (including the bunk area) fell into a "blind spot" and was not visible from the control room. This cell could be completely observed only if an officer viewed it from the hallway. The cell also had several "tie-off" points (bars and light fixtures from which a makeshift rope could be suspended), despite Sheriff Daniel's acknowledgment that a suicide prevention cell should not have such tie-off points and despite the fact that another inmate (James Halley) had previously committed suicide in the very same cell by hanging himself with a sheet from one of these tie-off points. To the best of Deputy Rabalais's knowledge, and pursuant to the Sheriff's directive, Jacobs was not given sheets on the first night of her detention, August 21.

On the morning of August 23, an attorney visited Jacobs at the jail. He requested that Sheriff Daniel leave Jacobs in the detox cell, and perhaps provide her with a blanket and towel. Sheriff Daniel instructed one of his deputies to give these items to Jacobs, but the record reflects only that Jacobs received a sheet (which she eventually used to kill herself), and there is no evidence that she received either a towel or a blanket.

Deputies Earl Reech and Rabalais were on duty at the West Feliciana jail facility from 11:30 p.m. the night of August 23, until 7:30 a.m. the next morning, August 24, 1996. The record reveals that the defendants still regarded Jacobs as a suicide risk during that time. Indeed, Sheriff Daniel testified that Jacobs was on a "precautionary," though not a "strict" suicide watch. Our review of the record reveals few discernible differences between these two types of suicide watches. When an inmate was on a "strict" suicide watch, the informal policy at the jail was to have the inmate checked on every fifteen minutes. Deputy Reech testified that he and Deputy Rabalais made periodic checks on Jacobs; however, it is unclear exactly how often the deputies checked on Jacobs while she was under the "precautionary" suicide watch. What is clear is that as many as 45 minutes elapsed from the time a deputy last checked on Jacobs to the time she was found hanging from the light fixture in the detox cell.

Specifically, the record reveals that Deputy Reech checked on Jacobs at 2:00 a.m. and observed her lying awake in her bunk. At approximately 2:44 a.m., Deputy Rabalais looked into the detox cell from the control room and saw what appeared to be part of an arm hanging from the ceiling. Concerned, he went to find Deputy Reech, who was still reading the newspaper. When the deputies arrived at the cell, they found Jacobs hanging from a sheet that had been tied around the caging surrounding a ceiling light fixture. Deputy Rabalais found a knife and enlisted the assistance of another inmate in cutting the sheet and lowering Jacobs onto the floor. The paramedics subsequently arrived and were unable to resuscitate Ms. Jacobs. Her death was the third suicide at the jail during Sheriff Daniel's tenure there. The family of Sheila Jacobs filed suit.

On September 13, 2000, the United States Court of Appeals for the 5th Circuit ruled that the family had sufficient grounds to sue then-Sheriff Bill Daniel and Deputy Rabalais. The court stated, in part, that: "The record before us reveals that Sheriff Daniel was aware that Jacobs had tried to kill herself once before and that she posed a serious risk of trying to do so again... We would find it difficult to say that this behavior could not support a jury finding that Sheriff Dalies acted with deliberate indifference, and likewise we find it even more difficult to say that this conduct was objectively reasonable... Deputy Reech was the senior deputy on duty when Jacobs killed herself. Like Sheriff Daniel and Deputy Rabalais, he had actual knowledge that Jacobs was a suicide risk at all times during her detention... Given Deputy Reech's level of knowledge about the significant risk that Jacobs would attempt to harm herself and his disregard for precautions he knew should be taken, we conclude that there is enough evidence in this record from which a reasonable jury could find subjective deliberate indifference..."

4) Sanville v. McCoagthy [266 F.3d 724 (7th Cir. 2001)]. Matt Sanville, a mentally ill inmate incarcerated at the Waupun Correctional Institution (WCI) in Wisconsin, committed suicide when he was left unsupervised for approximately 5 hours. He had a history of suicide attempts, hospitalizations, and drug treatments directed towards managing his multiple mental disorders. Matt arrived at the WCI on February 26, 1998. A week after his admission, he was seen for a psychiatric follow-up by Dr. Yogesh Pareek. Because Matt was having problems with nausea and
vomiting. Dr. Pareek advised him to go off his psychotropic medication until the problems subsided. As it turned out, Matt had an inflamed appendix, which required an emergency appendectomy on March 6, 1998. On March 10, his mother contacted the hospital to express concern that Matt had been taken off his medication. After the prison was contacted, the staff physician assured her that Matt's anti-psychotic medication had been reordered.

On March 26, 1998, about a week after his return to WCI, Matt saw Dr. Pareek for the second time. Dr. Pareek noted that Matt had a "history of psychotic disorder, but he [was] refusing to take medication" and that Matt denied "ever hearing voices or ever seeing things [or] ever being paranoid." The doctor decided to discontinue psychotropic medication "at the patient's request" and agreed to see him again in eight weeks.

While unmedicated, Matt's behavior became increasingly bizarre. In April, he defied an order to return to his cell, for which he was sent to solitary confinement. In early May, he scratched venereal, nonsensical threats on his bed sheets ("kill the raper [sic] and antichrist" and "go to hell"). On June 9, he flushed his socks and underwear down the toilet. Yet he also displayed some evidence of competence (perhaps consistent with his diagnosis that he exhibited "very paranoid behavior with sense of reality). The day prior to the sink flushing incident he requested to be placed in an anger management class. He also filed a lawsuit based upon the failure of one correctional officer to respond to his requests for medical attention during the appendectomy incident.

In late June, Matt asked to see Dr. Pareek, but then reported no mental health concerns and persisted in his decision to remain off his medication. Dr. Pareek provided neither treatment nor medication to Matt. At this point, Matt had lost 17 pounds since his WCI admission. On July 11, 1998, Matt assaulted another inmate and was placed in segregation. He then drafted a last will and testament (collected by correctional staff at an undetermined time) that was addressed to his mother and contemplated his imminent death. While in segregation, Matt's bizarre behavior continued. After receiving conduct reports for refusing to return his meal tray and bag lunch, Matt was served "nutri-loaf." Matt's weight loss continued and a subsequent autopsy confirmed that he lost about 45 pounds during his five months at WCI (nearly 25 of which occurred in the final month of his life while in segregation). Matt complained to his mother about the nutri-loaf, she called medical personnel at WCI and relayed her concern that Matt was paranoid, suicidal, and in serious trouble.

On July 24, 1998, Dr. Stephen Fleck (a psychologist) visited Matt in his cell in response to Mrs. Sanville's telephone call. Dr. Fleck was, however, satisfied with Matt's insistence that he had no plans to harm himself. Matt again refused clinical and psychiatric services. Dr. Fleck's report did not make any reference to Matt's weight.

Matt repeatedly asked correctional staff to bring him a regular meal but his requests were ignored. He mailed a letter to his mother on July 27, 1998 (which prison officials read) which alleged that he was being retaliated against because of the lawsuit that he had filed, asked for help in finding an attorney, requested clinical services, and again told her he was not eating the nutri-loaf. That same day Matt requested to see mental health staff, and Dr. Fleck visited him at his cell. Dr. Fleck's report indicated that Matt said his mood was not good but that "[he] denied any thoughts and plans to harm himself." Later the same day, Matt again requested to see someone from clinical services. Dr. Fleck received this request on July 28, and scheduled an appointment for July 30, 1998. Matt told corrections sometime during these two days that he was going to kill himself, but no action was taken.

On July 29, 1998, the day of Matt's suicide, Officer Ivy Scalburdine made her morning rounds to pass out breakfast. Matt had covered the openings in his cell (vents, call box, and window) with paper. Although a violation of prison policy, Officer Scalburdine did not serve Matt breakfast, instead she skipped his cell and continued on her rounds. When she later made the rounds to serve lunch, Matt's window was still covered and he again did not serve him a nutri-loaf meal. All of the officers observed Matt's covered cell window at some point during the day, but none took any action. At approximately 2:48 p.m., Officer Erle Schroeder was making his rounds. When he passed Matt's cell he noticed that "inmate Sanville was sitting on his floor in his cell up against the left wall of his cell with the left side of his body against the wall...he had his window partially covered with toilet paper making it somewhat difficult to see into his cell.

Officer Schroeder, who was not regularly assigned to the segregation unit, decided not to take any action because he had been instructed to assume that inmates who ignored him were simply refusing supplies. Officer Schroeder returned to the cell at 2:57 p.m. with another officer who offered Matt his nutri-loaf dinner, but the inmate did not respond. Officer Schroeder wrote in his report that "I then went to the window and observed that he hadn't moved since supplies were offered, nine minutes [sic] ago." The officer then attempted to call the segregation block sergeant, but was unable to because the battery in his radio was dead.
At approximately 3:00 p.m., Officer Schroeder left to find Sergeant Ann Ingolia. She followed the officer back to the cell door, peered inside, and noticed that Matt had a sheet around his neck. Sergeant Ingolia told officers to continue feeding the other inmates while she called the captain to alert him to a possible suicide. Sergeant Ingolia then returned to the cell and waited for the first responders. Upon arrival, they attempted unsuccessfully to revive Matt. At 3:10 p.m., rescue efforts ceased and Matt was pronounced dead. He had last been seen alive at 10:00 a.m.

On September 21, 2001, the United States Court of Appeals for the 7th Circuit ruled that several correctional officers failed to take "reasonable steps to prevent the inmate (Matthew A. Sanville) from committing suicide," thereby reversing a lower court opinion that had previously dismissed the case in favor of both health care and correctional personnel.

In part, the appeals court stated that doctors who assessed and treated Matt Sanville were not deliberately indifferent to his medical needs, but might have been negligent:

"... the evidence does not support a finding that the medical professionals at WCI were deliberately indifferent to Matt's serious medical needs. He was seen by medical professionals eleven times over the five months that he was incarcerated and most of these visits took place shortly after they were requested... The ultimate problem seems to be that none of the doctors ever noted that Matt might be a suicide risk, an observation that would not have seemed too obscure considering his mental illness and history of suicide attempts. Yet the doctors' failure to correctly diagnose and treat Matt is not, in this instance, evidence of anything more than medical malpractice. Though we find that plaintiff's claims against the doctor-defendants were properly dismissed by the district court, we note that plaintiff is certainly free to pursue her state law medical malpractice claims in state court."

In regard to the correctional officers, the court ruled that:

"there seems to be no evidence that the defendants took reasonable steps to prevent the inmate from committing suicide as is required by our case law. Matt was last seen alive by the defendants at 10:00 a.m. in the five hours during which Matt's cell window was covered with toilet paper, there was no apparent attempt to discern whether he was stable... The evidence here clearly supports an inference that at least some of the officers, if not all of them, were aware of Matt's serious medical need and demonstrated deliberate indifference to that need... Contrary to defendants' allegations, the fact that we have already found that the doctors cannot be held liable does not erect a legal bar that prevents anyone else in the prison from being held liable..."

In still another strange turn of events, in October 2002, a federal jury found that both Drs. Pareek and Flick liable for the suicide of Matthew Sanville, and ordered that they pay $1.825 million in compensatory and punitive damages. The jury found that the officers were not liable.

5) Wever v. Lincoln County [388 F.3d 601 (8th Cir. 2004)]. On December 8, 2001, Dennis Wever committed suicide in the Lincoln County Jail in North Platte, Nebraska, despite the fact he had threatened suicide to both arresting officers and jail personnel. His family subsequently filed a federal lawsuit against Lincoln County, its sheriff, the North Platte Police Department, its chief of police, and several officers alleging that their deliberate indifference was the proximate cause of Mr. Wever’s death. The complaint also alleged that the sheriff failed to take any corrective action in the areas of training and supervision of personnel following two other prior inmate suicides in the jail. On November 4, 2004, the U.S. Court of Appeals for the Eighth Circuit ruled that the sheriff was not entitled to qualified immunity.

With regard to potential liability for prior suicides within the facility, the complaint alleged Sheriff James Carmen was aware of two prior suicides in the Lincoln County Jail, one occurring in 1999 while he was sheriff, and one occurring in 1996, prior to his tenure. The sheriff argued that, as a matter of law, one or two suicides were insufficient to put him on notice that his training and supervision was constitutionally inadequate. The appeals court disagreed and stated that "Under his proposed rule, a sheriff may sit idly by until at least a third inmate known to be suicidal blows a blanket from an officer and hangs himself, only then ordering his officers not to place a suicidal person in an isolation cell and lend him a blanket."

The sheriff also argued that "the jail had a good-faith policy in place for dealing with those prisoners and pretrial detainees presenting suicidal risks. Furthermore, after the September 1999 incident, the policy was implemented for
approximately two (2) years before the incident at issue occurred." According to the appeals court, the implication of this statement was that after the 1999 suicide, the sheriff implemented a constitutionally adequate suicide policy that was in effect at the time of Mr. Wever's suicide. However, "the quoted assertion is entirely without support in the record. The "policy" Carmen cites is a single page offered by Wever, and wholly without context. One cannot tell when, how, or even whether it was adopted, why Carmen believed it would adequately respond to the problem of inmate suicide, or how officers were trained to implement it. His assertion that the "policy" was implemented after the 1999 suicide is also unsubstantiated. One cannot discern when the "policy" was adopted, and Carmen neglected to make any mention of it in his affidavit in support of his motion for summary judgment. As the district court stated, "Sheriff Carmen did not present any evidence showing what training procedures, if any, were in place for handling potentially suicidal detainees or inmates."

6) Clouthier v. County of Contra Costa [591 F.3d 1232 (9th Cir. 2010)] On the evening of July 26, 2005, after an argument with his father, Robert Clouthier became violent, destroyed a china cabinet, and jumped through a plate glass window, resulting in lacerations and severe bleeding. His family called the police and the sheriff's office responded. After his father signed a citizen's arrest for battery, Mr. Clouthier was taken into custody and initially taken by ambulance to the hospital for medical attention. He was extremely upset and hit his head against the side of the ambulance several times. Once at the hospital, he refused to have his wounds stitched. The next morning (July 27), Mr. Clouthier was booked into the Contra Costa County Jail-Martinez Detention Facility (MDF). At the MDF, he was assessed by a mental health clinician (Shariene Hanaway), self-reported suicidal ideation, and stated he wanted to be "unconscious for the rest of his life." Ms. Hanaway described Mr. Clouthier as "despondent, hopeless, suicidal" and "one of the most suicidal inmates she had ever seen." Her notes also stated Mr. Clouthier had made numerous past suicide attempts, including one incident two months earlier that required hospitalization after he cut his wrists. He had been off his psychotropic medication for several years.

Ms. Hanaway placed Mr. Clouthier in a "safety cell" in the intake area of the MDF. He was issued a safety and required to be observed at 15-minute intervals. She also approached another mental health clinician (Margaret Blush) and deputies in the intake area, advising them that Mr. Clouthier was "truly suicidal" and "the real deal." Ms. Hanaway spoke with Mr. Clouthier periodically throughout the morning of July 27, "talking to him and making sure he was okay and [asking] what his state of mind was." By that afternoon, Ms. Clouthier informed the clinician that he was not feeling suicidal anymore. Ms. Hanaway did not trust him, however, noting "he had multiple suicide attempts before, and given his history and his despondency, his hopelessness, you just don't recover that quickly." She tried to convince Mr. Clouthier to consider medication, and called for an emergency consultation with the psychiatrist who later prescribed psychotropic medication for depression. The psychiatrist also recommended that Mr. Clouthier be placed in M-Module, a housing section for unstable inmates, and that he subsequently be re-evaluated to determine whether short-term hospitalization would be necessary. Ms. Hanaway left the MDF around 6:10pm on July 27.

Approximately 30 minutes later at 7:00pm, Margaret Blush went up to M-Module and spoke with Mr. Clouthier for "less than five minutes." She informed an officer that the inmate could be removed from suicide precautions and given regular prison clothes and a blanket, but not any utensils or personal hygiene items. Ms. Blush testified that she took Mr. Clouthier off suicide precautions because in her view, the risk of suicide had decreased, although she "was uncertain whether it had disappeared." Ms. Blush explained that her "clinical judgment was that Robert was improving, would benefit from having normal jail clothes and bedding and could be further evaluated by mental health staff the following day." However, she felt that Mr. Clouthier was not "out of the woods" yet. Mr. Clouthier remained in the Observation Room from July 29 through July 31, but not on suicide precautions.

Mr. Clouthier was relocated to general population on August 1. At approximately 7:42pm that evening, a deputy and nurse discovered Mr. Clouthier hanging by the neck from the knotted sheet in his cell. Life-saving measures were initiated, but Robert Clouthier was subsequently pronounced dead at a local hospital.

The parents of Mr. Clouthier filed suit against Contra Costa County and various individual defendants, including the sheriff, several deputies, and Margaret Blush, the mental health clinician. The district court granted summary judgment in favor of all the defendants and the family appealed to the United States Court of Appeals for the 9th Circuit. The appeals court affirmed the district court's grant of summary judgment to all defendants except Ms. Blush. According to the court, "a rational jury could conclude that Blush was 'on notice' of Clouthier's suicidal condition and that she actually inferred from this information that [Clouthier] was at serious risk of harm if he did
not receive proper care... Bush also agreed that Clouthier was not "out of the woods" yet and that his condition could 'go either way.' She testified she was 'uncertain' whether his suicidal tendency had disappeared. Yet, Bush removed Clouthier from the Observation Log, told the deputies he could be given regular clothes and regular bedding, failed to instruct [a deputy] to keep Clouthier in the Observation Room, and neglected to determine if additional care was needed. From this circumstantial evidence, a jury could reasonably infer that Bush knew of Clouthier's depressive, suicidal condition and need for mental health treatment, and also knew of the risk of harm that he faced if denied medical attention." Therefore, there exists a genuine issue of material fact as to whether Bush was deliberately indifferent to a substantial risk of harm to Clouthier.

7) Sinkov v. Americor, Inc., 2011 WL 1595298 (2nd Cir., April 13, 2011). Spencer Sinkov, 21-years-old, was arrested by the Putnam County Sheriff's Department in New York on May 20, 2006. Charged with criminal possession and criminal sale of a controlled substance, he was booked into the Putnam County Correctional Facility shortly after midnight. He had no prior record and suffered from heroin addiction and was in withdrawal at the time of admission. Pursuant to regulations promulgated by the New York State Commission of Correction, jail staff administered the Suicide Prevention Screening Guidelines form to Mr. Sinkov. He scored "10" on the form, indicating of a high risk for suicide that required constant observation. Contrary to state regulations mandating constant observation of suicidal inmates, the suicide prevention policy of both the county and its health care provider (AmeriCor Inc.) was adapted to require observation at only 15-minute intervals for all suicidal inmates. Mr. Sinkov was subsequently placed in an unsafe cell with his clothes and on an observation level requiring 15-minute checks. It was also not monitored by medical staff for heroin withdrawal.

According to jail records, Mr. Sinkov met with his parents in the visiting area later that morning. As a result of the visit, his father expressed concern to an officer that Spencer was going through withdrawal and needed medical attention. The inmate was then returned to his cell and found hanged from the cell bars by a sweatshirt a few hours later. Spencer Sinkov was later pronounced dead at a local hospital.

Mr. Sinkov's parents later filed suit in federal court alleging both deliberate indifference and negligence. In October 2009, a jury found that AmeriCor was deliberately indifferent to Mr. Sinkov and awarded the plaintiff $750,000 in damages, and the court also awarded the plaintiff $234,720 in attorney fees. The jury found that AmeriCor was 35% at fault for the death, while assigning 65% of the liability to Putnam County and its employees (which had previously settled the case out of court). AmeriCor appealed the jury verdict and, in April 2011, the federal appeals court upheld the verdict and ruled that: "The jury heard evidence that AmeriCor knew of New York's minimum standards for detainees who present signs that they are at risk of suicide, that Sinkov answered "Yes" to 10 questions on the suicide screening form at intake, more than the number required to trigger constant monitoring, and that one of AmeriCor's nurses signed the first page of the packet that contained Sinkov's suicide screening form, in a box that signified that the nurse had received the intake packet and read all of it. That was evidence of what AmeriCor actually knew about Sinkov's risk of suicide, and not, as AmeriCor claims, merely evidence of what the company should have known. Taken together, that evidence was sufficient to support a conclusion by a reasonable juror that AmeriCor 'was actually aware' of Sinkov's risk of suicide and was deliberately indifferent to that risk."
A PRACTITIONER’S GUIDE TO DEVELOPING AND MAINTAINING A SOUND SUICIDE PREVENTION POLICY

Despite increased general awareness of the problem, research that has identified precipitating and situational risk factors, emerging correctional standards that advocate increased attention to suicidal inmates and demonstration of effective strategies, suicide prevention remains piecemeal and inmate suicides continue to pose a serious public health problem within correctional facilities throughout the country. In fact, although national suicide rates in both jails and prisons have been seemingly reduced during the past decade, hundreds of inmates continue to commit suicide in correctional facilities each year. Many of these deaths are preventable and we can do more to reduce these numbers.

Since its inception, the Jail Suicide/Mental Health Update has been devoted to providing timely information in the area of suicide prevention within correctional facilities, including pertinent research, training, standards, litigation, model programs, and case vignettes of preventable and或其他 tragic deaths. We have previously highlighted the fact that few state jail standards mandate comprehensive suicide prevention programming, and many correctional systems have either ignored or not fully implemented critically important suicide prevention components (as offered by national standards) into their policies. Within juvenile facilities, a recent national study found that few facilities experiencing a youth suicide maintained comprehensive suicide prevention programs.

In an effort to more adequately address piecemeal prevention efforts, this special issue is entirely devoted to developing and maintaining a sound suicide prevention policy, and includes the guiding principles to suicide prevention, critical components to a suicide prevention policy, and a sample suicide prevention policy (with attachments). Our hope is that the information contained in this special 24-page issue, as well as future issues highlighting model suicide prevention programs, will help jumpstart more comprehensive suicide prevention programming throughout the country.

According to available records, 49-year-old Michael Singer was originally arrested by the Evans County Sheriff’s Office on October 4, 2002 and charged with “defrauding a secured creditor and concealment or removal of secured property.” The arrest was based upon a warrant from a neighboring state. Mr. Singer was booked into the Evans County Jail and responded “no” to two questions regarding prior and current risk for suicide. Due to his employment as a sergeant at the Pinehurst State Prison, Mr. Singer was placed in a single cell in the jail. No bail was permitted.

During the afternoon of October 4, Mr. Singer’s wife (Susan) and brother-in-law (Bruce Tyler) visited with him in the jail. According to his wife and brother-in-law, Mr. Singer appeared distraught, confused and, as a correctional officer, feared for his safety. Most importantly, he also threatened suicide, stating to his wife and brother-in-law that he would be found “hanging in his cell.” Mrs. Singer and Mr. Tyler immediately informed Evans County Jail staff, specifically Officer Keith Smith, of the suicide threat. According to the subsequent deposition testimony of Susan Singer, Officer Smith informed them that “Don’t worry. I’ll take care of it and I promise we won’t let anything happen to Mike.” Officer Smith subsequently informed Sheriff David Pile of the threat and then went to talk with Mr. Smith who denied making a suicide threat. Apart from a brief notification in the Jail Officer’s Daily Log at 3:00pm on October 4 that read “Pass down from 270 (Sheriff Pyle), 271 (Under Sheriff Salisbury), and 286 (Officer Smith). Received word to watch Singer,” no other action was apparently taken in response to Mr. Singer’s risk or suicide.

Throughout his week of confinement at the Evans County Jail, Mr. Singer displayed disturbing behavior to jail staff. According to various staff, he was observed as being “very stressed,” “quiet,” “distraught,” “crying,” “pacing the cell,” “acting very peculiar,” etc. Mr. Singer was particularly concerned about his impending extradition to another

1In order to ensure complete confidentiality, certain identifying information regarding the victim, facility, and staff have been changed. No other modifications have been made.
state in a transportation vehicle containing other inmates who might recognize him as a correctional officer from Pinehurst State Prison. During the evening of October 7, 2002, Dispatcher Ralph Tanner, who had previously worked with Mr. Singer at the state prison, went back into the cell block area and briefly conversed with his friend. According to Mr. Tanner’s subsequent deposition testimony, Mr. Singer “was pacing a lot in the cell, you know. And he just looked like very stressed, you know. He was going through a hard time.” According to his incident report, Dispatcher Tanner wrote, in part, that during their October 7 conversation “I also told Mike I hope you are not going to do anything stupid, like suicide. Mike replied, ‘no I am not’….Then I told Mike I needed to get back to dispatch, if he needed anything let someone know, I also informed him I was watching him in the camera.”

During the evening of October 10, 2002, both jail and family members observed Mr. Singer (during a visit) to be very distraught and crying regarding his impending extradition, thought to be scheduled for the following day. According to the incident report written by Sheriff Pyle, Officer Jack Terry informed him at approximately 8:00pm on October 10 that Mr. Singer was “quiet and distraught” following the visit with his wife and “Mike looked like he had been crying and acted like he wanted to cry as he was walking but was trying to keep from showing emotions.”

Both Officer Paula Hacket and Dispatcher Tanner worked the overnight shift (11:00pm to 7:00am) of October 10-11, 2002. Both individuals noticed that Mr. Singer appeared agitated during the shift. According to Officer Hacket’s subsequent deposition testimony, Mr. Singer appeared distraught and was crying. According to Dispatcher Tanner, Mr. Singer “was constantly watching the window in his cell door,” pacing the cell, and “acting very peculiar.” Both Officer Hacket and Dispatcher Tanner agreed to “just keep an eye on him.” through making regular rounds of the cellblock area and observing Mr. Singer’s cell via closed circuit television monitoring (CCTV).

During the shift change in the early morning of October 11, both Officer Hacket and Dispatcher Tanner informed in-coming Officer Keith Smith of their observations and concerns regarding Mr. Singer during their shift. According to the subsequent deposition testimony of Dispatcher Tanner, “When Keith Smith came to work Paula and I informed him the way he’d been behaving and they needed to keep an eye on him ‘cause he wasn’t acting right at all… I don’t recall the exact words, but I said, Mike’s not acting right, something’s wrong, you know, something may be wrong with him, you know, he may do something, stupid, I don’t know, and that he needed to be watched and Paula addressed her concern to him also.” According to the dispatcher, when they informed Officer Smith of their concerns regarding Mr. Singer, Officer Smith “just basically shrugged his shoulders and said, oh, well, you know, it’s like it’s another day.” Dispatcher Tanner also informed the in-coming dispatcher, Ryan Houser, of their concerns. Mr. Houser apparently did not give any verbal reply, however, both Officer Hacket and Dispatcher Tanner subsequently testified that Dispatcher Houser had previously stated it was **not** his responsibility to monitor inmates via the CCTV equipment.

According to Officer Mike Weiner, he conducted a round of the cellblock area at approximately 9:00am on October 11, 2002 and observed Mr. Singer to be sitting on his bed. Approximately one hour later at 9:55am, Officer Weiner conducted another round and observed a blanket tied around the door of Mr. Singer’s cell, and the inmate could not be observed. Officer Weiner ran up to the control office to get assistance from Officer Smith. While returning to the cellblock area, Officer Weiner told Dispatcher Houser to turn on the CCTV monitor for Mr. Singer’s cell and try to locate the inmate. Officers Weiner and Smith, as well as Sheriff Pyle, arrived at Mr. Singer’s cell and initially had difficulty gaining entry because the blanket was tied around the door and soap had been jammed into the key hole. Upon entering the cell, Mr. Singer was discovered hanging from the shower knob by a bed sheet. His body was cut down and laid on the cell floor. Emergency medical services (EMS) personnel arrived, examined the victim, and decided not to initiate cardiopulmonary resuscitation. According to EMS personnel, Mr. Singer’s body “had molting on his back and buttocks area,” an apparent indication that the victim had been dead for a considerable period of time. Michael Singer was later pronounced dead.

Following the death, county attorney George Dawson told a local newspaper reporter that “Mr. Singer had been in jail a couple of days and otherwise was an unremarkable inmate. He didn’t appear despondent or unduly agitated. Our jail staff feels bad about it, but the suicide really wasn’t preventable.”

The family of Michael Singer disagreed and subsequently filed a federal lawsuit against Evans County, its sheriff and jail personnel. Among several allegations in the lawsuit was that the county failed to maintain a written suicide prevention policy. In fact, the practice of Evans County Jail personnel was simply to inform Sheriff Pyle if an inmate became suicidal during confinement. No mental health referral, no suicide precautions, no policy! The lawsuit is still pending.

In a similar case, readers of the **Update** will recall the recent federal appeals court ruling in **Wever v. Lincoln County** (No. 03-3633, 2004 U.S. App. Lexis 22974, 8th Cir. 2004). In November 2004, the U.S. Court of Appeals for the Eighth Circuit ruled that Lincoln County Sheriff Jim Carmen was not entitled to qualified immunity for the jail suicide of Dennis Wever. The lawsuit had alleged that the sheriff failed to take any corrective action in the areas of training and supervision of personnel following two other prior inmate suicides in the jail, as well as maintaining a grossly inadequate suicide prevention policy. The appeals court agreed and scolded the sheriff as follows:

> “Carmen asserts that ‘the jail had a good-faith policy in place for dealing with those prisoners and pretrial detainees presenting suicidal risks. Furthermore, after the September 1999 incident, the policy was implemented for approximately two (2) years before the incident at issue occurred.’…. The implication of this statement is that after the 1999 suicide, Carmen implemented a constitutionally adequate suicide policy that was in effect at the time of Wever’s suicide. However…..we note that the quoted assertion is entirely without support in the record. The ‘policy’ Carmen cites is a single page…..and wholly without context. One cannot tell when, how, or even whether it was adopted, why Carmen believed it would adequately respond to the problem of inmate suicide, or how officers were trained to implement it….One cannot discern when the ‘policy’ was adopted, and Carmen neglected to make any mention of it in his affidavit in support of his motion for summary judgment. As the district court stated, ‘Sheriff Carmen did not present any
evidence showing what training procedures, if any, were in place for handling potentially suicidal detainees or inmates.’

In June 2005, the case was settled for an undisclosed amount. It remains unclear as to whether Lincoln County developed a sound jail suicide prevention policy.

Guiding Principles to Suicide Prevention

More times than not, we do an admirable job of safely managing inmates identified as suicidal and placed on suicide precautions. After all, few inmates successfully commit suicide on suicide watch. When they do, you can surely expect to incur some liability. What we continue to struggle with is the ability to prevent the suicide of an inmate who is not easily identifiable as being at risk for self-harm. Kay Redfield Jamison, a prominent psychologist and author, has best articulated the point by stating that if “suicidal patients were able or willing to articulate the severity of their suicidal thoughts and plans, little risk would exist.”2 With this in mind, the following guiding principles to suicide prevention are offered.

1) The assessment of suicide risk should not be viewed as a single event, but as an on-going process. Because an inmate may become suicidal at any point during confinement, suicide prevention should begin at the point of arrest and continue until the inmate is released from the facility. In addition, once an inmate has been successfully managed on, and discharged from, suicide precautions, they should remain on a mental health caseload and assessed periodically until released from the facility.

2) Screening for suicide during the initial booking and intake process should be viewed as something similar to taking one’s temperature – it can identify a current fever, but not a future cold. The shelf life of behavior that is observed and/or self-reported during intake screening is time-limited, and we often place far too much weight upon this initial data collection stage. Following an inmate suicide, it is not unusual for the mortality review process to focus exclusively upon whether the victim threatened suicide during the booking and intake stage, a time period that could be far removed from the date of suicide. If the victim had answered in the negative to suicide risk during the booking stage, there is often a sense of relief expressed by participants of the mortality review, as well as a misguided conclusion that the death was not preventable. Although the intake screening form remains a valuable prevention tool, the more important determination of suicide risk is the current behavior expressed and/or displayed by the inmate.

3) Prior risk of suicide is strongly related to future risk. At a minimum, if an inmate had been placed on suicide precautions during a previous confinement in the facility or agency, such information should be accessible to both correctional and health care personnel when determining whether the inmate might be at risk during their current confinement.

4) We should not rely exclusively on the direct statements of an inmate who denies that they are suicidal and/or have a prior history of suicidal behavior, particularly when their behavior, actions and/or history suggest otherwise. Often, despite an inmate’s denial of suicidal ideation, their behavior, actions, and/or history speak louder then their words. For example:

WE’RE STILL LOOKING FOR A FEW GOOD PROGRAMS

Future issues of the Jail Suicide/Mental Health Update will be devoted to exemplary suicide prevention programs operating within correctional facilities throughout the country. Does your facility’s suicide prevention policy contain, and do your practices reflect, the following critical elements?

- Intake screening to detect both current and prior suicidal behavior, as well as further and periodic assessment of suicide risk by mental health staff;
- Suicide prevention training for correctional, medical, and mental health staff;
- Levels of communication between outside agencies, among facility staff, and with the suicidal inmate;
- Suicide-resistant, protrusion-free housing of suicidal inmates;
- Levels of supervision for suicidal inmates;
- Timely emergency intervention by correctional and medical personnel following a suicide attempt;
- Provision of critical incident stress debriefing to affected staff and inmates, as well as completion of a multidisciplinary mortality review following an inmate suicide and/or serious suicide attempt; and
- A low rate of inmate suicides for an extended period of time.

If you believe your correctional facility operates an exemplary suicide prevention program, and would like it to be considered as a possible case study in an upcoming issue of the Update, please send copies of your suicide prevention policy, screening/assessment forms utilized to identify suicidal inmates, and total number of suicides and your facility’s average daily population for each year from 1995 thru 2004 to:

Lindsay M. Hayes, Project Director

Jail Suicide/Mental Health Update

40 Lantern Lane

Mansfield, MA 02048

(508) 337-8806

Lhayesta@msn.com

---3---

In Washington State, an inmate was booked into a county jail and informed the intake officer that she had a history of mental illness, had attempted suicide two weeks earlier, but “will not hurt herself in jail.” Jail records indicated that the inmate threatened suicide during a recent prior confinement in the facility. The inmate attended a court hearing two days later and the escort officer noticed that she appeared despondent, was crying, and appeared worried about her children. She was not referred to mental health staff, nor placed on suicide precautions. The inmate committed suicide the following day.

In Michigan, police were called to the home of a man who accidentally shot and killed a friend during a domestic dispute with his estranged wife. Upon arrival of the police, the suspect placed a handgun to his head and clicked the trigger several times. He also encouraged the officers to shoot him. Following five hours of negotiations, the suspect surrendered without incident. He was transported to the county jail and denied being suicidal during the intake screening process. The inmate was not referred to mental health staff, nor placed on suicide precautions. He committed suicide the following day.

It is not all that surprising that these preventable deaths often escape our detection. Take, for example, the booking area of a jail facility. It is traditionally both chaotic and noisy; an environment where staff feel pressure to process a high number of arrestees in a short period of time. Two key ingredients for identifying suicidal behavior – time and privacy – are at a minimum. The ability to carefully assess the potential for suicide by asking the inmate a series of questions, interpreting their responses (including gauging the truthfulness of their denial of suicide risk), and observing their behavior is greatly compromised by an impersonal environment that lends itself to something quite the opposite. As a result, the clearly suicidal behavior of many arrestees, as well as circumstances that may lend themselves to potential self-injury, are lost.

In yet another example, a suicidal inmate may appear to be stable in front of a mental health clinician, even deny suicide risk, only to be discharged from suicide precautions and returned to the correctional facility from a hospital where they again revert to the same self-injurious behavior that prompted the initial referral. Given such a scenario, correctional staff should not assume that the clinician was cognizant or even appreciative of this cyclical behavior. On the contrary, regardless of what the clinician might have observed and/or recommended, as well as the inmate’s denial of risk, whenever correctional staff hear an inmate verbalize a desire or intent to commit suicide, observe an inmate engaging in suicidal behavior or otherwise believe an inmate is at risk for suicide, they should take immediate steps to ensure that the inmate’s safety.

5) Facility officials must provide useful pre-service and annual suicide prevention training to all staff. While implementing suicide precautions for an inmate that verbally threatens suicide requires little training, identifying suicidal behavior of inmates unwilling and/or unable to articulate their feelings, or who deny any ideation, requires both pre-service and annual training. Simply stated, correctional staff, as well as medical and mental health personnel, cannot detect, make an assessment, nor prevent a suicide for which they have little, if any, useful training.

All suicide prevention training must be meaningful, i.e., timely, long-lasting information that is reflective of our current knowledge base of the problem. Training should not be scheduled to simply comply with an accreditation standard. A workshop that is limited to an antiquated videotape, or recitation of the current policies and procedures, might demonstrate compliance (albeit wrongly) with an accreditation standard, but is not meaningful, nor helpful, to the goal of reducing inmate suicides. Without regular suicide prevention training, staff often make wrong and/or ill-informed decisions, demonstrate inaction, or react contrary to standard correctional practice, thereby incurring unnecessary liability.

6) As previously offered, many preventable suicides result from poor communication amongst correctional, medical and mental health staff. Communication problems are often caused by lack of respect, personality conflicts, and other boundary issues. Simply stated, facilities that maintain a multidisciplinary approach avoid preventable suicides. As aptly stated by one clinician:

The key to an effective team approach in suicide prevention and crisis intervention is found in throwing off the cloaks of territoriality and embracing a mutual respect for the detention officer’s and mental health clinician’s professional abilities, responsibilities and limitations. All of us, regardless of professional affiliation, need to make a dedicated commitment to come forward and acknowledge that suicide prevention and related mental health services are only effective when delivered by professionals acting in unison with each other. Just as the security officer alone can not ensure the safety and security of the jail facility, neither can the mental health clinician alone ensure the safety and emotional well-being of the individual inmate.

7) On size does not fit all and basic decisions regarding the management of a suicidal inmate should be based upon their individual clinical needs, not simply on the resources that are said to be available. For example, if an acutely suicidal inmate requires continuous, uninterrupted observation from staff, they should not be monitored via CCTV simply because that is the only option the system chooses to offer. Further, a clinician should never feel pressured, however subtle that pressure may be, to downward and/or discharge an inmate from suicide precautions simply because additional staff resources (e.g., overtime, post transfer, etc.) are required to maintain the desired level of observation. Although they would never admit it, clinicians have prematurely downgraded, discharged, and/or changed the management plan for a suicidal inmate based upon pressure from correctional officials.

8) We must avoid creating barriers that discourage an inmate from accessing mental health services. Often, certain management conditions of a facility’s policy on suicide precautions appear punitive to an inmate (e.g., automatic clothing removal/issuance of safety smock, lockdown, limited visiting, telephone, and shower access, etc), as well as excessive and unrelated to their level of suicide risk. As a result, an inmate who becomes suicidal and/or despondent during confinement may be reluctant to seek out mental health services, and even deny there is a problem, if they know that loss of these and other basic amenities are an automatic outcome. As such, these barriers should be avoided whenever possible and decisions regarding the management of a suicidal inmate should be based solely upon the individual’s level of risk.

9) Few issues challenge us more than that of inmates we perceive to be manipulative. It is not unusual for inmates to call attention to themselves by threatening suicide or even feigning an attempt in order to avoid a court appearance, or bolster an insanity defense; gain cell relocation, transfer to the local hospital or simply receive preferential staff treatment; or seek compassion from a previously unsympathetic spouse or other family member. Some inmates simply use manipulation as a survival technique.

Although the prevailing theory is that any inmate who would go to the extreme of threatening suicide or even engaging in self-injurious behavior is suffering from at least an emotional imbalance that requires special attention; too often we conclude that the inmate is simply attempting to manipulative their environment and, therefore, such behavior should be ignored and not reinforced through intervention. Too often, however, a feigned suicide attempt goes further than anticipated and results in death. Recent research has warned us that we should not assume that inmates who appear manipulative are not also suicidal, i.e., they are not necessarily members of mutually exclusive groups.

Although there are no perfect solutions to the management of manipulative inmate who threaten suicide or engage in self-injurious behavior for a perceived secondary gain, the critical issue is not how we label the behavior, but how we react to it. The reaction must include a multidisciplinary treatment/management plan.

10) As previously noted, few suicides take place when inmates are managed on suicide precautions. Rather, most deaths suicides take place in “special housing units” (intake/booking, classification, disciplinary/administrative segregation, mental health, etc.) of the facility. One effective prevention strategy is to create more interaction between inmates and correctional, medical and mental health personnel in these housing areas by: increasing rounds of medical and/or mental health staff, requiring regular follow-up of all inmates released from suicide precautions, increasing rounds of correctional staff, providing additional mental health screening to inmates admitted to disciplinary/administrative segregation, and avoiding lockdown due to staff shortages (and the resulting limited access of medical and mental health personnel to the units).

11) A lack of inmates on suicide precautions should not be interpreted to mean that there are no currently suicidal inmates in the facility, nor a barometer of sound suicide prevention practices. We cannot make the argument that our correctional systems are increasingly housing more mentally ill and/or other high risk individuals and then state there are not any suicidal inmates in our facility today. Correctional facilities contain suicidal inmates every day; the challenge is to find them. The goal should not be “zero” number of inmates on suicide precautions; rather the goal should be to identify, manage and stabilize suicidal inmates in our custody.

12) We must avoid the obstacles to prevention. Experience has shown that negative attitudes often impede meaningful suicide prevention efforts. These obstacles to prevention often embody a state of mind (before any inquiry begins) that inmate suicides cannot be prevented (e.g., “If someone really wants to kill themselves there’s generally nothing you can do about it” and/or “We did everything we could to prevent this death, but he showed no signs of suicidal behavior,” etc.) There are numerous ways to overcome these obstacles, the most powerful of which is to demonstrate prevention programs that have effectively reduced the incidence of suicide and suicidal behavior within correctional facilities. As one administrator has offered: “When you begin to use excuses to justify a bad outcome, whether it be low staffing levels, inadequate funding, physical plant concerns, etc., issues we struggle with each day, you lack the philosophy that even one death is not acceptable. If you are going to tolerate a few deaths in your jail system, then you’ve already lost the battle.”

13) We must create and maintain a comprehensive suicide prevention programs that include the following essential components: staff training, intake screening/assessment, communication, housing, levels of observation, intervention, reporting, follow-up/mortality review.

**Critical Components to a Sound Suicide Prevention Policy**

Comprehensive suicide prevention programming has been advocated nationally by such organizations as the American Correctional Association (ACA), American Psychiatric Association (APA), and National Commission on Correctional Health Care (NCCHC). As offered in our last issue (see *Jail Suicide/Mental Health Update*, Volume 13, Number 3, Winter 2004), these groups have promulgated national correctional standards that are adaptable to individual jail, prison and juvenile facilities. The APA and NCCHC standards provide the more instructive standards/guidelines that offer recommended ingredients for a suicide prevention program: identification, training, assessment, monitoring, housing, referral, communication, intervention, notification, reporting, review, and critical incident debriefing. Consistent with these national correctional standards, the following eight (8) components encompass a sound suicide prevention policy.

---

**Staff Training**

The essential component to any suicide prevention program is properly trained correctional staff, who form the backbone of any correctional facility. Very few suicides are directly prevented by mental health, medical or other professional staff because suicides are usually attempted in inmate housing units, and often during late evening hours or on weekends when program staff are not present. Suicides, therefore, must be prevented by correctional staff who have been trained in suicide prevention and have developed an intuitive sense about the inmates under their care. Correctional officers are often the only staff available 24 hours a day and form the primary line of defense in preventing suicides.

Although not specified in national correctional standards, it is strongly recommended that all correctional staff, as well as medical and mental health personnel, receive at least eight (8) hours of initial suicide prevention training, followed by two (2) hours of refresher training each year. Training should include why correctional environments are conducive to suicidal behavior, staff attitudes about suicide, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, identification of suicide risk despite the denial of risk, liability issues, critical incident stress debriefing, recent suicides and/or serious suicides attempts within the facility/agency, and details of the facility/agency’s suicide prevention policy. In addition, all staff who have routine contact with inmates should receive standard first aid and cardiopulmonary resuscitation (CPR) training. All staff should also be trained in the use of various emergency equipment located in each housing unit. In an effort to ensure an efficient emergency response to suicide attempts, “mock drills” should be incorporated into both initial and refresher training.

**Intake Screening/Assessment**

Screening and assessment of inmates when they enter a facility is critical to a correctional facility’s suicide prevention efforts. Although there is no single set of risk factors that mental health and medical communities agree can be used to predict suicide, there is little disagreement about the value of screening and assessment in preventing suicide. Intake screening for all inmates and ongoing assessment of inmates at risk is critical because research consistently reports that two thirds or more of all suicide attempts, "mock drills" should be incorporated into both initial and refresher training.

Screening for suicide risk may be contained within the medical screening form or as a separate form, and should include inquiry regarding the following: past suicidal ideation or attempts; current ideation, threat, plan; prior mental health treatment-hospitalization; recent significant loss (job, relationship, death of family member/close other, etc.); history of suicidal behavior by family member/close other; suicide risk during prior confinement; and arresting-transporting officer(s) belief that inmate is currently at risk. The process should also include referral procedures to mental health and/or medical personnel for assessment. Following the intake process, if staff hear an inmate verbalize a desire or intent to commit suicide, observe an inmate engaging in any self-harm, or otherwise believe an inmate is at risk for self-harm or suicide, referral procedures should be implemented. Such procedures direct staff to take immediate steps ensuring that the inmate is continuously observed until appropriate medical, mental health, and supervisory assistance is obtained.

In addition, given the strong association between inmate suicide and special management (i.e., disciplinary and/or administrative segregation) housing unit placement, any inmate assigned to such a special housing unit should receive a written assessment for suicide risk by mental health (or medical) staff upon admission. In addition, the inmate’s health care records should be thoroughly reviewed to ensure that the placement is not contraindicated or requires special treatment.

Finally, the screening and assessment process is only one of several tools that increases the opportunity to identify suicide risk in inmates. This process, coupled with staff training, will only be successful if an effective method of communication is in place within the correctional facility.

**Communication**

Certain behavioral signs exhibited by the inmate may be indicative of suicidal behavior and, if detected and communicated to others, may prevent a suicide. There are essentially three levels of communication in preventing inmate suicides: 1) communication between the arresting or transporting officer and correctional staff; 2) communication between and among facility staff, including medical and mental health personnel; and 3) communication between facility staff and the suicidal inmate.

In many ways, suicide prevention begins at the point of arrest. What an individual says and how they behave during arrest, transportation to the jail, and at booking are crucial in detecting suicidal behavior. The scene of arrest is often the most volatile and emotional time. Arresting officers should pay close attention to the arrestee during this time; thoughts of suicide or suicidal behavior may be occasioned by the anxiety or hopelessness of the situation, and previous behavior can be confirmed by onlookers such as family and friends. Any pertinent information regarding the arrestee’s well-being must be communicated by the arresting or transporting officer to correctional staff. It is also critically important for correctional staff to maintain open lines of communication with family members who often have pertinent information regarding the mental health status of inmates.

Effective management of suicidal inmates in the facility is based on communication among correctional officers and other professional staff. Because inmates can become suicidal at any point during incarceration, correctional officers must maintain awareness, share information and make appropriate referrals to mental health and medical staff. At a minimum, the facility’s shift supervisor should ensure that appropriate correctional staff are properly informed of the status of each inmate placed on suicide precautions. The shift supervisor should also be responsible for briefing the incoming shift supervisor regarding the status of
all inmates on suicide precautions. Multi-disciplinary team meetings (to include correctional, medical and mental health personnel) should occur on a regular basis to discuss the status of inmates on suicide precautions. Finally, the authorization for suicide precautions, any changes in suicide precautions, and observation of inmates placed on precautions should be documented on designated forms and distributed to appropriate staff.

Facility staff must use various communication skills with the suicidal inmate, including active listening, physically staying with the inmate if they suspect immediate danger, and maintaining contact through conversation, eye contact, and body language. Correctional staff should trust their own judgment and observation of risk behavior, and avoid being misled by others (including mental health staff) into ignoring signs of suicidal behavior.

The communication breakdown between correctional, medical, and mental health personnel is a common factor found in the reviews of many inmate suicides. Communication problems are often caused by lack of respect, personality conflicts, and other boundary issues. Simply stated, facilities that maintain a multidisciplinary approach generally avoid preventable suicides.

**Housing**

In determining the most appropriate housing location for a suicidal inmate, correctional officials (with concurrence from medical or mental health staff) often tend to physically isolate and sometimes restrain the individual. These responses might be more convenient for all staff, but they are detrimental to the inmate because the use of isolation escalates the inmate’s sense of alienation and further removes the individual from proper staff supervision. To every extent possible, suicidal inmates should be housed in the general population, medical health unit, or medical infirmary, located close to staff. Further, removal of an inmate’s clothing (excluding belts and shoelaces) and the use of physical restraints (e.g., restraint chairs or boards, leather straps, straitjackets, etc.) should be avoided whenever possible, and used only as a last resort when the inmate is physically engaging in self-destructive behavior. Handcuffs should not be used to restrain a suicidal inmate. Housing assignments should be based on the ability to maximize staff interaction with the inmate, avoiding assignments that heighten the depersonalizing aspects of incarceration.

All cells designated to house suicidal inmates should be suicide-resistant, free of all obvious protrusions, and provide full visibility. These cells should contain tamper-proof light fixtures and ceiling air vents that are protrusion-free. Each cell door should contain a heavy gauge Lexan (or equivalent grade) glass panel that is large enough to allow staff a full and unobstructed view of the cell interior. Cells housing suicidal inmates should not contain any electrical switches or outlets, bunks with holes and ladders, towel racks on desks and sinks, radiator vents, corded telephones of any length, clothing hooks (of any kind), or any other object that provides an easy anchoring device for hanging. Finally, each housing unit in the facility should contain various emergency equipment, including a first aid kit, pocket mask or face shield, Ambu-bag, and rescue tool (to quickly cut through fibrous material). Correctional staff should ensure that such equipment is in working order on a daily basis.

**Levels of Supervision**

The promptness of response to suicide attempts in correctional facilities is often driven by the level of supervision afforded the inmate. Brain damage from strangulation caused by a suicide attempt can occur within four minutes, and death often within five to six minutes. Standard correctional practice (and ACA standards) requires that “special management inmates,” including those housed in administrative segregation, disciplinary detention and protective custody, be observed at intervals not exceeding every 30 minutes, with mentally ill inmates observed more frequently. According to NCCHC standards, inmates held in medical restraints and “therapeutic seclusion” should be observed at intervals that do not exceed every 15 minutes. In addition, health care personnel should conduct rounds of special management units and observe each inmate (not simply those receiving medication and/or on a mental health caseload) at least three times per week.

Consistent with national correctional standards and practices, two levels of supervision are generally recommended for suicidal inmates: close observation and constant observation. Close Observation is reserved for the inmate who is not actively suicidal, but expresses suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) or has a recent prior history of self-destructive behavior. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, should be placed under close observation. Staff should observe such an inmate at staggered intervals not to exceed every 15 minutes (e.g., 5, 10, 7 minutes, etc.). Constant observation is reserved for the inmate who is actively suicidal, either threatening or engaging in suicidal behavior. Staff should observe such an inmate on a continuous, uninterrupted basis.

Other aids (e.g., closed-circuit television monitoring, inmate companions or watchers, etc.) can be used as a supplement to, but never as a substitute for, these observation levels. In addition, suicidal inmates should never be placed on a protocol level requiring observation at 30-minute intervals. Finally, mental health staff should assess and interact with (not just observe) suicidal inmates on a daily basis.

**Intervention**

The degree and promptness of staff intervention often determines whether the victim will survive a suicide attempt. A correctional facility’s policy regarding intervention should contain three primary components. First, all staff who come into contact with inmates should be trained in standard first aid procedures and cardiopulmonary resuscitation (CPR). Second, any staff member who discovers an inmate engaging in self-harm should immediately survey the scene to assess the severity of the emergency, alert other staff to call for medical personnel if necessary, and begin standard first aid and/or CPR as necessary. If facility policy prohibits an officer from entering a cell without backup support, the first responding officer should, at a minimum, make the proper notification for backup support and medical personnel, secure the area outside the cell, and retrieve the housing unit’s emergency response bag (that should include a first aid kit, pocket mask or face shield, Ambu-bag, and rescue tool). Third, staff should never presume that the inmate is dead, but rather should...
initiate and continue appropriate life-saving measures until relieved by arriving medical personnel. In addition, medical personnel should ensure that all emergency response equipment is in working order on a daily basis.

**Reporting**

In the event of a suicide attempt or suicide, all appropriate correctional officials should be notified through the chain of command. Following the incident, the victim’s family should be immediately notified, as well as appropriate outside authorities. All staff who came into contact with the victim prior to the incident should be required to submit a statement including their full knowledge of the inmate and incident.

**Follow-Up/Mortality Review**

An inmate suicide is extremely stressful for staff, who may feel angry, guilty, and even ostracized by fellow personnel and administration officials. Following a suicide, reasonable guilt is sometimes displayed by the officer who wonders: “What if I had made my cell check earlier?” When suicide or suicidal crises occur, staff affected by such a traumatic event should receive appropriate assistance. One form of assistance is critical incident stress debriefing (CISD). A CISD team, made up of professionals trained in crisis intervention and traumatic stress awareness (e.g., police officers, paramedics, fire fighters, clergy, and mental health personnel), provides affected staff an opportunity to process their feelings about the incident, develop an understanding of critical stress symptoms, and develop ways of dealing with those symptoms. For maximum effectiveness, the CISD process or other appropriate support services should occur within 24 to 72 hours of the critical incident.

Experience has demonstrated that many correctional systems have reduced the likelihood of future suicides by critically reviewing the circumstances surrounding instances as they occur. While all deaths are investigated either internally or by outside agencies to ensure impartiality, these investigations are normally limited to determining the cause of death and whether there was any criminal wrongdoing. The primary focus of a mortality review should be two-fold: What happened in the case under review and what can be learned to help prevent future incidents? To be successful, the mortality review team must be multidisciplinary and include representatives of both line and management level staff from the corrections, medical and mental health divisions.

Therefore, every completed suicide, as well as each suicide attempt of high lethality (e.g., requiring hospitalization), should be examined through a mortality review process. (If resources permit, clinical review through a psychological autopsy is also recommended.) The mortality review should include: (a) critical review of the circumstances surrounding the incident; (b) critical review of jail procedures relevant to the incident; (c) synopsis of all relevant training received by involved staff; (d) pertinent medical and mental health services/reports involving the victim; (e) possible precipitating factors leading to the suicide; and (f) recommendations, if any, for change in policy, training, physical plant, medical or mental health services, and operational procedures.

---

**A MODEL SUICIDE PREVENTION POLICY**

<table>
<thead>
<tr>
<th>GENERAL ORDER</th>
<th>DATE OF ISSUE</th>
<th>EFFECTIVE DATE</th>
<th>DIRECTIVE NO.</th>
</tr>
</thead>
<tbody>
<tr>
<td>REFERENCE</td>
<td></td>
<td>RESCINDS</td>
<td></td>
</tr>
</tbody>
</table>

**INDEXAS: SUICIDE PREVENTION PROCEDURES**

**SUICIDE PREVENTION PROCEDURES**

**I. PURPOSE:**
To outline specific measures taken to identify and respond to the needs of suicidal inmates.

**II. PROCEDURE:**
The following measures comprise the eight (8) step suicide prevention program: staff training, identification/referral/assessment, communication, housing, levels of observation, intervention, reporting, follow-up/mortality review.

**A) Staff Training**

A1. All staff (including correctional, medical, and mental health personnel) who have regular contact with inmates shall be initially trained in the identification and management of suicidal inmates, as well as in the eight components of the agency’s suicide prevention program. Initial training shall encompass eight (8) hours of instruction. New employees shall receive such instruction through the training academy. Current staff shall receive such instruction through scheduled training workshops.

A2. The initial training should include inmate suicide research, why the environments of correctional facilities are conducive to suicidal behavior, staff attitudes about suicide, potential predisposing factors to suicide, high-risk suicide periods, warning signs and symptoms, identifying suicidal inmates despite their denial of risk, components of the facility’s suicide prevention policy, critical incident stress debriefing, and liability issues associated with inmate suicide.

A3. All staff who have regular contact with inmates shall receive two (2) hours of annual suicide prevention training. The two-hour
training workshop shall include a review of predisposing risk factors, warning signs and symptoms, identifying suicidal inmates despite their denial of risk, and review of any changes to the agency’s suicide prevention program. The annual training shall also include general discussion of any recent suicides and/or suicide attempts in the agency.

A4. All staff who have regular contact with inmates shall receive standard first aid and cardiopulmonary resuscitation (CPR) training. All staff shall also be trained in the use of various emergency equipment located in each housing unit. In an effort to ensure an efficient emergency response to suicide attempts, “mock drills” shall be incorporated into both initial and refresher training for all staff (see also Section F).

B) Identification/Referral/Assessment

B1. All inmates (apart from those exceptions listed in No. 10 below) shall be administered the Intake Screening Form prior to placement in any housing unit. The Intake Screening Form (Attachment A) shall be administered during the admission and booking process by the Booking Officer or other designated staff (e.g., medical staff).

B2. The Intake Screening Form shall include inquiry regarding: past suicidal ideation and/or attempts; current ideation, threat, plan; prior mental health treatment/hospitalization; recent significant loss (job, relationship, death of family member/close friend, etc.); history of suicidal behavior by family member/close friend; suicide risk during prior confinement; and arresting/transporting officer(s) belief that the detainee is currently at risk.

B3. The Booking Officer or Designee shall question the arresting and/or transporting officer(s) regarding their assessment of the inmate’s medical, mental health or suicide risk. The Arresting and/or Transporting Officer Questionnaire (Attachment B) shall include observed behavior and information from family members and/or others. Such information shall also be documented on the Intake Screening Form.

B4. If the inmate is being received from another facility (e.g., county jail, intra-system, etc.), the sending agency shall be required to complete a Sending Agency Transfer Form (Attachment C) which documents any medical, mental health, and suicide risk needs of the inmate.

B5. The Booking Officer or Designee shall determine (either through the inmate management system or manual check) whether the inmate was a medical, mental health or suicide risk during any prior contact and/or confinement within the agency. Such information shall be documented on the Intake Screening Form.

B6. The Booking Officer or Designee shall make all appropriate observations, and ask all questions, as contained on the Intake Screening Form. All information received shall be entered in the appropriate spaces of the Intake Screening Form.

B7. Although an inmate’s verbal responses during the intake screening process are critically important to assessing the risk of suicide, staff should not exclusively rely on an inmate’s denial that they are suicidal and/or have a history of mental illness and suicidal behavior, particularly when their behavior and/or actions or even previous confinement in the facility suggest otherwise.

B8. Following completion of the Intake Screening Form, the Booking Officer or Designee shall confer with the Shift Supervisor. The Shift Supervisor will review the form for accuracy and completeness, and then confer with medical and/or mental health personnel in determining the appropriate disposition (i.e., general population, suicide precautions, hospital, mental health referral, release, etc.). The Intake Screening Form shall be signed by both the Booking Officer or Designee and Shift Supervisor.

B9. If identified as a risk for suicide, the inmate shall be immediately placed on “Suicide Precautions” (see Section E) and the Shift Supervisor shall immediately contact medical and/or mental health personnel for further assessment.

B10. The assessment of suicide risk by medical and/or mental health staff shall include, but not be limited to, the following: description of the antecedent events and precipitating factors; suicidal indicators; mental status examination; previous psychiatric and suicide risk history, level of lethality; current medication and diagnosis; and recommendations/treatment plan. Findings from the assessment shall be documented on both the Suicide Risk Assessment (Attachment D) and health care record.

B11. Although any facility staff may place an inmate on Suicide Precautions and/or upgrade those precautions, only designated mental health (or medical) staff may downgrade and discontinue Suicide Precautions. Medical staff must confer with mental health staff prior to downgrading or discontinuing suicide precautions.

B12. A completed Intake Screening Form shall be performed on all inmates prior to assignment to a housing unit, except under the following circumstances: a) Inmate refuses to comply with process; b) Inmate is severely intoxicated or otherwise incapacitated; c) Inmate is violent or otherwise belligerent; or d) Inmate is undergoing a “court-ordered” booking and will be immediately released.

B13. For inmates listed in 8:a-c above, the Booking Officer or Designee shall still complete all non-questionnaire sections of the inmate’s Intake Screening Form and make a notation on the form regarding why the inmate was unable to answer the questionnaire section. The Shift Supervisor shall then make the appropriate Disposition. A continuing, but reasonable effort shall be made to complete the entire Intake Screening Form on inmates listed on 8:a-c above at least every two (2) hours.

B14. Any inmate placed in a housing unit without having been administered a completed Intake Screening Form shall be placed on Suicide Precautions until such time as the Form is completed or until the inmate is released from the facility.

B15. A nursing supervisor staff shall review each completed Intake Screening Form for accuracy and completeness within 24 hours.

B16. All inmates shall be asked to sign a release of information form authorizing the disclosure of health records from outside providers. Medical staff shall make a reasonable effort to obtain records of
previous medical and mental health treatment, including both in-patient and out-patient treatment services.

B17. Within 14 days of admission into the facility, all inmates shall receive post-admission mental health screening by mental health and/or trained medical staff. The screening shall include inquiry into history of psychiatric treatment, violent and suicidal behavior, victimization, learning disabilities, cerebral trauma or seizures, and sex offenses; and current mental status, psychotropic medication, suicidal ideation, drug and alcohol use, and orientation to person, place, and time; and emotional response to incarceration. Inmates with a positive screening for mental health issues shall be referred to mental health staff for a full mental health evaluation.

B18. Given the strong association between inmate suicide and special management (e.g., disciplinary and/or administrative segregation) housing unit placement, any inmate assigned to such a special housing unit shall receive a written assessment for suicide risk by mental health and/or medical staff upon admission to the special unit. Full mental health evaluation, including orientation to person, place, and time, and emotional response to incarceration must be completed. The scene of arrest is often the most volatile and emotional time for the individual. Arresting and/or transporting officers shall pay close attention to the inmate during this time; suicidal behavior may be manifested by the anxiety or hopelessness of the situation, and previous behavior can be confirmed by onlookers such as family members and friends. Any pertinent information regarding the inmate’s well-being must be communicated by the arresting or transporting officer to Booking Officer or Designee.

C) Communication

C1. What an inmate says and how they behave during arrest, transport to the facility, and at intake are crucial in detecting suicidal behavior. The scene of arrest is often the most volatile and emotional time for the individual. Arresting and/or transporting officers shall pay close attention to the inmate during this time; suicidal behavior may be manifested by the anxiety or hopelessness of the situation, and previous behavior can be confirmed by onlookers such as family members and friends. Any pertinent information regarding the inmate’s well-being must be communicated by the arresting or transporting officer to Booking Officer or Designee.

C2. All staff shall maintain awareness, share information and make appropriate referrals to mental health and medical staff.

D) Housing

D1. Any inmate placed on Suicide Precautions shall be housed in a cell that has the most visibility to staff. All cells designated to house suicidal inmates shall be as suicide-resistant as is reasonably possible, free of all obvious protrusions, and provide full visibility.

D2. Removal of an inmate’s clothing (excluding belts and shoelaces) and the use of any physical restraints (e.g., restraint chairs or boards, leather straps, etc.) shall be avoided whenever possible, and used only as a last resort when the inmate is physically engaging in self-destructive behavior. Metal handcuffs shall never be utilized for restraint.

D3. If the decision is made to remove clothing from a suicidal inmate, they shall be issued a safety smock or other protective clothing that is suicide-resistant.
D4. The Shift Supervisor shall immediately notify medical and/or mental health personnel when a decision has been made to remove an inmate’s clothing or to apply any physical restraints.

D5. Regardless of whether restraints are initiated by custody or health care personnel, the use of any restraints shall include adherence to the following minimal guidelines:

a) Restraints shall not be used for punitive purposes;

b) Restraints require an order by a qualified health care professional (physician, nurse practitioner, or physician’s assistant) order;

c) Inmates shall never be restrained in an unnatural position;

d) Restraint equipment must be medically appropriate;

e) Inmates placed in restraints shall be under the constant observation of correctional staff;

f) Vital signs of inmates placed in restraints shall be assessed every 30 minutes by medical staff;

g) Each restrained limb shall be untied for at least 10 minutes every two hours to allow for proper circulation;

h) Restrained inmates shall be allowed bathroom privileges as soon as practical;

i) Restraint orders shall be reviewed by the qualified health care professional every 2 hours, and must be reduced as quickly as possible to the level of least restriction necessary to protect the inmate and others as determined by the qualified health care professional; and

j) Restraint orders shall be automatically terminated after 12 hours and, if the inmate remains in a highly agitated state after 12 hours that they cannot be released because of physical danger to self or others, they shall be transferred to the hospital.

D6. Unless contraindicated by medical and/or mental health staff, each inmate on Suicide Precautions shall continue to receive regular privileges (e.g., showers, telephone, visiting, recreation, etc.) commensurate with their security level.

D7. Given the strong association between inmate suicide and special management (e.g., disciplinary and/or administrative segregation) housing unit placement, medical staff shall make rounds of the special housing unit at least three (3) times per week and mental health staff shall make rounds at least once (1) per week. At a minimum, medical and mental health staff shall visually observe each inmate confined in the unit (not simply those receiving medication, requesting services, and/or on a caseload). Documentation of the rounds shall be made in the housing unit log, with any significant findings documented in the inmate’s health care record.

D8. Each housing unit in the facility should contain various emergency equipment, including a first aid kit; pocket mask, face shield, or Ambu-bag; and emergency rescue tool (to quickly cut through fibrous material). The Shift Supervisor staff should ensure that such equipment is in working order on a daily basis.

E) Levels of Observation

E1. “Suicide Precautions” is defined as an observational status placed on suicidal inmates requiring increased surveillance and management by staff. Suicide Precautions shall include two levels of observation:

a) Close Observation: Reserved for the inmate who is not actively suicidal, but expresses suicidal ideation (e.g., expressing a wish to die without a specific threat or plan) and/or has a recent prior history of self-destructive behavior. In addition, an inmate who denies suicidal ideation or does not threaten suicide, but demonstrates other concerning behavior (through actions, current circumstances, or recent history) indicating the potential for self-injury, shall be placed under close observation. Staff shall observe the inmate at staggered intervals not to exceed every 15 minutes (e.g., 5, 10, 7 minutes).

b) Constant Observation: Reserved for the inmate who is actively suicidal, either threatening or engaging in self-injurious behavior. Staff shall observe such an inmate on a continuous, uninterrupted basis and have a clear non-obstructed view of the inmate at all times.

E2. Other supervision aids, including closed-circuit television monitoring, use of other inmates, etc., can be used as a supplement to, but shall never be a substitute for, the physical observation checks provided by staff.

E3. For each inmate placed on Suicide Precautions, staff shall document the close observation check as it occurs (but no more than staggered 15-minute intervals), and the constant observation check every 15 minutes, on a Suicide Precautions Observation Sheet (Attachment F).

E4. The Shift Supervisor shall make periodic visits to the housing units containing inmates on Suicide Precautions to ensure that Suicide Precautions Observation Sheets are complete and accurate.

E5. Suicidal inmates shall remain on Suicide Precautions until such time as they are transferred and/or released from the facility, or removed from the status by medical and/or mental health personnel.

E6. Medical and/or mental health staff shall assess and interact with (not just observe) inmates on Suicide Precautions on a daily basis.

E7. An inmate shall not be downgraded or discharged from Suicide Precautions until the responsible medical and/or mental health staff has assessed the inmate, thoroughly reviewed the inmate’s health care record, as well as conferred with correctional personnel regarding the inmate’s stability.

E8. An inmate placed on constant observation shall always be downgraded to close observation for a reasonable period of time prior to being discharged from Suicide Precautions.

E9. In order to ensure the continuity of care for suicidal inmates, all inmates discharged from Suicide Precautions shall remain on the mental health caseload and receive regularly scheduled follow-up assessment by mental health staff until their release from the facility. Unless their individual treatment plan directs otherwise, the reassessment schedule shall be as follows: daily for 5 days, once a week for 2 weeks, and then once every month until release.
F) Intervention

F1. All staff who come into contact with inmates shall be trained in standard first aid and cardiopulmonary resuscitation (CPR).

F2. All staff who come into contact with inmates shall participate in annual “mock drill” training to ensure a prompt emergency response to all suicide attempts.

F3. All housing units shall contain an emergency response bag that includes a first aid kit; pocket mask, face shield, or Ambu-bag; latex gloves; and emergency rescue tool. All staff who come into regular contact with inmates shall know the location of this emergency response bag and be trained in its use.

F4. Any staff member who discovers an inmate attempting suicide shall immediately respond, survey the scene to ensure the emergency is genuine, alert other staff to call for the facility’s medical personnel, and bring the emergency response bag to the cell. If the suicide attempt is life-threatening, Central Control personnel shall be instructed to immediately notify outside (“911”) Emergency Medical Services (EMS). The exact nature (e.g., “hanging attempt”) and location of the emergency shall be communicated to both facility medical staff and EMS personnel.

F5. Following appropriate notification of the emergency, the First Responding Officer shall use their professional discretion in regard to entering the cell without waiting for backup staff to arrive. With no exceptions, if cell entry is not immediate, it shall occur no later than four (4) minutes from initial notification of the emergency.

F6. Should the emergency take place within the Special Housing Unit and require use of the Cell Entry Team, the Team shall be assembled, equipped and enter the cell as soon as possible, and no later than four minutes (4) from initial notification of the emergency. Correctional staff shall never wait for medical personnel to arrive before entering a cell or before initiating appropriate life-saving measures (e.g., first aid and CPR).

F7. Upon entering the cell, correctional staff shall never presume that the victim is dead, rather life-saving measures shall be initiated immediately. In hanging attempts, the victim shall first be released from the ligature (using the emergency rescue tool if necessary). Staff shall assume a neck/spinal cord injury and carefully place the victim on the floor. Should the victim lack vital signs, CPR shall be initiated immediately. All life-saving measures shall be continued by correctional staff until relieved by medical personnel.

F8. The Shift Supervisor shall ensure that both arriving facility medical staff and EMS personnel have unimpeded access to the scene in order to provide prompt medical services to, and evacuation of, the victim.

F9. Although the scene of the emergency shall be preserved as much as possible, the first priority shall always be to provide immediate life-saving measures to the victim. Scene preservation shall receive secondary priority.

F10. An Automated External Defibrillator (AED) shall be located in the Medical Unit and/or Special Housing Unit. All medical staff, as well as designated correctional personnel, shall be trained (both initial and annual instruction) in its use. The Medical Director or Designee shall provide direct oversight of AED use and maintenance.

F11. The Medical Director or Designee shall ensure that all equipment utilized in the response to medical emergencies (e.g., crash cart, oxygen tank, AED, etc.) is inspected and in proper working order on a daily basis.

F12. All staff and inmates involved in the incident will be offered critical incident stress debriefing (see Section H).

F13. Although not all suicide attempts require emergency medical intervention, all suicide attempts shall result in the inmate receiving immediate intervention and assessment by mental health staff.

G) Reporting/Notification

G1. In the event of a suicide, all appropriate officials shall be notified through the chain of command.

G2. Following the incident, the victim’s family shall be immediately notified, as well as appropriate outside authorities.

G3. All staff who came into contact with the victim before the incident shall be required to submit a statement including their full knowledge of the inmate and incident.

H) Follow-Up/Mortality Review

H1. Critical Incident Stress Debriefing (CISD) provides affected staff and inmates an opportunity to process their feelings about the incident, develop an understanding of critical stress symptoms, and seek ways of dealing with those symptoms. In the event of a serious suicide attempt (i.e., requiring medical treatment and/or hospitalization) or suicide, all affected staff and inmates shall be offered CISD. For maximum effectiveness, the CISD process and other appropriate support services shall occur within 24 to 72 hours of the critical incident (see CISD policy).

H2. Every completed suicide, as well as serious suicide attempt (e.g., requiring hospitalization), shall be examined by a multidisciplinary Mortality Review Team that includes representatives of both line and management level staff from the corrections, medical and mental health divisions.

H3. The Mortality Review process shall comprise a critical inquiry of: a) circumstances surrounding the incident; b) facility procedures relevant to the incident; c) all relevant training received by involved staff; d) pertinent medical and mental health services/reports involving the victim; e) possible precipitating factors leading to the suicide; and f) recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and operational procedures. The inquiry shall follow the outline described in the Mortality Review Checklist (Attachment G).

H4. When appropriate, the Mortality Review Team shall develop a written plan (and timetable) to address areas that require corrective action. The plan, as well as all written documentation pertaining to the Mortality Review process, shall be maintained by the Quality Assurance Coordinator in a locked file cabinet.
INMATE'S NAME: __________________________ Date of Birth: ______ Sex: ______ Date: ______ Time: ______

Most Serious Charge: __________________________ I.D. Number: ______ Screening Officer: __________________________

Was inmate a medical, mental health or suicide risk during any prior contact and/or confinement within the facility? Yes___ No___ If Yes, explain: __________________________

Does the arresting and/or transporting officer have any information (e.g., from observed behavior, documentation from sending agency/facility, family member/guardian, etc.) that indicates inmate is a medical, mental health or suicide risk now? Yes___ No___ If Yes, explain: __________________________

STAFF OBSERVATION

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

Explain: __________________________

MEDICAL HISTORY

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

Explain: __________________________

DO YOU SUFFER FROM ANY OF THE FOLLOWING

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

Explain: __________________________
# SUICIDE RISK ASSESSMENT

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Have you ever attempted suicide?** If Yes, When? ________ Why? ________________________________ How? ________________________________

**Have you ever considered suicide?** If Yes, When? ________ Why? ________________________________

**Are you now or have you ever been treated for mental health or emotional problems?** If Yes, When? ________ Inpatient: ________ Outpatient: ________ Both: ________

**Have you recently experienced a significant loss (relationship, death of family member/close friend, job, etc.)?** If Yes, explain: ________________________________

**Has a family member/close friend ever attempted or committed suicide?** If Yes, explain: ________________________________

**Do you feel there is nothing to look forward to in the immediate future (inmate expressing helplessness and/or hopelessness)?** If Yes, explain: ________________________________

**Are you thinking of hurting and/or killing yourself?** If Yes, explain: ________________________________

**Additional Remarks:**

---

## DISPOSITION

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**General Population**

**Suicide Precautions**

1. Supervision Levels: CLOSE (5-15 Minutes)______ CONSTANT______ OTHER______
2. Housing Assignment: Infirmary______ Mental Health Unit______ Room #______
3. Other Precautions Taken (restraints, safety smock, bedding, etc., if appropriate)

**Local Hospital.** If inmate is later returned to facility, list any special observation recommendations: ________________________________

**Other Disposition/Referral/Transfer:** ________________________________

---

## FAILURE TO ANSWER/REFUSAL OF TREATMENT

Inmate refused to answer (circle) or unable to answer (circle and state why) verbal response sections of this form.

I, ______________________________ (print name) refuse any type of medical treatment.

**SIGNATURES:**

Inmate: ______________________________
Screening Officer: ______________________________ Supervisor: ______________________________
### ARRESTING/TRANSPORTING OFFICER QUESTIONNAIRE

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

**Does the detainee appear to be under the influence of alcohol and/or drugs?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

**Has the detainee made any comments (e.g., “I’m going to kill myself,” “I want to die,” “I have nothing to live for,” “Everyone would be better off without me around”) or engaged in any behavior that would be cause for concern? If Yes, explain:**

<table>
<thead>
<tr>
<th>___</th>
<th>___</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

**Has another individual with knowledge of detainee informed you and/or made comments that suggest that detainee is potentially suicidal and/or has a history of suicidal behavior, has a history of mental illness, has medical problems, or is under the influence of alcohol and/or drugs? If Yes, explain:**

<table>
<thead>
<tr>
<th>___</th>
<th>___</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

**Does the detainee appear to be overly ashamed, embarrassed, scared, depressed, or exhibiting bizarre behavior? If Yes, explain:**

<table>
<thead>
<tr>
<th>___</th>
<th>___</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

**Are there any facts or circumstances surrounding the arrest and/or alleged crime that may suggest the detainee is potentially suicidal? If Yes, explain:**

<table>
<thead>
<tr>
<th>___</th>
<th>___</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

**Do you have any other information that would be helpful to us while the detainee is confined in this facility? If Yes, explain:**

<table>
<thead>
<tr>
<th>___</th>
<th>___</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

---

**COMPLETED BY: ____________________________ (Print and Sign)**

Agency: ____________________________ Date: ____________________________
Attachment C

SENDING AGENCY TRANSFER FORM

Sending Agency Section

Inmate’s Name: ___________________________ Date of Birth: _______ Sex: _______ Date: _______ Time: _______

Was inmate a medical, mental health or suicide risk during any prior contact and/or confinement within your facility?
Yes___ No___ If Yes, explain: ____________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

Is the inmate currently taking any medication? __________ Yes ___ No ___
If Yes, list type(s), dose(s), and frequency:
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

Is the inmate currently receiving mental health services? Yes ___ No ___
If Yes, explain: __________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

Is the inmate currently on suicide precautions and/or had a history of suicidal behavior in your facility? Yes ___ No ___
If Yes, explain: __________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

Additional Information:
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

SIGNATURE/TITLE (Sending Agency): ___________________________ DATE: __________ TIME: __________

Transporting Officer Section

Do you have any information (e.g., from observed behavior, documentation from sending agency/facility, family member/guardian, etc.) that indicates inmate is a medical, mental health or suicide risk now? Yes ___ No ___
If Yes, explain: __________________________________________________________________________________________
_____________________________________________________________________________________________________
_____________________________________________________________________________________________________

SIGNATURE/TITLE (Transporting Officer): ___________________________ DATE: __________ TIME: __________

Receiving Agency Section

Received Medical File, Mental Health File, Court-Order Evaluation, Other (__________________). Circle all that apply.

SIGNATURE/TITLE (Receiving Agency): ___________________________ DATE: __________ TIME: __________
SUICIDE RISK ASSESSMENT

Inmate's Name: ________________________ I.D. Number: ________________________

DOB: _______ Age: _____ Sex: ______ Initial Assessment: _______ Reassessment: _______ Date: _______

Suicide Precautions During Prior Confinement: Yes ___ (Most Recent Date: ____________) No ___

Reason for Referral/Precipitating Factors: ____________________________________________________

Suicidal Indicators (Check all that apply):

- Suicide Attempt
- Depressed
- Hostile/Aggressive
- Lethargy
- Giving Away Possessions
- Afraid/Fearful
- Suicide Ideation/Gesture
- Agitated
- Sleep Problems
- Excessive Weight Gain/Loss
- Intoxicated
- Bizarre Behavior (explain above)
- Mood Change
- Recent Loss
- Withdrawal
- Hopeless/Helpless
- Other (explain above)

Type of Threat/Attempt:  ☐ Hanging  ☐ Cutting  ☐ Jumping  ☐ Ingestion  ☐ Overdose  ☐ Other __________________________

Previous Psychiatric/Suicide History: __________________________________________________________

Current Medications: ________________________________________________________________

Assessment of Lethality: Low (1)___________ Medium (2)___________ High (3)__________

Diagnosis:

- Schizophrenia
- Major Depression
- Generalized Anxiety Disorder
- Borderline Personality
- Panic Disorder
- Bi-Polar Disorder
- Substance Abuse Disorder
- Other __________________________

Findings/Recommendations/Treatment Plan: ____________________________________________________

Actions:  Suicide Precautions Authorized:  ☐ Yes  ☐ No

Level:  ☐ Close (Physical checks at staggered intervals not to exceed every 15 minutes)

☐ Constant (Continuous, uninterrupted observation)

☐ Other (Specify)

Restraints:  ☐ Yes  ☐ No

Safety Smock:  ☐ Yes  ☐ No

Items Allowed (Check):

☐ Clothing  ☐ Undergarments  ☐ Blankets  ☐ Mattress  ☐ Pillow

☐ Reading Materials  ☐ Toiletries  ☐ Other

Housing Assignment: _____________________________________________________________

Transfer Recommendations: ______________________________________________________

Other Referrals/Recommendations: __________________________________________________

Signature/Title: ___________________________________________ Time: _______________________

(Qualified Mental Health Professional)
Attachment E

AUTHORIZATION FOR SUICIDE PRECAUTIONS/REASSESSMENT OR CHANGE IN OBSERVATION LEVEL

Inmate’s Name: ___________________________ I.D. Number: ___________________________

(Last) (First) (M.I.)

☐ Placed on Close Observation (physical checks at staggered intervals not to exceed every 15 minutes)

☐ Placed on Constant Observation (continuous, uninterrupted)

☐ Transferred from Constant Observation to Close Observation *

☐ Transferred from Close Observation to Constant Observation

☐ Continued on Close Observation

☐ Released from Close Observation*

*May only be authorized following face-to-face consultation with a qualified mental health professional.

Housing Assignment: ___________________________ Restraints: ☐ Yes ☐ No

Safety Smock: ☐ Yes ☐ No

Items Allowed (Check): ☐ Clothing ☐ Undergarments ☐ Blankets ☐ Mattress ☐ Pillow

☐ Reading Materials ☐ Toiletries ☐ Other

Transfer Recommendations: ___________________________

Other Referrals/Recommendations: ___________________________

Reason for Observation (Provide Details):

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Follow-Up Recommendations: ___________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

SIGNATURE/TITLE: ___________________________ DATE: ____________ TIME: ____________

(Shift Supervisor)

APPROVED BY (SIGNATURE): ___________________________ DATE: ____________ TIME: ____________

(Qualified Mental Health Professional)
SUICIDE PRECAUTIONS OBSERVATION SHEET

Inmate’s Name: ___________________________ I.D. Number: ___________________________

Start Date: ___________________________ Start Time: ___________________________ Cell Location: ___________________________

Suicide Precaution Level:
☐ CLOSE (Physical checks at staggered intervals not to exceed every 15 minutes, e.g., 5, 12, 10 minutes)
☐ CONSTANT (Continuous, uninterrupted observation)
☐ OTHER (Specify) ___________________________

Restraints: ☐ Yes ☐ No

Safety Smock: ☐ Yes ☐ No

CODE FOR INMATE BEHAVIOR AND STAFF INTERVENTIONS

A. Self-Injurious Behavior  F. Quite/Seclusive  K. Sleeping  P. Yelling/Screaming
B. Assaultive Behavior  G. Self-Contained Activity  L. Medical  Q. Telephone Call
C. Destructive Behavior  H. Social Activity/Program  M. Mental Health  R. Visit
D. Hyperactive  I. Medication  N. Eating  S. Incoherent
E. Active  J. Toilet/Shower  O. Crying  T. Other ___________________________

<table>
<thead>
<tr>
<th>Time</th>
<th>Codes</th>
<th>Staff Name</th>
<th>Time</th>
<th>Codes</th>
<th>Staff Name</th>
<th>Time</th>
<th>Codes</th>
<th>Staff Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SHIFT SUPERVISOR SIGNATURE: ___________________________ DATE: _____________ TIME: _____________
1) **TRAINING**
   - Had all correctional, medical, and mental health staff involved in the incident received both basic and annual training in the area of suicide prevention prior to the suicide?
   - Had all staff who responded to the incident received training (and were currently certified) in standard first aid and cardiopulmonary resuscitation (CPR) prior to the suicide?

2) **IDENTIFICATION/REFERRAL/ASSESSMENT**
   - Upon this inmate’s initial entry into the facility, were the arresting/transporting officer(s), as well as sending agency (if applicable) asked whether they believed the inmate was at risk for suicide? If so, what was the response?
   - Had the inmate been screened for potentially suicidal behavior upon entry into the facility?
   - Did the screening include inquiry regarding: past suicidal ideation and/or attempts; current ideation, threat, plan; prior mental health treatment/hospitalization; recent significant loss (job, relationship, death of family member/close friend, etc.); and history of suicidal behavior by family member/close friend?
   - If the screening process indicated a potential risk for suicide, was the inmate properly referred to mental health and/or medical personnel?
   - Did the inmate receive a post-admission mental health screening within 14 days of his/her confinement?
   - Had the inmate previously been confined in the facility/system? If so, had the inmate been on suicide precautions during a prior confinement in the facility/system? Was such information available to staff responsible for the current intake and post-admission screenings?

3) **COMMUNICATION**
   - Was there information regarding the inmate’s prior and/or current suicide risk from outside agencies that was not communicated to the correctional facility?
   - Was there information regarding the inmate’s prior and/or current suicide risk from correctional, mental health and/or medical personnel that was not communicated throughout the facility to appropriate personnel?
   - Did the inmate engage in any type of behavior that might have been indicative of a potential risk of suicide? If so, was this observed behavior communicated throughout the facility to appropriate personnel?

4) **HOUSING**
   - Where was the inmate housed and why was he/she assigned to this housing unit?
   - If placed in a “special management” (e.g., disciplinary and/or administrative segregation) housing unit at the time of death, had the inmate received a written assessment for suicide risk by mental health and/or medical staff upon admission to the special unit?
   - Was there anything regarding the physical design of the inmate’s cell and/or housing unit that contributed to the suicide (e.g., poor visibility, protrusions in cell conducive to hanging attempts, etc.)?

5) **LEVELS OF SUPERVISION**
   - What level and frequency of supervision was the inmate under immediate prior to the incident?
   - Given the inmate’s observed behavior prior to the incident, was the level of supervision adequate?
   - When was the inmate last physically observed by correctional staff prior to the incident?
   - Was there any reason to question the accuracy of the last reported observation by correctional staff?
   - If the inmate was not physically observed within the required time interval prior to the incident, what reason(s) was determined to cause the delay in supervision?
   - Was the inmate on a mental health and/or medical caseload? If so, what was the frequency of contact between the inmate and mental health and/or medical personnel?
   - When was the inmate last seen by mental health and/or medical personnel?
   - Was there any reason to question the accuracy of the last reported observation by mental health and/or medical personnel?
   - If the inmate was not on a mental health and/or medical caseload, should he/she have been?
   - If the inmate was not on suicide precautions at the time of the incident, should he/she have been?

6) **INTERVENTION**
   - Did the staff member(s) who discovered the inmate follow proper intervention procedures, i.e., surveyed the scene to ensure the emergency was genuine, called for backup support, ensured that medical personnel were immediately notified, and initiated standard first aid and/or CPR?
   - Did the inmate’s housing unit contain proper emergency equipment for correctional staff to effectively respond to a suicide attempt, i.e., first aid kit, gloves, pocket mask, mouth shield, or Ambu bag; and emergency rescue tool?
   - Were there any delays in either correctional or medical personnel immediately responding to the incident? Were medical personnel properly notified as to the nature of the emergency and did they respond with appropriate equipment? Was all the medical equipment working properly?

7) **REPORTING**
   - Were all appropriate officials and personnel notified of the incident in a timely manner?
   - Were other notifications, including the inmate’s family and appropriate outside authorities, made in a timely manner?
   - Did all staff who came into contact with the inmate prior to the incident submit a report and/or statement as to their full knowledge of the inmate and incident? Was there any reason to question the accuracy and/or completeness of any report and/or statement?

8) **FOLLOW-UP/MORTALITY REVIEW**
   - Were all affected staff and inmates offered critical incident stress debriefing following the incident?
   - Were there any other investigations conducted (or that should be authorized) into the incident that may be helpful to the mortality review?
   - As a result of this mortality review, were there any possible precipitating factors (i.e., circumstances which may have caused the victim to commit suicide) offered and discussed?
   - Were there any findings and/or recommendations from previous mortality reviews of inmate suicides that are relevant to this mortality review?
   - As a result of this mortality review, what recommendations (if any) are necessary for revisions in policy, training, physical plant, medical or mental health services, and operational procedures to reduce the likelihood of future incidents?
When he heard about the third suicide, Sheriff Dan Walsh felt a sinking feeling in his stomach. It was December 4, 2004 in Champaign County, Illinois, a racially mixed community of 186,000 people. 25-year-old Terrell Layfield, in jail for giving officers a false name during a drug arrest, had hung himself in his cell using his bed sheet. Walsh, elected county sheriff in 2002, oversees two jails in Urbana, a growing town 90 miles from Springfield. As many as 350 prisoners are housed in the separate facilities, with up to 30 prisoners entering its walls each day.

Two inmates had killed themselves earlier in the year — the first in June, the second in July. One inmate, Joseph Beavers, had managed to commit suicide only six hours after his intake interview, using a telephone cord to strangle himself in his booking cell. In six months, three young men were dead — with little explanation of why.

Only a mile from the Champaign County Jail, on Vine Street in Urbana, Sandra Ahten read about Layfield’s suicide in the newspaper with a growing sense of outrage. Ahten, a local artist and diet counselor, had first-hand experience with incarceration at the county jail: the year before, her 22-year-old son had been arrested. Ahten thought about how isolated and scared her son had been as an inmate, cut off from family and friends. Ahten began to do research on how many suicides had occurred in Illinois county jails over the past year. The numbers surprised her.

Throughout the county jail system, there had been eight suicides in the state of Illinois — and three had been in Champaign County. “I didn’t know if this was normal,” Ahten said. “There was no press release...it was just reported as another death. It didn’t look like there was going to be an investigation.”

Ahten acknowledges that, for her, the deaths were a very personal matter. “Having had my son in the jail, it is a very real place — it is part of our community,” Ahten said. “For most people, they just drive by. Inmates are a forgotten population.”

Closer to home, Ravalli County (Montana) Sheriff Chris Hoffman is now grimly familiar with the Champaign County sheriff’s predicament. On February 20, 2004, Mark Daniel Wilson was found hanging in his cell at the Ravalli County Detention Center in Hamilton. In September, detention officers found another inmate strangling himself with his bed sheets, but managed to lower him to the ground and transport him to the hospital.

Then in March, a sudden string of suicides, one after another, caught the attention of the community. On March 21, Bradley Palin, 42, a father of four, hanged himself only a week after being arrested under suspicion of starting two fires in a rural neighborhood south of Hamilton. In April, detention officers found Ryan Heath, a 27-year-old Hamilton High School graduate, dead in his cell. One month later, Scott Lewis, incarcerated on methamphetamine charges, was also found dead of an apparent suicide.

At a press conference on May 23, Hoffman expressed frustration at the string of deaths within his facility. He also pointed out that Ravalli County was not the only detention center facing a sudden rash of inmate suicide attempts. Hoffman cited Sheriff Walsh in Champaign County — he too had to explain to his community why a handful of young men had died under his watch. Hoffman promised that the National Institute of Corrections would send an expert consultant to assess the Ravalli County Detention Center for weaknesses in their suicide prevention policies.

But Hoffman told the grieving families gathered at the courthouse press conference that sometimes suicides were in the hands of only one person — the inmate. “They made choices that ended them in (jail),” Hoffman said. “We are reactive. They get the chance to do what they do first.”

For Lindsay Hayes, jail suicides are a difficult problem — but they are also a preventable one. Literally and figuratively, Hayes has written the book on jail and prison suicides. A project director for the National Center on Institutions and Alternatives in Mansfield, Massachusetts, Hayes has conducted hundreds of jail suicide assessments across the country for the National Institute of Corrections. In 1980, he wrote the only national study on suicide in correctional facilities for the U.S. Department of Justice. Hayes now serves as editor for the NIC publication — Jail Suicide/Mental Health Update, a quarterly newsletter.

Inmate suicides are a problem every detention facility — large and small — must face, according to Hayes. According to the latest figures from the Justice Department’s Census of Jails, suicide is the second leading cause of death in the nation’s jails — second only to illnesses and other natural causes, and far exceeding death rates from AIDS, drug overdoses and injuries. However, if natural causes were broken down into separate illnesses, suicide would be the leading cause of death, Hayes said. “Every jail is susceptible to suicide — they are incarcerating people,” said Hayes. But when jails experience a string of suicides over a short period of time, in Hayes’ experience, there is usually a serious problem. The census figures agree: Only five percent of jails that reported suicides had more than one death occur in a one-year period.

When Hayes heard that four suicides have occurred at the 78-bed Ravalli County Detention Center, three since March, shock crept into his voice. “That’s one of the largest ratios of suicides to number of beds that I’ve seen in 25 years of research (and consulting),” he said. “There’s something very wrong at that jail.”

But what is wrong can be fixed, in Hayes’ opinion. After studying more than 1,500 cases of jail suicide nationwide in his career, Hayes has outlined eight factors that go into an effective detention suicide prevention program. Those eight factors include thorough officer training; careful intake screening; effective communication between law enforcement and mental health counselors; a safe environment to put suicidal prisoners; and rigorous observation techniques; as well as medical...
intervention, reporting and assessment when a suicide attempt occurs.

These elements should be in place in every correctional institution: large or small, well-funded or not, according to Hayes. “It doesn’t have much to do with the size of the jail or the resources available,” Hayes said. Law enforcement officers can be trained to identify suicidal signs in prisoners. Inmates can be screened more closely during the intake process. Communication between officers and mental health staff can be improved, so that if an arresting officer sees telltale signs, that information is passed along effectively down the line to counselors.

It is easy for communication to break down between the numerous staff members that deal with each inmate, according to Hayes. “An arresting officer might have heard something on the scene at the arrest and didn’t pass it along to mental health staff,” Hayes said. Officers also must learn to recognize the type of inmate most at risk, Hayes said.

The typical suicide within the jail system is a young, white, single male, incarcerated for a nonviolent offense. Often, a suicide will occur within the first 48 hours after a prisoner is booked. Inmates who successfully commit suicide are often intoxicated or under the influence of drugs at the time they are arrested, Hayes said. “The level of intoxication plays a huge role,” he said. Overwhelmingly — 92 percent, according to census figures suicide victims die by asphyxiation, using bed sheets or clothing.

After multiple suicides, local officials at smaller detention facilities often blame a lack of funding, or say that there’s little they can do about suicide, according to Hayes. But that’s simply not true, he said. “If they didn’t have this problem two years ago, they need to evaluate their program,” he said.

Whether a jail holds 78 beds or 5,000, officials need to make sure that all eight of those factors are in place — in practice, not just in an unopened policy manual, according to Hayes. “It’s one thing to have a policy that looks good on paper, but then it (might) not be happening in practice,” he said. Most of the program elements cost little to put into place — changing an intake screening form or training, for example, can be done with minimal cost, according to Hayes.

In the end, it becomes a matter of priorities. Top elected officials, from county commissioners to the sheriff, must have zero tolerance for suicides in their jail if the program is to be successful, says Hayes. “You don’t have to accept inmate suicides in your jail system,” Hayes said. “A lot of it has to do with attitude. You can’t be 100 percent successful. But there are a lot of things a sheriff can do to prevent a completed suicide in their facility.”

At Orange County Jail, suicide prevention has become a mantra from elected officials to rookie deputies. The vast jail system, five facilities known as the Orange County Complex, books an average of 60,000 prisoners a year. It is the 4th largest jail system in the state of California and the 13th largest in the nation, holding about 5,000 inmates each day. Despite its vast size, the jail system’s low suicide rate reflects a commitment to prevention at every level.

As of this year, there have been only five successful suicides in the last decade, according to Kevin Smith, Administrative Manager for Correctional Mental Health for the Orange County jails. Smith credits the low suicide rates to a sense of teamwork between deputies, health care professionals and counselors. “It’s truly a collaborative team,” Smith said. “I feel that is one of the key ingredients. There has got to be leadership from the top down.”

Mental health staff is on-site — if they determine the inmate to be at risk, preventative steps are implemented. The inmate is placed in a mental health center, guaranteeing more effective observation. The jail system has also designed a special smock so that at-risk prisoners cannot use clothing to strangle themselves. In addition, each deputy holds a laminated card in his or her uniform pocket, listing symptoms to look for. Smith said. The card represents each officer’s commitment to prevent another suicide on his or her watch, according to Smith. “They touch that card every time they change their uniform,” Smith said. “It’s sort of a symbol that pulls the group together.”

In Champaign County, Sandra Ahten had decided that three suicides were three too many. Ahten began to show up at county commission meetings. She argued that the jail’s restrictive visitation and phone call policies were contributing to the escalating number of suicides. After an initial phone call, inmates had to pay collect to call outside — often as high as $6 for a 15-minute call, according to Ahten. Visits were also heavily restricted — the sheriff’s department only allowed 50 visitors per day, and family members often had to wait hours trying to get in, according to Ahten. These restrictive policies left family members unable to detect warning signs of depression, according to Ahten.

In early March, Sheriff Walsh loosened visitation and phone call rules, allowing inmates more access to their families. Ahten and other members of Champaign-Urbana Citizens for Peace and Justice, a grassroots citizens group, also pushed for a National Institute of Corrections assessment to be conducted. The report, released in March, indicated that training for officers needed to be expanded, and that all inmates should go through a screening process, conducted by mental health professionals, within two weeks after intake. The report also recommended that prisoners at a high level of risk for a suicide attempt be monitored more closely.

In the wake of community activism, Sheriff Walsh turned to the Champaign County Board of Commissioners to help fulfill the report’s goals. The county commissioners were committed to ending the cycle, according to Walsh.

Since the report came out, the detention center has tripled its clinical staff, and brought in a part-time in-house psychiatrist. Officers now do not have to take the security risk, as they did previously, of bringing prisoners off-site for mental health evaluations. “The county Board has been very supportive,” Walsh said. “I said, ‘I know money is tight, but we need to do this.’” Within his department, the attitude regarding inmate suicide has also changed significantly, according to Walsh. “The officers are much more vigilant,” he said. “They’re trying
to pay attention to even the small details about how an inmate is acting.”

According to Sheriff Walsh, the changes have relieved a weight on the shoulders of his team, which includes about 185 full and part-time officers and support staff. After the third suicide, depression and anxiety had begun to affect the ranks of his department, according to Walsh. “From the officers to me, you know these people,” Walsh said. “(These) are members of the community – they’re just in a secure environment.” Preventing suicides in the jail was important to the community — but also to the morale of detention staff, Walsh found. “We are hoping that by doing this, it will improve things for inmates — but also my employees,” Walsh said. “They were under (enormous) stress.”

When multiple suicides occur, bringing in the NIC to do a jail assessment is the right first step, according to Hayes. The National Institute of Corrections, under the auspices of the Justice Department, offers technical assistance, resources, and information to state and local correction agencies across the country. The NIC helps local detention facilities plan for expansion, provides information on mental health issues among inmate populations, and conducts operational assessments and inmate management reviews, said Jim Barbee, a correctional programs specialist with the NIC’s jails division.

An NIC assessment is scheduled at the Ravalli County Detention Center this week, and that could help target policy problems, Barbee said. “Sometimes a set of fresh eyes helps,” Barbee said. “Sometimes (officials) are so close to the forest they can’t see the trees.”

But for the Ravalli County Detention Center, a professional assessment is only the beginning, in Hayes’ view. The NIC assessment is strictly non-regulatory — a consultant will be sent in only when requested by local law enforcement officials, and they have power only to make recommendations, not to enforce any changes. “This is not an investigation,” Barbee said. “Our sole purpose is to provide technical assistance and problem solving.”

Once the assessment is conducted, the community needs to remain vigilant to be sure elected officials are committed to making necessary changes, Hayes said. Sheriff’s departments can — and should — be held responsible for suicides within their facilities, according to Hayes. “Ultimately, they are responsible for what goes on within those walls,” he said.

But the community also can play a large role in tackling the root causes of inmate suicides. In Champaign County, Aaron Ammons, a CUCPJ co-founder and activist, says that the group’s members have tried to take a hard look at the bigger social problems facing their community — of which jail suicides are just one symptom. Drug use, lack of mental health counseling, suicide rates among the general population and overzealous prosecutions can all play a role, Ammons believes. Ammons said that prosecutors in Champaign County have pursued felony convictions at a rate that leaves little hope for first-time and nonviolent offenders. Cuts in mental health funding have also played a role, Ammons added.

---

**Jail Mental Health Services Initiative from the National Institute of Corrections (Jails Division)**

Nearly 6 to 8 percent of the more than 10 million annual commitments to jails are individuals with severe mental illnesses. Many sheriffs and jail administrators view the challenge of responding to the needs of this population as one of the major issues in jail management. In response, the National Institute of Corrections (NIC) has worked collaboratively with the National Institute of Mental Health for the past several years, and more recently, with the Substance Abuse and Mental Health Services Administration’s Center for Mental Health Services to increase and improve these services. As a result of these collaborations, the NIC Jails Division has developed a mental health initiative for jails.

An important component of the initiative is the offering of regional workshops conducted in collaboration with state, regional, and local jurisdictions. The 21-hour regional workshops will be provided upon request to help small and medium-sized jails enhance mental health services and service delivery for inmates. Several jurisdictions in a region can each send a three-person team consisting of a jail administrator, a representative of the jail’s community mental health provider, and the person who coordinates mental health services for inmates. Each workshop will include: overview of the problem, planning principles, contract development, leadership and managing change, implementation strategies, staffing and cross-training, and coalition building. The workshops are conducted at the request of a host agency, which is responsible for furnishing the training rooms and equipment. The NIC Jails Division provides two trainers, the curriculum and training materials. Participants are responsible for their own expenses.

In addition to the workshops, the NIC Jails Division’s mental health initiative includes the following services:

- **On-site Technical Assistance**: This assistance usually consists of an assessment of a jail system’s mental health needs, but also can be targeted at suicide prevention issues in the jail;
- **Newsletter**: The NIC Jails Division funds the Jail Suicide/Mental Health Update, a newsletter which is distributed free of charge on a quarterly basis;
- **Information Resources**: The NIC Information Center has compiled a jail mental health information resource order form that contains 22 items. The form is available at the mental health workshops held in Longmont, Colorado and at regional sites. It can also be obtained by calling the Information Center at (800) 877-1461.

For more information on the NIC Jails Division’s mental health initiative, on-site technical assistance, and the mental health workshops, contact the agency at (800) 995-6429, or visit their website at: www.nicic.org

---
Ultimately, the community sets the priorities — and they have the choice of whether or not to take action. “(The community is) going to have to stay vigilant,” Ammons said. “The elected officials are going to think you’ll go away. But officials must know that the (public) is not going to go away.” Ammons said that his organization’s efforts to eliminate jail suicides go beyond merely protests — it is about shaping the kind of community where everyone is safe and protected, even those who have broken the law. “They can see we’re not just out here protesting,” Ammons said. “We want to be part of this process — to help them do their jobs better.”

For Sheriff Walsh, that job now includes not just locking up prisoners, but also protecting them. “These people downstairs, they are almost like my children,” he said. “I have a statutory duty to take care of them.”

As for Ahten, she has become a tireless advocate for inmate rights, who has gained the grudging respect of local elected officials and community leaders in Urbana. Ahten is now working on a new goal to provide a library service for Champaign County inmates. Despite the fact that the jail is less than two blocks from the University of Illinois campus, inmates do not have access to books, according to Ahten. Her ultimate goal, Ahten says, is to get the community to see inmates as real people with problems — not just statistics in the daily newspaper. A recovering alcoholic, Ahten said she has compassion for individuals struggling to turn their lives around. In her view, community resources should go toward tutoring, job training, drug counseling and recovery — not just adding beds in the jail. “What I’m hoping to do is get the whole community thinking about the jail,” she said. “As a community, we can start to think preventatively. These people are not put away and never coming back. They are community members. You can’t pretend they don’t exist.”

In Ravalli County, the families of the inmates who committed suicide are just starting to ask questions — to try to find out why. Becky Rickman, Ryan Heath’s maternal grandmother, lives in Portland. Rickman traveled to the Bitterroot to help her daughter, Linda Heath, Ryan’s mother, when she heard the news that Ryan had been arrested for an alleged sexual assault. Trying to set aside visitation hours for other family members, Rickman was unable to see Ryan in the two weeks before his death.

Rickman still doesn’t know why — why Ryan was so despondent, or whether his death could have been prevented. “I didn’t get in to talk to him at all,” she said. “Somewhere there was a breakdown in communication.” Ryan was severely hearing impaired — but Rickman said she still doesn’t know whether detention guards were aware of that fact. Mostly, Ryan’s family simply wants answers, Rickman said. “The whole family feels his death was entirely needless,” Rickman said. “Right now, all I can say is that there is a great deal of unanswered questions.”

The above article was written by Dana Green, a staff writer for the Ravalli Republic in Hamilton, Montana. It appeared in the June 8, 2005 edition of the newspaper and is reprinted with the permission of the Ravalli Republic.
APPENDIX IX
LEGAL ISSUES
PREA
Supervisor Liability

Inmate Communication (Postcards; Publications)

Arrestee Strip Searches (The Supreme Court Has Ruled)

Religious Rights

PREA

Use of Force

Avoiding Deliberate Indifference

- The law does not require “perfection” but requires that you are not “deliberately indifferent” to it.
- Do something! Gather the requisite knowledge so that you are aware and take corrective action if necessary.

Using Audits and Inspections to Beat Deliberate Indifferent Claims

A jail official or sheriff "would not escape liability if the evidence showed that he merely refused to verify underlying facts that he strongly suspected to be true, or declined to confirm inferences of risk that he strongly suspected to exist."

**Legal Updates are Critical**

- But Then...
- You must do something with the knowledge...

**Starr v. Baca**, Civ No 09-55233 (9th Cir. February 11, 2011)(cert. denied) (remanded)
- Supervisor OR Sheriff may be personally liable for damages IF it can be shown that he or she was deliberately indifferent to the rights of inmates under their care/control.

---

**USING AUDITS TO BEAT DELIBERATE INDIFFERENCE**

1. Know the law (federal, circuit, state)
   - Create, distribute and train on legal-based guidelines
   - Modify policy and procedure accordingly
2. Create an inside out audit program
   - What is the purpose of the audit?
   - Change the mindset
   - Verify and avoid
3. Assign Corrective Action Plan
4. Document All Action Taken, creating a proactive defense

---

**LEGAL DEFINITIONS=STANDARDS MATTER**

- **First Amendment:**
  - Legitimate governmental interest.
- **Religious Rights:**
  - RLUIPA: Compelling Necessities Test
- **Fourth Amendment:**
  - “Reasonableness”
  - Legitimate Governmental Interest
- **Eighth Amendment:**
  - Conditions of Confinement
  - Deliberate Indifference
- **Eighth Amendment:**
  - Force
    - Excessive force: Was the force applied in a good faith effort to maintain and restore order, or maliciously and sadistically for the very purpose of causing harm.
    - Reasonableness
    - 6th Circuit: “Objective Reasonableness”
What five factors set forth by the US Supreme Court against which use of force incidents will be evaluated?

**Five Factors Set Forth by the US Supreme Court:***

1. **Threat Perceived by the Responsible Officer:**
   - Whether in the judgment of the officer, the threat perceived by the officer was such that the officer was justified in using force to prevent further harm.

2. **Reasonableness of Force:**
   - Whether it was reasonable to infer that force was necessary to resolve the exigency.

3. **Efforts to Temper Force:**
   - What efforts were made by officials to temper the forceful response.

4. **Amount of Force Used:**
   - Whether the force used was reasonable in relation to the need for force.

5. **Injuries Suffered:**
   - Whether injuries suffered by the officer were clearly of greater severity than the circumstances could plausibly justify.

**Rationale:**

The standard for use of force which applies to law enforcement officers working the streets is the 4th Amendment’s objective reasonableness; however, in jails and other correctional facilities, there is a far less demanding test. The standard for use of force in jails is the sadistic and malicious test which is based on the 8th Amendment (for convicted prisoners) and the 14th Amendment (for pretrial detainees). This standard for evaluating use of force in jails and other correctional facilities was established by the U.S. Supreme Court in *Whitley v. Albers* and *Hudson v. McMillian*. The court discussed the factors which must be used to evaluate the reasonableness of force. Those factors are those set forth above in the text of this standard.

**Compliance:**

Compliance with this standard can be achieved by:

1. Adopting and implementing written policies and procedures which include the five factors listed above.
2. Adopting and implementing a format for reporting use of force that requires each of the five factors to be separately addressed in the report.
3. Completion of use of force training for each jail officer that is taught using legal based guidelines as a premise.

**Annotation:**

First Amendment:

- Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof, or abridging the freedom of speech, or of the press, or the right of the people peaceably to assemble, and to petition the government for a redress of grievances.”

U.S. Supreme Court requires lower federal courts to give deference to the expertise, judgment, and discretion of corrections officials.

Before the courts can assume jurisdiction, they must consider “4” factors to determine whether a violation of the First Amendment exists.


**FACTS:**

**Turner v. Safley** Test

1. Is there a “valid, rational connection” between the regulation and the legitimate governmental interest put forward to justify it?
2. Are there alternative means of exercising the basic right that remain available to the inmate?
3. The impact accommodation of the asserted right will have on officers and other inmates and on the allocation of prison resources?
4. The existence of obvious, easy alternatives-“exaggerated response”

**MAIL DEFINITIONS**

- **Personal Mail Definition:**
  - All incoming and outgoing mail not from the inmate’s attorney
- **Privileged/Attorney Mail Definition:**
  - All incoming and outgoing mail from an inmate’s attorney of record, including their staff.
- **Misc. Privileged Mail Definition:**
  - Some states consider mail to and from the Attorney General, Elected Officials, Prosecutors and ACLU as “privileged.”
POSTCARDS (STILL A HOT TOPIC)

Arizona

  - Sheriff Arpaio’s mail policy that banned incoming letters and restricted incoming mail to metered postcards was reasonably related to legitimate governmental interests in reducing contraband and smuggling.

California (Ventura)

- *Garcia v. Pentis*
  - plaintiffs argue “…postcard rule is cruel and unusual punishment, subjecting inmates to unnecessary emotional and psychological distress and a sense of despair”
- State Supreme Court to rule in favor of Jail January 2012

Utah (Tucker v. Cache County)

- *Religious Correspondence*? (deeply spiritual matters)
- Various Options (3 ½ X 5 1/2; 11 X 5 ½)


Settled. Only incoming and publications.

Florida, Santa Rosa (Hamilton v. Hall)

Settled. Both postcards and regular mail

POSTCARDS

DO NOT IMPLEMENT “POSTCARD ONLY” POLICIES FOR LEGAL MAIL

- Define “legal/privileged” mail
- Define “official or business” mail
- Define “personal” mail

HAVE A SEPARATE POLICY ON PUBLICATIONS

PUBLICATIONS

Overview

- Individuals in the “free world” have a First Amendment right to correspond with inmates.
- However, those rights may be restricted when dealing with inmates.
- Any restriction(s) on mail of individuals corresponding with inmates must be “reasonable.”
- “IF” rejected, on an ISSUE by ISSUE basis.
- “IF” rejected:
  - entitled to notice;
  - reason for the rejection;
  - and opportunity to challenge to an individual of authority.

  + Reasonableness.
FIRST AMENDMENT: MAIL

Restricting Publications:

- Notification:
  - Provide inmate with reason for decision;
  - Provide the publisher with notice of the rejection and the specifics for the decision;
  - Allow the publisher and/or inmate to object/file a grievance with an individual of authority.

- Thornburgh v. Abbott, 490 U.S. 401 (1989);
- Montcalm Publishing v. Beck, 80 F.3d 105 (CA4 1996);
- Martin v. Kelley, 803 F.2d 236 (6th Cir. 1986);

FIRST AMENDMENT: PUBLICATIONS

Music Publications:

- **Frazier, Ortiz**, Civ. No. 10-1133 (Unpub. 10th Cir. March 28, 2011)
  - A sex offender was denied music publications thought to be sexually oriented.
  - Qualified immunity (inmate didn’t prove how his First Amendment rights were violated and he still received other publications not adverse to his rehabilitation).

  - An inmate’s rights may be violated when the facility denied him from receiving his comic book determined to be “violent”
    - Initially believed to be “too violent” (yet, Japanese children watched this comic strip on television)
  - LGI exists to prohibit mail containing material that might incite violence.
  - Other publications were allowed that depicted violence ("WWE, Guns and Ammo, Karate, Football Weekly and Boxing")
  - Case was remanded to determine if a LGI exists or whether the “violent mail” policy was an exaggerated response.

- **Van Den Bosch v. Raemisch**, Civ. No. 09-4112/10-1408 (7th Cir. September 15, 2011).
  - No First Amendment violation when inmates were denied receiving “The New Abolitionist” (aka “Wisconsin Prison Watch”).
  - A prison reform newsletter which arguably contains misleading information, encourages distrust of prison staff and could undermine the prison’s rehabilitative initiatives.
  - The inmates failed to show that classifying the publication as “harmful” was unreasonable.
**FIRST AMENDMENT: PUBLICATIONS**

- *PLN v. Fulton County*: Settles First Amendment Censorship Suit, Pays $149,759.21 (only $30,000 was for damages)
- *PLN v. Berkeley County and Sheriff DeWitt*: United States District Court of South Carolina—Civil Action No. 2:10-02594-MBS
  - PLN: ACLU; DOJ
  - Refusing the acceptance of publications that have staples
  - Refusing the acceptance of publications which depict sexual images (activity)
  - Daily Bread’s Publication contains staples; thereby denying religious access.
  - Due Process
  - Volume is relevant

**ISSUES:**
- Staples (who removes?)
- Jail denies (security; burdensome, staff intensive...)
- Plaintiffs argue no security threat or jail could remove
- Unsolicited (what to do?)
  - Obtaining copies of inmates name from internet and sending in mail

**PERIODICALS: SETTLEMENTS**

- *PLN v. Berkeley County and Sheriff DeWitt*: United States District Court of South Carolina—Civil Action No. 2:10-02594-MBS
  - DOJ argued that there should be unrestricted to any and all religious materials (even if unsolicited) and (even if the publication has staples) (i.e. Daily Bread; Prison Legal News...)
  - DOJ: 7,000 subscribers out of 2.3 million inmates (14 at the Berkeley County Jail)
  - Jail refused the acceptance of publications that had staples
  - Daily Bread’s Publications contain staples
  - Jail refused the acceptance of publications which depicted sexual images (activity)
  - Don’t use pornography (can’t define)
  - Due Process
  - Volume is relevant

**FIRST AMENDMENT: PUBLICATIONS**

- Your Rationale for rejecting is relevant:
  - Relying solely on fire safety arguments may not fly.
  - May still require notice to offender and publisher.
  - *Prison Legal News v. Cook*: 238 F.3d 1145 (9th Cir. 2001), held that publishers and prisoners “have a constitutionally protected right to receive subscription non-profit bulk mail and that a ban on bulk mail was unconstitutional as applied to such mail.”
  - *Morrison v. Hall*: 261 F.3d 896 (9th Cir. 2001) Oregon administrative rule which prohibited inmates from receiving bulk, third and fourth class mail was unconstitutional as applied to “pre-paid” and “for-profit” subscription publications (no rational connection between the postage rate and an increase in contraband)
    - “But prohibiting inmates from receiving mail based on the postage rate at which the mail was sent is an arbitrary means of achieving the goal of volume control.”
  - *Bahrampour v. Lamper*: 356 F.3d 969 (9th Cir. 2004)
    - The “right” of inmates to receive bulk mail was not clearly established law.
    - However, an outright denial of bulk mail is unconstitutional.

- *Prison Legal News v. Lehman*: 397 F.3d 692 (9th Cir. 2005)
  - Banning non-subscription bulk mail and catalogs did not meet the Turner requirements of being reasonably related to legitimate penological interests (increase paper accumulation-fire hazards; increase in contraband in bulk mail vs. 1st or 2nd class mail; increase in staff time)
  - If the inmate’s name is on the mail, it should be delivered-absent a legitimate penological interest. (Relevant—inmate requested the publication, not the fact that they didn’t pay for it.)
  - QI was granted for the non-subscription bulk-mail issue because at the time it was not clearly established law.
  - “This case was distinguishable from Jones v. North Carolina’s Prisoners’ Labor Union, Inc., 433 U.S. 119 (1977), in which the Supreme Court upheld a ban on junk mail sent indiscriminately to all inmates. In Jones the inmates were permitted to receive mail that was sent to them individually”
**FIRST AMENDMENT: PUBLICATIONS**

  - Jail’s policy of providing issues of PLN in their law library met the Turner requirements.
    - Length of stay was relevant (ALOS: 30.5 days - PLN takes 4 weeks to process subscriptions. Even longer term inmates still had access. No request for PLN was ever denied. Rather only 3 requests in one year.
  - Jail’s policy did not allow personal publications, but rather the jail subscribed to @32 different publications for the inmates to check out.
    - PLN was not part of the 32 but rather part of the law library.
  - Due Process requirements were met, even if not perfect, as PLN was offering “samples” of their publications.

- **Jones v. Salt Lake County**, Civ. No. 04-4185 (10th Cir, September 28, 2007)
  - Prison policy which rejected bulk mail except “for authorized subscriptions” did not violate the inmate’s rights.
    - Although “authorized subscriptions” was not defined, the policy referred to the “publisher’s only rule” requiring that the subscription come from the publisher.
  - Failure to deliver PLN was a result of human failure not the prison policy.

- **Hrdlicka v. Reniff**, Civ. No. 09-15768 (9th Cir, January 31, 2011)(cert denied)
  - Inmates and Crime, Justice & America claimed their First Amendment rights were violated when CJA, an unsolicited publication, was denied in two California jails.
  - District Court found in favor of Defendants, applying the Turner test.
    - Police prohibited the distribution of unsolicited publications regardless of content or postage rate.
    - Ninth Circuit overturned, saying defendants did not have legitimate governmental reasons for denying the unsolicited publication (32 counties allow it in). Calif DOC allows it.
  - CJA is delivered to jail and put in the common area or if not accepted, it is delivered directly to the inmate by obtaining a copy of the inmate roster. 1 periodical per 10 inmates.

- **Parkhurst v. Lampert**, Civ. No. 10-8078 (Unpub. 10th Cir. March 30, 2011)
  - Regardless of content, unsolicited bulk mailings may be withheld.
    - (Rationale: increase tensions and result in disruptive behavior)
FIRST AMENDMENT: PUBLICATIONS

Overview:
- Definitions Matter (personal vs. privileged)
- Have a policy regarding notification when publications are rejected requiring notice, reason for rejection and opportunity to appeal
- Consider subscribing to publications
- Review your state laws: are you restricted from allowing any type of advertisements (bonds etc...)?
- What is your policy on removing of staples?

ARRESTEE STRIP SEARCHES: IT’S GETTING EXCITING………
- “Arrestee” strip search cases were/are highly litigated!
  + Huge monetary awards
- The Supreme Court had not addressed this issue since its decision in Bell v. Wolfish in 1979.
  + History: Blanket strip search policy for all arrestees is unconstitutional absent reasonable suspicion to believe they are carrying drugs, weapons or contraband.
  + 4 federal court of appeals’ decisions forced the Supreme Court to finally rule on this issue.
    - See Powell (11th Cir.); Bull (9th Cir.); Florence (3rd Cir.) and Jimenez (5th Cir.)

STRIP SEARCH: JUSTIFICATION (HISTORY)
- General Rule: permitted when reasonable and furthers a legitimate penological interest
  - Bell v. Wolfish 441 U.S. 520, 558 (1979)
- The Court held that routine strip searching of pretrial detainees was not a per se violation of the Fourth Amendment prohibition against unreasonable searches and seizures.
- In articulating the balancing test applicable to such searches, the Court stated: The test of reasonableness under the Fourth Amendment is not capable of precise definition or mechanical application
ARRESTEE STRIP SEARCHES: CONSTITUTIONAL STANDARDS:  **BELL TEST**

- Balance need for the search against the invasion imposed on the inmate:
  - Institution’s need for the search; against
  - How intrusive is the search;
  - The manner in which the search is conducted; and
  - The place in which the search is to be conducted.
- More intrusive the search, the greater the institution’s need.
- Institution’s need is usually safety and security.
  - Prevention indiction of contraband into the facility

ARRESTEE STRIP SEARCHES:  **HISTORY**

- Rule:
  - Blanket strip searches of arrestees are unconstitutional absent reasonable suspicion to believe the arrestee is concealing drugs, weapons or contraband.
- Justification:
  - Permitted when reasonable and furthers a legitimate penological interest (safety, security...)

ARRESTEE STRIP SEARCHES:  **DEFINITION IS CRITICAL**

- The visual inspection of a disrobed or partially disrobed subject (no touching)
  + Subject may even have underwear on;
  + Any search of an area for which there exists a reasonable expectation of privacy (breast; opening the blouse; lifting bottom edge of panties and bra)
  + Called many things (strip search; clothing exchange, medical check)
- Amount of Intrusion (Very Intrusive)

*ARRESTEE STRIP SEARCHES: HISTORY
MOVING INTO GENERAL POPULATION: REASONABLE SUSPICION NOT REQUIRED*

- **Powell v. Barrett**, Civ. No. 05-16734 (11th Cir. September 4, 2008),
  - Sitting en banc, the Eleventh Circuit reversed its prior decisions and interpretation of Bell v. Wolfish.
  - Reasonable suspicion  **is not** required before strip searching an arrestee as part of the booking process and moving them into general population.
- **Bull v. City and County of San Francisco**, 2010 U.S. App. LEXIS 2684 (9th Cir. en banc February 9, 2010)
  - Reasonable Suspicion  **is not** required prior to moving arrestees into general housing: The policy is reasonable under the Fourth Amendment
  - **Edgerly v. City and County of San Francisco**, Civ. No. 05-15080, 05-15382 (9th Cir. March 19, 2010),
    - One month after the Bull decision, the Ninth Circuit reaffirmed prior precedent and prohibited the routine strip search of such individuals who were not being introduced into the general housing and jail population.
Florence v. Board of Chosen Freeholders of the County of Burlington, (566 U.S. - 2012)

- Reasonable suspicion is not required prior to moving arrestees into general population

The Court relied and upheld on Bell v. Wolfish and Turner v. Safley.
- In a 5-4 decision the Justices justify the strip searching of all arrestees entering “general population” for the following reasons:
  1. The prevention of disease, specifically MRSA. Of these three, the potential for smuggling of weapons, drugs, and other contraband poses the greatest security threat.
  2. The identification of gang members by observing their tattoos, and
  3. The detection and deterrence of smuggling weapons, drugs or other contraband into the facility.
- It was a case of first impression for the High Court.
- Deference/Substantial Deference to the administrator!!!!!

Justice Kennedy delivered the 5/4 opinion
- Correctional officials have a legitimate interest, indeed a responsibility, to ensure that jails are not made less secure by reason of what new detainees may carry in on their bodies, Facility personnel, other inmates, and the new detainee himself or herself may be in danger if these threats are introduced into the jail population.
- Strip Search defined/imprecise
- The difficulties of operating a detention center must not be underestimated by the courts. Turner v. Safley, 482 U.S. 78, 84–85 (1987). Jails (in the stricter sense of the term, excluding prison facilities) admit more than 13 million inmates a year.

The difficulties of operating a detention center must not be underestimated by the courts. Turner v. Safley, 482 U.S. 78, 84–85 (1987). Jails (in the stricter sense of the term, excluding prison facilities) admit more than 13 million inmates a year.
- Maintaining safety and order at these institutions requires the expertise of correctional officials, who must have substantial discretion to devise reasonable solutions to the problems they face. The Court has confirmed the importance of deference to correctional officials and explained that a regulation impinging on an inmate’s constitutional rights must be upheld “if it is reasonably related to legitimate penological interests.”
Jails are often crowded, unsanitary, and dangerous places. There is a substantial interest in preventing any new inmate, either of his own will or as a result of coercion, from putting all who live or work at these institutions at even greater risk when he is admitted to the general population.

People detained for minor offenses can turn out to be the most devious and dangerous criminals. Even if people arrested for a minor offense do not themselves wish to introduce contraband into a jail, they may be coerced into doing so by others. If, for example, a person arrested and detained for unpaid traffic citations is not subject to the same search as others, this will be well known to other detainees with jail experience. A hardened criminal or gang member can, in just a few minutes, approach the person and coerce him into hiding the fruits of a crime, a weapon, or some other contraband. Exempting people arrested for minor offenses from a standard search protocol thus may put them at greater risk and result in more contraband being brought into the detention facility. This is a substantial reason not to mandate the exception petitioner seeks as a matter of constitutional law.

It also may be difficult, as a practical matter, to classify inmates by their current and prior offenses before the intake search. Jails can be even more dangerous than prisons because officials there know so little about the people they admit at the outset. The record provides evidence that the seriousness of an offense is a poor predictor of who has contraband and that it would be difficult in practice to determine whether individual detainees fall within the proposed exemption.

This case does not require the Court to rule on the types of searches that would be reasonable in instances where, for example, a detainee will be held without assignment to the general jail population and without substantial contact with other detainee. The accommodations provided in these situations may diminish the need to conduct some aspects of the searches at issue. There also may be legitimate concerns about the invasiveness of searches that involve the touching of detainees. These issues are not implicated on the facts of this case, however, and it is unnecessary to consider them here.
CROSS GENDER SEARCHES: NEW IN 2011- YOUR DEFINITIONS ARE CRITICAL!!!!!

- Byrd v. Maricopa County Sheriff's Department, Civ. No 07-16640 (9th Cir. January 04, 2011)(Final)
- Cross Gender Strip Searches of inmates, absent an exigent circumstance, was ruled unconstitutional by the 9th Circuit.
- "If the search conducted were in fact a "pat-down" search of a partially clothed inmate, we would probably agree that the search was reasonable. However, because Byrd was subjected to a cross-gender strip search while nearly nude, we conclude that the search was patently unreasonable."
- The dissent is excellent.

AFTER FLORENCE: CARRIE'S "NON-LEGAL"ADVICE

Reasonable Suspicion is not required prior to moving an arrestee into general population
- Define "general population"
- Define "strip search" and "pat search"
- Verify that you do not have any current statutory language; standards; consent decrees that restrict you.
- If so, you must have them either amended or changed.
- Absent an exigent circumstance, cross gender strip searches are unconstitutional
- Do not strip arrestees returning with release orders
- There is a difference between a strip search and a "forced clothing removal"
- Do not conduct group strip searches
- Be ready for issues regarding transsexual, transgendered, intersex arrestees
- Pat Searches: females inmates-female officers; male inmates—either male or female correctional officers
- Provide training and testing on searches
- Draft legal based policies and procedures with rationale statements
- Professionalism and Respect for Privacy are Key
  - Bell v. Wolfish; Turner v. Safley; and Florence vs. Board of Chosen Freeholders are your key leading Supreme Court decisions regarding search. Use them! Articulate your rationale!

"ALTERNATIVE IMAGING TECHNOLOGY" THE STRIP SEARCH ALTERNATIVE?
- Being Used in Federal Facilities; Cook County, Collier County etc...
- Cost (scanner).
  - Less intrusive consistent with Bell v. Wolfish
  - Cost to buy v. Cost to pay out
    - (SCAT Monies: Forfeiture Monies: Leases)
- Unresolved questions about privacy.
- One jail: prior to eliminate arrestee strip AND pat searches with Imaging.
  - Jail interests: more thorough searches; less "hands on"; better contraband detection; reducing contraband potential in housing units
  - Reducing: No "don’t touch me" fights in booking?
  - "Manner and Place" Concerns
RELIGIOUS RIGHTS: OVERVIEW

- First Amendment:
  - Free Exercise of Religion; and
  - Establishment Clauses
- Supreme Court Decisions:
- RLUIPA:
  - Supreme Court Decision
    - Sossamon v. Texas, No. 08-1438 (U.S. April 20, 2011)

FREE EXERCISE CLAUSE: ELEMENTS

Turner v. Safley Test (Deference Expected)

1. Is there a ‘valid, rational connection’ between the regulation and the legitimate governmental interest put forward to justify it?
2. Are there alternative means of exercising the basic right that remain available to the inmate?
3. The impact accommodation of the asserted right will have on officers and other inmates and on the allocation of prison resources?
4. The existence of obvious, easy alternatives—“exaggerated response”

ESTABLISHMENT CLAUSE: ELEMENTS

- An action (institutional regulation) is unconstitutional if:
  - it lacks a secular (non-religious) purpose,
  - its primary effect either advances or inhibits religion; or
  - it fosters an excessive entanglement of government with religion.

Lamb v. Arpaio, CV-09-0052 (D. Ariz. 2009)

Constant and continuous playing of Christmas music between 9am-7pm in the day room, was not a violation of the Establishment Clause:
“[n]o government shall impose a substantial burden on the religious exercise of a person residing in or confined to an institution” unless the burden “is in furtherance of a compelling governmental interest” and “is the least restrictive means” of furthering that interest. 42 U.S.C. §2000cc-1(a).

In a unanimous decision by the United States Supreme Court, Justice Ginsberg delivering the opinion stated: “On its face,”...“the Act [RLUIPA] qualifies as a permissible legislative accommodation of religion that is not barred by the Establishment Clause.”

Has the policy substantially burdened the exercise of the religion? Inmate Proves

If “yes” does the regulation create a substantial burden on the prisoner’s free exercise of religion, then officials must have a compelling governmental interest for its actions. Jail/Prison Proves

If “yes” then the religious practice must be restricted in the least restrictive means. Jail/Prison Proves
  - Use objective criteria; and
  - Make a genuine effort to consider alternatives.

Not all regulation of religious activity or expression triggers the protection of RLUIPA.

The statutory protections of RLUIPA are required only if restrictions impose a substantial burden on a prisoner’s religious practices.
There is no reason to anticipate that abusive prisoner litigation will overburden state and local institutions. However, should inmate requests for religious accommodations become excessive, impose unjustified burdens on other institutionalized persons, or jeopardize an institution's effective functioning, the facility would be free to resist the imposition. In that event, adjudication in as-applied challenges would be in order. Pp. 13-16. Cutter v. Wilkinson, U.S. (2007)

1. Has the policy substantially burdened the exercise of the religion? Inmate must prove.
   A. The Supreme Court “assumed” that the religions in question were bona fide religions. (Nonmainstream religions involved in Cutter: Satanist; Wicca; Asatru; and Church of Jesus Christ Christian)

   B. Is the burdened activity “religious exercise”? Religious Exercise defined: “any exercise of religion, whether or not compelled by, or central to, a system of religious belief.”
   No matter what, the inmate does not have to prove that the “exercise” is “compelled by or central to” their religious beliefs.

   Although RLUIPA bars inquiry into whether a particular belief or practice is “central” to a prisoner's religion, the Act does not preclude inquiry into the sincerity of a prisoner’s professed religiosity. Cutter v. Wilkinson, 544 U.S. 709, 725 (U.S. 2005).

1. Has the policy substantially burdened the exercise of the religion? Inmate must prove.
   A. Is the religion “bona fide”? Interesting Question
   B. Is the burdened activity “religious exercise”?
   C. If so, is the burden “substantial”?
   “Sincerity of Belief”? SC explained that a burden on religious exercise is “substantial” and, therefore, impermissible when it influences an adherent to act in a way that violates his or her sincerely held religious beliefs. (Bitner v. Williams; Kosher kitchen example-wearing gloves?)
C. If so, is the burden “substantial”? “Sincerity of Belief”?

- SC explained that a burden on religious exercise is “substantial” and, therefore, impermissible when it influences an adherent to act in a way that violates his or her sincerely held religious beliefs.
- RLUIPA does not permit the assumption that because an adherent lacks sincerity or “religiosity” with respect to one practice does not mean that they lack sincerity with respect to other tenants of their faith. See 42 U.S.C. § 2000cc-5(7)(A) (“providing protection for “any exercise of religion”) (emphasis added); see also Reed v. Faulker, 642 F.2d 960, 963 (7th Cir. 1981) (recognizing “the fact that a person [who] does not adhere steadfastly to every tenant of his faith” may still be sincere about participating in some religious practices”.

**RLUIPA TEST**

1. Has the policy substantively burdened the exercise of the religion? Inmate Proves

2. If “yes” does the regulation create a substantial burden on the prisoner’s free exercise of religion, then officials must have a compelling governmental interest for its actions. Jail/Prison Proves

3. If “yes” then the religious practice must be restricted in the least restrictive means.

   + Use objective criteria; and
   + Make a genuine effort to consider alternatives.

**CHAPLAINS**

- **Maddox v. Love**, Civ. No 10-1139 (7th Cir. 2011)
  - “Prisons need not provide every religious sect or group within a prison with identical facilities or personnel and need not employ chaplains representing every faith among the inmate population.

- **McCollum v. California DOC**, 647 F.3d 870 (9th Cir. 2011)
  - A Wiccan chaplain lacked standing to claim that hiring only chaplains of the five major faith, Protestant, Catholic, Jewish, Muslim and Native American religions was unconstitutional.
PERIODICALS: SETTLEMENT

- **PLN v. Berkeley County and Sheriff DeWitt**, (United States District Court of South Carolina - Civil Action No. 2:10-02594-MBS)
  - PLN; ACLU; DOJ together
  - DOJ argued that there should be unrestricted access to any and all religious materials (even if unsolicited) and (even if the publication has staples) (i.e. Daily Bread, Prison Legal News...)
  - PLN: 7,000 subscribers out of 2.3 million inmates (14 at the Berkeley County Jail)
  - Jail refused the acceptance of publications that had staples
  - Daily Bread's Publications contain staples
  - Jail refused the acceptance of publications which depicted sexual images (activity)
  - Don't use pornography (can't define)
  - Due Process
  - Volume is relevant

JUDAISM: PRIVATE PROVIDERS

- **Florer v. Congregation Pidyon Shevuyim**, Civ. No. 07-35866 (9th Cir. April 15, 2011)
  - Inmates at the Washing DOC sued private religious contractors for failing to recognize them as "Jewish" therefore denying them the ability to have access to the Torah, visit from a Rabbi, Jewish calendar etc...
  - Services will be open to all offenders, however, the Jewish authorities will determine who can participate in liturgical related activities.
  - The 9th Circuit disagreed finding that the private religious providers were "private parties" and not state actors, and did not "foster or further" any government policy. They therefore could not be sued for allegedly violating the prisoner's civil rights.
  - But the record indicates that Florer had the opportunity to make phone calls and write letters to contact religious organizations outside the prison, and that he actually did so. There is nothing in the record that indicates that Defendants blocked his access to other religious communities or his ability to request religious materials and information from other individuals and

ISLAM/MUSLIMS: NOT OBSERVANT

- **Hall v. Ekpe**, Civ. No. 09-4492 (Unpub. 2nd Cir. December, 2010)
  - Officials were successful in denying an inmate participation in Ramadan as a result of not being an "observant Muslim".
  - Must have attended 3 of the 4 Jumu’ah prayer services.
  - Allowed to observe Ramadan and pray on his own.
  - They articulated legitimate governmental interests.
    - 1) security by reducing unnecessary inmate movement;
    - 2) economy by minimizing unnecessary expenses associated with providing Ramadan privileges.
  - The prison did not bar the prisoner from observing Ramadan by fasting and praying on his own, and when he later resumed regularly attending Friday prayer meetings, he was again allowed to participate in subsequent formal prison Islamic activities, "including the post-Ramadan fast of Shawwal."

RLUIPA: MISC.

- **PIERCINGS**
  - **Cortez v. Noll**, Civ. No. 09-15690 (Unpub. 9th Cir. August 22, 2010)
    - Case was remanded to determine whether a "compelling" governmental interest existed in requiring an inmate to remove his body piercings violated RLUIPA.

- **SERVICES**
  - **Chemtob v. Nevada**, Civ. No. 08-38330 (Unpub. 9th Cir. July 23, 2010)
    - Case was remanded to determine whether a "compelling" governmental interest existed in denying an inmate access to a sweat lodge.
  - *Tyson v. Gustashaw*, 509 WL 1584212 (9th Cir. 2009)
    - Remanded to determine if the inmate's rights under RLUIPA were violated for not being allowed to attend Friday Jum'ah prayers for a period of one year.

- **TAROT CARDS**
  - **Singson v. Norris**, 553 F.3d 660 (8th Cir. 2009)
    - No violation of RLUIPA or the First Amendment when Tarot cards were denied in an inmate's cell for his use but were allowed during the Chaplain service.

- **HEADCOVERINGS**
  - **Khabb v. County of Orange, et al** Civ. No. 08-56423 (9th Cir: March 15, 2011)
    - RLUIPA applies to temporary holding facilities.
  - The case was remanded to the district court to determine if security concerns justified prohibiting the plaintiff from wearing her hijab.

- **Sovereign Immunity; Rule of Unequivocal Waiver**
  - **Sossamon v. Texas**, No. 08-1438 (U.S. April 20, 2011)
    - RLUIPA does not contain an unambiguous waiver of sovereign immunity, so it does not authorize individuals to recover money damages against a state.
MUST YOU PROVIDE A RELIGIOUS DIET? QUICK OVERVIEW

- **“Yes”** according to Fegans v. Norris, Civ. No. 06-3473 (8th Cir. August 11, 2008). Failure to provide a kosher diet to a follower of the Assemblies of Yahweh was a violation of RLUIPA.

- **“Maybe”** according to Wofford v. Williams, 2008 U.S. Dist. Lexis 63946 (D.O., 2008). Argument that all 7th Day Adventists want a kosher meal, cost too high, is not persuasive to the court.

- **“No”** according to Linehan v. Crosby, 2008 U.S. Dist. LEXIS 63738 (N.D. Fl., 2008) Providing a 7th Day Adventist a vegan/vegetarian diet instead of a kosher diet-OK. Cost of providing kosher diets for Florida DOC, too costly (CGI). No kosher meals were provided.

- **“Yes”** according to Nelson v. Miller, Civ. No. 08-2044 (7th Cir. July 1, 2009). Failing to provide a religious diet and meat free meals to a strict catholic (monk).  
  - Remanded to determine if CCI existed

- **“No”** according to Miles v. Aramark, Civ. No. 07-33622 (Unpub. 3rd Cir. 2009), Aramark “substantially performed” its obligations to provide kosher meals.  
  - Inmate received 23 out of 25 meals.

- **“No”** according to Daly v. Davis, Civ. No. 08-2046 (unpub. 7th Cir. 2009), District court upheld suspension of inmate’s kosher meals when he was found buying and eating non-kosher food on 3 different occasions.  
  - The rules were not a substantial burden.
**MUST YOU PROVIDE A RELIGIOUS DIET? QUICK OVERVIEW**

- **Yes then No-Festivus**: Orange County, CA
  - Bona Fide Religion?
  - Sincerity
  - If the Judge can’t figure it out….how are we?
  - No violation for two week delay in providing the kosher meal. Validating the sincerity of the inmate’s belief justified the delay.
  - Cold and meals lacking “variety” also did not violate the inmate’s rights.
- **Yes-Vinning-Ev v. Evans**, Civ. No 10-1881 (7th Cir. September 16, 2011)
  - Morrish Science Temple asked for a vegan diet. Chaplain denied it saying the religion allows for members to eat a variety of fish and meat. Remanded. It is not the Chaplain’s interpretation of the faith that is relevant but the sincerity “espoused” by the inmate.

  - The district court granted the defendants’ motion for summary judgment, finding that the decision to restrict Kosher meals to prisoners registered as Orthodox Jews had a reasonable relationship to the legitimate penological interest of cost control for budgetary reasons.

- **No-Gallagher v. Shelton**, 587 F.3d 1063 (10th Cir. 2009).
  - Isolated acts of negligence, in which prison officials failed to approve the state prisoner’s requests for religious accommodations in a timely fashion, did not amount to a violation of the prisoner’s right to free exercise of religion:
    - (failed to approve a request for fried foods (until after the holiday); failed to provide two sack lunch accommodations for religious fasting (until after the holiday); improper cleaning of kosher utensils and non-Kosher utensils.
  - Not a custom, policy or practice. The omissions were seen as individual violations and not a custom, policy or practice. No intent to deliberately contaminate the kosher utensils.
**RLUIPA: RELIGIOUS DIETS**

- **Fairly Safe Guide to Providing a Religious Diet:**
  - Assuming it is a *Bona Fide Religion*;
  - Assuming Sincerity of Belief Is Not In Question;
  - Absent a safety and security reason (compelling governmental reason), err on the side of the diet.
  - Encourage the use of a contract and commissary monitoring.

**SOVEREIGN IMMUNITY**

Sovereign Immunity: Rule of Unequivocal Waiver

- **Sossamon v. Texas.** No. 08–1438 (U.S. April 20, 2011)

  + RLUIPA does not contain an unambiguous waiver of sovereign immunity, so it does not authorize individuals to recover money damages against a state.

**DOJ PRESS RELEASE ON PREA: MAY 17, 2012**

The Justice Department today released a final rule to prevent, detect and respond to sexual abuse in confinement facilities, in accordance with the Prison Rape Elimination Act of 2003 (PREA). This landmark rule sets national standards for four categories of facilities:

- adult prisons and jails.
- lockups,
- community confinement facilities and
- juvenile facilities.

Today’s rule is the first-ever federal effort to set standards aimed at protecting inmates in all such facilities at the federal, state and local levels.
PREA:

- The statute directs the Attorney General to publish a final rule adopting “national standards for the detection, prevention, reduction, and punishment of prison rape . . . 42 U.S.C. 15607(a)(1)-(2).
- However, the standards may not “impose substantial additional costs compared to the costs presently expended by Federal, State, and local prison authorities.” 42 U.S.C. 15607(a)(3).

PREA: FINAL STANDARDS RELEASED

- DOJ standards released on May 17th, 2012
  + The Prison Rape Elimination Act of 2003, §42 U.S.C 15601
- Published: June 20th, 2012
- Effective Date: August 20th, 2012
- “Compliance” Date: August, 20th 2013
- 1st Set of Audits (1/3rd): August 20th 2014
- All Facilities Audited: August 20th 2016

PREA: EFFECTIVE DATE

- Effective Date:
  + Federal Facilities-Immediate
    + 42 USC 15607(b)
  + 60 Days after registered.
    + Registered: June 20th, 2012
    + Official: August 20th, 2012

PREA: EXECUTIVE SUMMARY: LEADERSHIP

- The success of the PREA standards in combating sexual abuse in confinement facilities will depend on effective agency and facility leadership, and the development of an agency culture that prioritizes efforts to combat sexual abuse.
- Effective leadership and culture cannot, of course, be directly mandated by rule. Yet implementation of the standards will help foster a change in culture by institutionalizing policies and practices that bring these concerns to the fore.
PREA: EXECUTIVE REPORT
INCREASE IN INCIDENTS MEANS ???

- An increase in incidents reported to facility administrators might reflect increased abuse, or it might just reflect inmates’ increased willingness to report abuse, due to the facility’s success at assuring inmates that reporting will yield positive outcomes and not result in retaliation.
- Likewise, an increase in substantiated incidents could mean either that a facility is failing to protect inmates, or else simply that it has improved its effectiveness at investigating allegations.
- For these reasons, the standards generally aim to inculcate policies and procedures that will reduce and ameliorate bad outcomes, recognizing that one possible consequence of improved performance is that evidence of more incidents will come to light.

PREA: EXECUTIVE SUMMARY
BEST PRACTICES VS. CONSTITUTIONAL

- The standards are not intended to define the contours of constitutionally required conditions of confinement. Accordingly, compliance with the standards does not establish a safe harbor with regard to otherwise constitutionally deficient conditions involving inmate sexual abuse.
- Furthermore, while the standards aim to include a variety of best practices, they do not incorporate every promising avenue of combating sexual abuse, due to the need to adopt national standards applicable to a wide range of facilities, while taking costs into consideration.
- The standards consist of policies and practices that are attainable by all affected agencies, recognizing that agencies can, and some currently do, exceed the standards in a variety of ways. The Department applauds such efforts, encourages agencies to adopt or continue best practices that exceed the standards, and intends to support further the identification and adoption of innovative methods to protect inmates from harm.

CONSTITUTIONAL REQUIREMENT (DIFFERENT FROM PREA)

- “Prison conditions may be “restrictive and even harsh,” Rhodes, supra, at 347, but gratuitously allowing the beating or rape of one prisoner by another serves no “legitimate penological objectiv[e],” Hudson v. Palmer at 548.
- “Being violently assaulted in prison is simply not “part of the penalty that criminal offenders pay for their offenses against society.” Rhodes at 347. Farmer v. Brennen.

CONSTITUTIONAL REQUIREMENT: TEST

8th Amendment protects against cruel & unusual punishment.

- Conditions violate the 8th Amendment if:
  1. The prisoner suffered “sufficiently serious harm” (deprived of an essential human need); and
  2. Correctional officials were “deliberately indifferent” to the rights, health or safety of the prisoner.
Prisoner suffered **serious harm or substantial risk of serious harm**

- "...a prisoner can establish exposure to a sufficiently serious risk of harm 'by showing that he belongs to an identifiable group of prisoners who are frequently singled out for violent attack by other inmates'.
- If, for example, prison officials were aware that inmate "rape was so common and uncontrolled that some potential victims dared not sleep [but] instead . . . would leave their beds and spend the night clinging to the bars nearest the guards’ station." Farmer citing *Hutto v. Finney*, 437 U.S. 678, 681-682n. 4 (1978)

**FARMER: THE SUBJECTIVE TEST**

- "The second requirement follows from the principle that **only the unnecessary and wanton infliction of pain** implicates the Eighth Amendment." *Wilson v. Seiter*, 501 U.S. 294 (1991)
- In prison conditions cases that **state of mind** is one of “deliberate indifference” to inmate health or safety. *Wilson*

**FARMER: THE SUBJECTIVE TEST**

- Had knowledge of a substantial risk of harm
  + Knew or drew inference of need
  + Knew or drew inference that actions or inactions would consciously disregard need
  + Knowledge is a “Question of Fact”
  + Circumstantial evidence is relevant
  + Current conduct and attitude affects availability of Prospective Relief
**FARMER: THE SUBJECTIVE TEST**

- Knowingly or recklessly disregarded the substantial risk by failing to take reasonable measures to abate the risk
  - Aware of risk from the facts, and
  - Drew the inference that risk existed and
  - Action or inaction caused the harm

**PREA: TO WHOM DOES THE ACT APPLY TO?**

- The standards contained in this final rule apply to facilities operated by, or on behalf of, State and local governments and the Department of Justice.
- Definition of “prison” as “any confinement facility of a Federal, State, or local government, whether administered by such government or by a private organization on behalf of such government.” 42 U.S.C. 15609

---

**PREA: TO WHOM DOES THE ACT APPLY TO?**

**YES** - It applies to Jails

**PREA: APPLIES TO ALL JAILS**

- The final standard also extends to all jails (rather than, as in the proposed standards, only those jails whose rated capacity exceeds 500 inmates)
PREA: ENFORCEMENT FOR STATE

- Governor of any State who does not certify full compliance with the standards is subject to the loss of 5% of Federal Funding of any DOJ Grant funds otherwise received for prison purposes.
- Unless Governor submits an assurance that the 5% will be used for purposes of enabling the state to achieve and certify full compliance with the standards in future years.
- The final rule specifies that the Governor’s certification applies to all facilities in the State under the operational control of the State’s executive branch, including facilities operated by private entities on behalf of the State’s executive branch. In addition, any correctional accreditation organization that seeks Federal grants must adopt accreditation standards regarding sexual abuse that are consistent with the national standards in this final rule. 42 U.S.C. 15608.

WHO IS COMPULLED TO COMPLY?

- Feds only have the ability to impose financial penalties on states for non-compliance of state controlled facilities.
- County and local jurisdictions don’t offer that same opportunity for Feds to impose such penalties.

COMPLIANCE

- State facilities
  - Includes facilities contracting with state
  - Potentially includes all adult, juvenile and community-based facilities “under the operational control of the state
  - This includes private contractors
  - Inmates housed in another state

PENALTIES FOR NON-COMPLIANCE

- Governor must certify compliance of facilities under the operational control of state
- 5% penalty imposed
- Demonstrate such dollars are going toward compliance
- No equivalent penalty for local jurisdictions
**PREA: ENFORCEMENT FOR JAILS**

- PREA is not Mandatory for Jails
  - It is VOLUNTARY
- There are no Penalties for the Jail
  - Potential “Consequences”
    - Potential for Increased Liability in the event of a §1983 action
    - Potential the Court will find “lack of compliance” with the PREA standards as “Indifference” Knew and were indifferent
    - If you house “State” inmates, the State could either require the jails to comply with PREA or loose the potential to hold STATE inmates. Loss of $$$$$$$$

**COMPLIANCE**

- Jails
  - County operational control
- Police Lockups
  - Local jurisdictional control

**COMPLIANCE**

- Juvenile facilities
  - Typically under state control
  - Applies to private contractors
- Community-based facilities

**PREA: DEFINITIONS-INMATE**

- “Inmate” as “any person incarcerated or detained in any facility who is accused of, convicted of, sentenced for, or adjudicated delinquent for, violations of criminal law or the terms and conditions of parole, probation, pretrial release, or diversionary program.” 42 U.S.C. 15609(2).
- this language does not necessitate the adoption of standards to govern probation, parole, pretrial release, or diversionary programs. To be sure, former inmates may report to a parole officer sexual abuse that occurred while they were in a confinement facility. However, former inmates—unlike current inmates—generally possess ample ability to report abuse through the same channels as any other person living in the community.
**PREA: INTENT**

- **INTENT** of the PREA Standards:
  - PREVENT
  - DETECT
  - RESPOND to sexual abuse

**PREA: SEXUAL ABUSE DEFINITION**

- Sexual abuse includes—
  - (1) **Sexual abuse** of an inmate, detainee, or resident by another inmate, detainee, or resident; and
  - (2) **Sexual abuse** of an inmate, detainee, or resident by a staff member, contractor, or volunteer.

**PREA: SEXUAL ABUSE BY INMATE**

- **Sexual abuse** of an inmate, detainee, or resident by another inmate, detainee, or resident includes any of the following acts, if the victim does not consent, is coerced into such act by overt or implied threats of violence, or is unable to consent or refuse:
  - (1) Contact between the penis and the vulva or the penis and the anus, including penetration, however slight;
  - (2) Contact between the mouth and the penis, vulva, or anus;
  - (3) Penetration of the anal or genital opening of another person, however slight, by a hand, finger, object, or other instrument; and
  - (4) Any other intentional touching, either directly or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or the buttocks of another person, excluding contact incidental to a physical altercation.

**PREA: SEXUAL ABUSE BY STAFF ....**

- **Sexual abuse** of an inmate, detainee, or resident by a staff member, contractor, or volunteer includes any of the following acts, with or without consent of the inmate, detainee, or resident: (1) Contact between the penis and the vulva or the penis and the anus, including penetration, however slight; (2) Contact between the mouth and the penis, vulva, or anus; (3) Contact between the mouth and any body part where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire; (4) Penetration of the anal or genital opening, however slight, by a hand, finger, object, or other instrument, that is unrelated to official duties or where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire;.
(5) Any other intentional contact, either directly or through the clothing, of or with the genitalia, anus, groin, breast, inner thigh, or the buttocks, that is unrelated to official duties or where the staff member, contractor, or volunteer has the intent to abuse, arouse, or gratify sexual desire; (6) Any attempt, threat, or request by a staff member, contractor, or volunteer to engage in the activities described in paragraphs (1)–(5) of this section; (7) Any display by a staff member, contractor, or volunteer of his or her uncovered genitalia, buttocks, or breast in the presence of an inmate, detainee, or resident; and (8) Voyeurism by a staff member, contractor, or volunteer.

(8) Voyeurism by a staff member, contractor, or volunteer.

Voyeurism by a staff member, contractor, or volunteer means an invasion of privacy of an inmate...by staff for reasons unrelated to official duties, such as peering at an inmate who is using a toilet in his or her cell to perform bodily functions; requiring an inmate to expose his or her buttocks, genitals, or breasts; or taking images of all or part of an inmate’s naked body or of an inmate performing bodily functions.

Sexual harassment includes—

(1) Repeated and unwelcome sexual advances, requests for sexual favors, or verbal comments, gestures, or actions of a derogatory or offensive sexual nature by one inmate, detainee, or resident directed toward another; and

(2) Repeated verbal comments or gestures of a sexual nature to an inmate, detainee, or resident by a staff member, contractor, or volunteer, including demeaning references to gender, sexually suggestive or derogatory comments about body or clothing, or obscene language or gestures.

Develop and maintain a zero-tolerance policy regarding sexual abuse; Designate a PREA point person to coordinate compliance efforts; Screen inmates for risk of being sexually abused or sexually abusive, and use screening information to inform housing, bed, work, education and program assignments; Develop a staffing plan that provides for adequate levels of staffing and, where applicable, video monitoring; Train employees on their responsibilities in preventing, recognizing and responding to sexual abuse; Perform background checks on prospective employees and not hire abusers; Prevent juveniles from being housed with adult inmates or having unsupervised contact with adult inmates in common spaces; Ban cross-gender pat-down searches of female inmates in prisons and jails and of both male and female residents of juvenile facilities; Incorporate unique vulnerabilities of lesbian, gay, bisexual, transgender, intersex and gender nonconforming inmates into training and screening protocols; Enable inmates to shower, perform bodily functions and change clothing without improper viewing by staff of the opposite gender; Restrict the use of solitary confinement as a means of protecting vulnerable inmates; and Enter into or renew contracts only with outside entities that agree to comply with the standards.
PREA: EXECUTIVE SUMMARY

To ensure that preventing sexual abuse receives appropriate attention, the standards require that each agency and facility designate a PREA point person with sufficient time and authority to coordinate compliance efforts.

PREA: SCREENING

§ 115.41 Screening for risk of victimization and abusiveness. (a) All inmates shall be assessed during an intake screening and upon transfer to another facility for their risk of being sexually abused by other inmates or sexually abusive toward other inmates. (b) Intake screening shall ordinarily take place within 72 hours of arrival at the facility. (c) Such assessments shall be conducted using an objective screening instrument.

PREA: DEFINITIONS-PREA COORDINATOR VS. PREA COMPLIANCE MANAGER

- Coordinator:
  - Not a full time position
  - “sufficient time and authority” to perform the required responsibilities
  - Must have access to Leadership at a high level to be set by the agency and the ability to exercise change.

- Compliance Manager
  - Where an agency has multiple facilities, a “point person” must be designated.
  - The final standard also requires that any agency that operates more than one facility (regardless of agency size) designate a PREA compliance manager at each facility with sufficient time and authority to coordinate the facility’s efforts to comply with the PREA standards.
  - Does not need to be an upper management position of authority as the PREA Coordinator must be.

PREA: USE OF SCREENING INFO

- The agency shall use information from the risk screening required by § 115.41 to inform housing, bed, work, education, and program assignments with the goal of keeping separate those inmates at high risk of being sexually victimized from those at high risk of being sexually abusive.
- The agency shall make individualized determinations about how to ensure the safety of each inmate.
- In deciding whether to assign a transgender or intersex inmate to a facility for male or female inmates, and in making other housing and programming assignments, the agency shall consider on a case-by-case basis whether a placement would ensure the inmate’s health and safety, and whether the placement would present management or security problems.
PREA: USE OF SCREENING INFO

- (d) Placement and programming assignments for each transgender or intersex inmate shall be reassessed at least twice each year to review any threats to safety experienced by the inmate.
- (e) A transgender or intersex inmate’s own views with respect to his or her own safety shall be given serious consideration.
- (f) Transgender and intersex inmates shall be given the opportunity to shower separately from other inmates. (g) The agency shall not place lesbian, gay, bisexual, transgender, or intersex inmates in dedicated facilities, units, or wings solely on the basis of such identification or status, unless such placement is in a dedicated facility, unit, or wing established in connection with a consent decree, legal settlement, or legal judgment for the purpose of protecting such inmates.

PREA: PROTECTIVE CUSTODY

- (a) Inmates at high risk for sexual victimization shall not be placed in involuntary segregated housing unless an assessment of all available alternatives has been made, and a determination has been made that there is no available alternative means of separation from likely abusers. If a facility cannot conduct such an assessment immediately, the facility may hold the inmate in involuntary segregated housing for less than 24 hours while completing the assessment. (b) Inmates placed in segregated housing for this purpose shall have access to programs, privileges, education, and work opportunities to the extent possible. If the facility restricts access to programs, privileges, education, or work opportunities, the facility shall document: (1) The opportunities that have been limited; (2) The duration of the limitation; and (3) The reasons for such limitations.

- (c) The facility shall assign such inmates to involuntary segregated housing only until an alternative means of separation from likely abusers can be arranged, and such an assignment shall not ordinarily exceed a period of 30 days. (d) If an involuntary segregated housing assignment is made pursuant to paragraph (a) of this section, the facility shall clearly document: (1) The basis for the facility’s concern for the inmate’s safety; and (2) The reason why no alternative means of separation can be arranged. (e) Every 30 days, the facility shall afford each such inmate a review to determine whether there is a continuing need for separation from the general population.

PREA: SUPERVISION AND MONITORING

+ The final standard requires each prison, jail, and juvenile facility to develop and document a staffing plan that provides for adequate levels of staffing, and, where applicable, video monitoring, to protect inmates against sexual abuse.
The facility is in the best position not only to determine the need for such technology but also to determine how and where to place cameras. The Department recognizes that technology is best utilized to supplement, but not replace, staff supervision.

Camera surveillance is a powerful deterrent and a useful tool in post-incident investigations. But it cannot substitute for more direct forms of staff supervision (in part because blind spots are inevitable even in facilities with comprehensive video monitoring), and cannot replace the interactions between inmates or residents and staff that may prove valuable at identifying or preventing abuse.

In addition, cameras generally do not translate into a reduction of staff levels—additional staff may be required to properly monitor the new cameras. Indeed, many cameras in correctional facilities are currently not continuously monitored. While the Department encourages increased use of video monitoring technology to supplement sexual abuse prevention, detection, and response efforts, the agency is in the best position to determine if current or future funds are best directed at increasing the agency’s use of technology.

115.15 requires that all facilities implement policies and procedures that enable inmates to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in the case of emergency (now reworded as “exigent circumstances”) or when such viewing is incidental to routine cell checks.

Such policies and procedures shall require staff of the opposite gender to announce their presence when entering an inmate housing unit (for jails and prisons) or an area where detainees or residents are likely to be showering, performing bodily functions, or changing clothing. Accordingly, no staff should monitor a camera that is likely to view inmates of the opposite gender while they are showering, performing bodily functions, or changing clothing.

In calculating adequate staffing levels and determining the need for video monitoring, facilities must consider several factors, including: (1) generally accepted detention and correctional practices; (2) any judicial findings of inadequacy; (3) any findings of inadequacy from Federal investigative agencies; (4) any findings of inadequacy from internal or external oversight bodies; (5) all components of the facility’s physical plant (including “blind spots” or areas where staff or inmates may be isolated);
Staffing Levels:
- (6) the composition of the inmate population; (7) the number and placement of supervisory staff; (8) institution programs occurring on a particular shift; (9) any applicable State or local laws, regulations, or standards; (10) the prevalence of substantiated and unsubstantiated incidents of sexual abuse; and (11) any other relevant factors. Prisons and jails must use “best efforts” to comply with the staffing plan on a regular basis and are required to document and justify deviations from the staffing plan.

Given the intricacies involved in formulating an adequate staffing plan, the Department does not include specific staffing ratios for adult facilities in the final standard.

The final determination as to adequate staffing levels remains in the discretion of the facility or agency administration. In addition, the facility is encouraged to reassess its staffing plan as often as necessary to account for changes in the facility’s demographics or needs.

With regard to the cost of staffing, the Department notes that the Constitution requires that correctional facilities provide inmates with reasonable safety and security from violence, see Farmer v. Brennan, 511 U.S. 825, 832 (1994), and sufficient staff supervision is essential to that requirement.

“best efforts to comply on a regular basis” (best practices vs. constitutional"

the final standard requires that, at least annually, the agency must assess, determine, and document whether adjustments are needed to the staffing plan, but does not require implementation of such adjustments.
PREA: UNANNOUNCED SUPERVISORY ROUNDS

- The requirement of unannounced supervisory rounds to identify and deter staff sexual abuse and sexual harassment.
  + How often determined by agency
  + Intermediate level or higher-level supervisors conduct and document unannounced rounds.
- In order to address concerns that some staff members might prevent such rounds from being “unannounced” by providing surreptitious warnings, the final standard adds a requirement that agencies have a policy to prohibit staff members from alerting their colleagues that such supervisory rounds are occurring, unless such announcement is related to the legitimate operational functions of the facility.

PREA: DEFINITIONS-YOUTHFUL INMATES

- Sections 115.14 and 115.114 regulate the placement of persons under the age of 18 in adult prisons, jails, and lockups. The final rule refers to under-18 persons in such facilities as “youthful inmates” (in adult prisons and jails).
  + Standard that restricts, but does not forbid, the placement of juveniles in adult facilities. The standard applies only to persons under the age of 18 who are under adult court supervision and incarcerated or detained in a prison, jail, or lockup. Such persons are, for the purposes of this standard, referred to as “youthful inmates” (or, in lockups, “youthful detainees”).

PREA: YOUTHFUL INMATES

- The standard imposes three requirements for juveniles placed in adult prisons or jails.
  + First:
    × It mandates that no youthful inmate may be placed in a housing unit in which he or she will have contact with any adult inmate through use of a shared day room or other common space, shower area, or sleeping quarters.

PREA: YOUTHFUL INMATES

- Second:
  + It requires that, outside of housing units, agencies either maintain “sight and sound separation” between youthful inmates and adult inmates—i.e., prevent adult inmates from seeing or communicating with youth—or provide direct staff supervision when youthful inmates and adult inmates are together.
PREA: YOUTHFUL INMATES

Third:
+ it requires that agencies make their best efforts to avoid placing youthful inmates in isolation to comply with this provision and that, absent exigent circumstances, agencies comply with this standard in a manner that affords youthful inmates daily large-muscle exercise and any legally required special education services, and provides access to other programs and work opportunities to the extent possible.

PREA: SEARCHES

DEFINITIONS MATTER:
- PAT SEARCH
- STRIP SEARCH
- EXIGENT CIRCUMSTANCES

PREA: SEARCHES

- Pat-down search:
  + means a running of the hands over the clothed body of an inmate, detainee, or resident by an employee to determine whether the individual possesses contraband.
PREA: Searches

- **Pat Searches:**
  + ban on cross-gender pat-down searches of female inmates in adult prisons and jails and in community confinement facilities, absent exigent circumstances.
  + To facilitate compliance, most facilities will have three years to comply. Recognizing that this requirement may be more difficult for smaller facilities to implement, facilities with a rated capacity of less than 50 inmates are provided five years in which to implement the ban.
  + The final standard also clarified that women’s access to programming or out-of-cell opportunities should not be restricted to comply with this provision.
  + In addition, the final standard requires facilities to document all cross-gender searches of female inmates.

- **“EXIGENT”**
  + Exigent circumstances means any set of temporary and unforeseen circumstances that require immediate action in order to combat a threat to the security or institutional order of a facility.

PREA: Strip Search

- **Strip search:**
  + means a search that requires a person to remove or arrange some or all clothing so as to permit a visual inspection of the person’s breasts, buttocks, or genitalia.

- **Cross Gender Strip Searches:**
  + The final standard retains the general rule against cross-gender strip searches and body cavity searches and clarifies that “body cavity searches” means searches of the anal or genital opening.
  + The exception for medical practitioners has been retained; the emergency exception has been replaced with an exception for “exigent circumstances” to be consistent with similar changes from “emergency” to “exigent” throughout the final standards.
PREA: SHOWERING

× (d) The facility shall implement policies and procedures that enable inmates to shower, perform bodily functions, and change clothing without nonmedical staff of the opposite gender viewing their breasts, buttocks, or genitalia, except in exigent circumstances or when such viewing is incidental to routine cell checks. Such policies and procedures shall require staff of the opposite gender to announce their presence when entering an inmate housing unit.

PREA: GENDER NONCONFORMING

× Gender nonconforming.

+ The term is defined to mean “a person whose appearance or manner does not conform to traditional societal gender expectations.”

PREA: INTERSEX

× Intersex.

+ “A person whose sexual or reproductive anatomy or chromosomal pattern does not seem to fit typical definitions of male or female.”

+ The definition also notes that “[i]ntersex medical conditions are sometimes referred to as disorders of sex development.”

PREA: TRANSGENDER

× Transgender.

+ “A person whose gender identity (i.e., internal sense of feeling male or female) is different from the person’s assigned sex at birth”—reflects the suggestions of numerous advocacy commenters.
PREA: SEARCHING TRANSGENDER/INTERSEX

- (e) The facility shall not search or physically examine a transgender or intersex inmate for the sole purpose of determining the inmate’s genital status.
- If the inmate’s genital status is unknown, it may be determined during conversations with the inmate, by reviewing medical records, or, if necessary, by learning that information as part of a broader medical examination conducted in private by a medical practitioner.
- (f) The agency shall train security staff in how to conduct cross-gender pat-down searches, and searches of transgender and intersex inmates, in a professional and respectful manner, and in the least intrusive manner possible, consistent with security needs.

PREA: TRAINING

- All current employees who have not received such training shall be trained within one year of the effective date of the PREA standards, and the agency shall provide each employee with refresher training every two years to ensure that all employees know the agency’s current sexual abuse and sexual harassment policies and procedures.
- In years in which an employee does not receive refresher training, the agency shall provide refresher information on current sexual abuse and sexual harassment policies.

DETECT

- Make inmates aware of facility policies and inform them of how to report sexual abuse;
- Provide multiple channels for inmates to report sexual abuse, including by contacting an outside entity, and allow inmates to report abuse anonymously upon request;
- Provide a method for staff and other third parties to report abuse on behalf of an inmate;
- Develop policies to prevent and detect any retaliation against those who report sexual abuse or cooperate with investigations; and
- Ensure effective communication about facility policies and how to report sexual abuse with inmates with disabilities and inmates who are limited English proficient;

PREA: INMATE EDUCATION

- During the intake process, inmates shall receive information explaining the agency’s zero-tolerance policy regarding sexual abuse and sexual harassment and how to report incidents or suspicions of sexual abuse or sexual harassment.
- (b) Within 30 days of intake, the agency shall provide comprehensive education to inmates either in person or through video regarding their rights to be free from sexual abuse and sexual harassment and to be free from retaliation for reporting such incidents, and regarding agency policies and procedures for responding to such incidents.
- (c) Current inmates who have not received such education shall be educated within one year of the effective date of the PREA standards, and shall receive education upon transfer to a different facility to the extent that the policies and procedures of the inmate’s new facility differ from those of the previous facility.
RESPOND

- Provide timely and appropriate medical and mental health care to victims of sexual abuse;
- Where available, provide access to victim advocates from rape crisis centers for emotional support services related to sexual abuse;
- Establish an evidence protocol to preserve evidence following an incident and offer victims no-cost access to forensic medical examinations;
- Investigate all allegations of sexual abuse promptly and thoroughly, and deem allegations substantiated if supported by a preponderance of the evidence;
- Discipline staff and inmate assailants appropriately, with termination as the presumptive disciplinary sanction for staff who commit sexual abuse;
- Allow inmates a full and fair opportunity to file grievances regarding sexual abuse so as to preserve their ability to seek judicial redress after exhausting administrative remedies; and
- Maintain records of incidents of abuse and use those records to inform future prevention planning.

PREA: AUDITS

- Audits Every Three (3) Years to Ensure Compliance with the PREA Standards
  + Commence three years, plus one year plus 60 days (August 20, 2016)
  + Within first year and 60 days that at least 1/3rd of the agency is audited. (August 20, 2014)
- Recommended tool by DOJ to assist in the auditing component
- Auditors must be certified by DOJ
- (c) For each PREA standard, the auditor shall determine whether the audited facility reaches one of the following findings: Exceeds Standard (substantially exceeds requirement of standard); Meets Standard (substantial compliance; complies in all material ways with the standard for the relevant review period); Does Not Meet Standard (requires corrective action). The audit summary shall indicate, among other things, the number of provisions the facility has achieved at each grade level.

AUDITS/AUDIT INSTRUMENT/AUDITORS

- Audits begin August 2013
- No audit tool has yet been developed
- Look back period of documentation is 1 year
- Auditor certification / training
- Jails not obligated to engage with any particular audit organization or auditor

PREA OVERVIEW

- Candidates* for compliance and audit need to:
  + Acquire a thorough understanding of standards
  + Review of existing policies and procedures
  + Know available resources
  + PREA Resource Center
- * Department or facility
PREA: DEFINITIONS “FULL COMPLIANCE”

- The final rule defines “full compliance” as “compliance with all material requirements of each standard except for de minimis violations, or discrete and temporary violations during otherwise sustained periods of compliance.”

PREA: GOVERNOR

- State Compliance § 115.501 State determination and certification of full compliance. (a) In determining pursuant to 42 U.S.C. 15607(c)(2) whether the State is in full compliance with the PREA standards, the Governor shall consider the results of the most recent agency audits.
- (b) The Governor’s certification shall apply to all facilities in the State under the operational control of the State’s executive branch, including facilities operated by private entities on behalf of the State’s executive branch.

ELECTRONIC RESOURCES


DUTY TO PROTECT REMAINS

- The Eighth Amendment’s Prohibition against Cruel and Unusual Punishment remains.
  + Deliberate Indifference Test
THE STANDARD

Substantial Risk of Serious Harm

Conduct Caused Harm

Knowledge of Risk

Disregard Risk

RESOURCES

- Supplementary Information preceding rules
- Copy of PREA Standards
- Regulatory Impact Assessment (RIA)
  - www.ojp.usdoj.gov/programs/pdfs/prea_ria.pdf
- Tool kit for Jails

RESOURCES—LINKS

- www.prearesourcecenter.org
- www.prearesourcecenter.org/about/contact-us
- http://nicic.gov/

PROJECT ON ADDRESSING PRISON RAPE
WASHINGTON SCHOOL OF LAW

- Brenda V. Smith
  - bvsmit@wcl.american.edu
- Jamie Yarussi
  - jyarussi@wcl.american.edu
USE OF FORCE: STREET

- **Leading Authority:** Objective Reasonableness

USE OF FORCE: JAIL/PRISON

- **Leading Authorities:** (Malicious and Sadistic)
  - *Wilkins v. Gaddy,* 2010 U.S. LEXIS 1036

- **Exception in 6th Circuit ONLY**
    - The 6th Circuit ruled that the Fourth Amendment, not the Fourteenth, protects pre-trial detainees arrested without a warrant through the completion of this probable-cause hearing.
    - The objective reasonableness test would apply. (The Fourth Amendment's standard only permits an officer to use reasonable force to protect himself from a reasonable threat)
**USE OF FORCE: JAIL/PRISON**

- **Whitley** set the standard for use-of-force scenarios which involve “exigent circumstances”
  - “Maliciously or sadistically for the very purpose of causing harm”.
  - “Deliberate Indifference” is not the test.
- **Hudson** is a use-of-force case which did not involve a need to restore order. It set the standard for all other use-of-force scenarios by establishing a five-part test.

**USE OF FORCE: WHITLEY V. ALBERS**

- Exigent Circumstances:
  - Issue: Whether force was applied in a **good faith effort** to maintain or restore discipline or **maliciously and sadistically** for the very purpose of causing harm?

**USE OF FORCE: HUDSON V. MCMILLIAN**

- All Other Use of Force Scenarios:
  - The **extent of the injury** is “one” of the factors considered in determining whether the force was necessary and wanton.
  - The use of excessive force against a prisoner may constitute cruel and unusual punishment even though the inmate **does not suffer** serious injury.

**USE OF FORCE: HUDSON V. MCMILLIAN**

Key Factors in determining whether excessive force (malicious and sadistic) was used?

1. Threat perceived by a reasonable officer.
2. Need for Use of Force
3. Amount of Force used in relation to the need for force
4. Effort(s) made to temper forceful response
5. Extent of the Injury
   - A. Exigent circumstances: one factor to be considered in determining whether the use of force was wanton and unnecessary.
   - B. All other use of force scenarios—serious injury is not a requirement.
USE OF FORCE

**Wilkins v. Gaddy.** 2010 U.S. LEXIS 1036

- Reaffirmed Hudson v. McMillian.
  - The extent of the injury is one factor to be considered.
  - The justification for the amount of force used in relation to the need for the use of force is controlling.
  - The “nature” of the force
  - “Injury and force, however, are only imperfectly correlated, and it is the latter that ultimately counts”

USE OF FORCE: MISCELLANEOUS CASES

- **LA Heat Ray Gun** to subdue violent inmates and curb side incidents.
  - Currently a “cease and desist” on it until there is further evaluation.
- **Council v. Sutton.** 2010 WL 476708 (11th Cir. 2010)
  - Once the threat has abated, must stop. Use of a Taser and Beanbag rounds to subdue a compliant inmate.
- **Forrest v. Prine.** Civ. No. 09-3471 (7th Cir. August 31, 2010)
  - The use of a Taser was “a reasonable, good faith effort to maintain or restore discipline within the jail.”
- **Nasseri v. City of Athens.** Civ. 09-11473 (unpub. 11th Cir. 2010)
  - An arrestee’s allegation that he was sprayed with pepper spray in the booking area of the jail and then later transported back in the patrol car, and not allowed to decontaminate stated a viable claim.
- **Browne v. San Francisco Sheriff’s Dept.** 2009 U.S. Dist. Lexis 40515 (N.D. Cal.)
  - Claim by an inmate that an officer used excessive force by placing a lethal venomous white tipped spider in his cell was not substantiated.
APPENDIX X
MARKETING/SURVIVAL STRATEGIES
Surviving in Hard Times: Marketing the Jail Inspection Process

Chief Inspectors Network Meeting
Aurora, Colorado
July 18-19, 2012

Once upon a time in a land far, far, away…..there lived a happy jail inspector who had no problems……

What do you mean we are going to be eliminated?

What saved us?

- Support from Sheriff’s and Jail Administrators
- Data related to:
  - Cost of Jail Standards Program vs. Counties doing it on their own
  - Litigation compared to other states
  - Inmate Complaints
  - Cost of replicating services related to:
    - Training
    - Consulting
    - Technical Assistance
Support from:
- Nebraska Sheriff's Association
- Nebraska Association of County Officials
- Nebraska Insurance & Risk Management Association
- Nebraska County Attorneys Association
- ACLU
- Federal Prosecutor for the State of Nebraska

Effective Marketing of our Program!
Local Ownership of the Program!

Marketing your Services

We have what you want! You have what we want!

Product
Price
Promotion
Place

Consumer
Cost
Communication
Convenience

Product

<table>
<thead>
<tr>
<th>Jail Standards Organization</th>
<th>Consumer (Jail, County or City, Insurance Group, Inmates, Community)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Product</td>
<td>Consumer</td>
</tr>
<tr>
<td>Expertise &amp; Information</td>
<td>Compliance</td>
</tr>
<tr>
<td>Liability Protection</td>
<td>Support</td>
</tr>
<tr>
<td>Programming and Needs</td>
<td>Trust</td>
</tr>
<tr>
<td>Assessment Assistance</td>
<td>Investment in the program</td>
</tr>
</tbody>
</table>

Price

<table>
<thead>
<tr>
<th>Jail Standards Organization</th>
<th>Consumer (Jail, County or City, Insurance Group, Inmates, Community)</th>
</tr>
</thead>
<tbody>
<tr>
<td>We provide value through:</td>
<td>Cost</td>
</tr>
<tr>
<td>Reduced Liability</td>
<td>They gain value through:</td>
</tr>
<tr>
<td>Shared Expertise</td>
<td>Passing inspections</td>
</tr>
<tr>
<td>Shared Human Resources</td>
<td>Reduced Insurance Rates</td>
</tr>
<tr>
<td>Shared Capitol Resources</td>
<td>Improved facilities</td>
</tr>
<tr>
<td></td>
<td>Improved operations</td>
</tr>
<tr>
<td></td>
<td>Reduced costs for Attorney’s</td>
</tr>
<tr>
<td></td>
<td>Reduced legal action</td>
</tr>
</tbody>
</table>
Promotion

<table>
<thead>
<tr>
<th>Jail Standards Organization</th>
<th>Consumer (Jail, County or City, Insurance Group, Inmates, Community)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promotion</td>
<td>Communication</td>
</tr>
<tr>
<td>Advertising</td>
<td>Evaluate Everything!</td>
</tr>
<tr>
<td>Public relations</td>
<td>Information from exit interviews</td>
</tr>
<tr>
<td>Personal selling</td>
<td>Local needs information</td>
</tr>
<tr>
<td>Conferences</td>
<td>Regular Contact with the decision makers</td>
</tr>
<tr>
<td>Be Available</td>
<td></td>
</tr>
<tr>
<td>Support other Organizations</td>
<td></td>
</tr>
</tbody>
</table>

Place

<table>
<thead>
<tr>
<th>Jail Standards Organization</th>
<th>Consumer (Jail, County or City, Insurance Group, Inmates, Community)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place</td>
<td>Convenience</td>
</tr>
<tr>
<td>We can come to you</td>
<td>Ease of buying</td>
</tr>
<tr>
<td>We can use technology</td>
<td>Ease of finding product</td>
</tr>
<tr>
<td>You can come to us</td>
<td>Ease of finding information</td>
</tr>
<tr>
<td>We can all get together</td>
<td>Jails don't have to do it all alone</td>
</tr>
</tbody>
</table>

Basic Marketing Questions

1. What is our goal as a jail inspection agency?
2. Who are our core customers? Allies? Opponents?
3. What are the needs of our customers? Allies? Opponents?
4. What financial and physical resources do we have to utilize? Who else wants those resources?
5. What products or services can we provide or develop to meet the needs of our customers?

- How can we prepare the customers to use the products and services we offer?
- What barriers do we face?
- How can we distribute products and services to our target markets?
- What are we doing that would constitute advertising? public relations? good customer service?
- How does marketing our product well enhance the role of our organization in the system?
Survival Strategies

Know your Consumer
- Who are your consumers

Know what they NEED!
- How do you gather information on what your consumers need?
  - Asking
  - Task Analysis
  - Needs Assessment
  - Evaluations
  - Listening
  - Going to their events
  - Inmate complaints

Be Innovative
- Look for new technologies you can use to improve the system
  - Management Systems
  - Security Systems
  - Better Mattresses
  - Give them information and show them new things
Its not about what you can make people do. Its about what you can make them want to do.

- What do you do to EMPOWER:
  - The people who work in your jails
  - The people who run your jails
  - The people who pay for your jails
  - The people who are in your jails

Create Value!

- Save people money!
  - On Construction
  - On Litigation
  - On Attorneys
  - On Staffing
  - On?????

Build Relationships

- Know people everywhere!
  - Legislators
  - Agency and Organizational Leaders
  - Sheriffs and Administrators
  - Officers
  - Attorneys
  - Ombudsman folks
  - ACLU
- Be Trusted!

Educate and Foster Learning

- Raise the Expectations
- Provide opportunities for learning
  - Conferences
  - On line training
  - Specialty Trainings
  - Film and Book Library
  - Clearing house on Technology and Contacts
- Be an example
Provide Leadership and BE A GOOD PERSON!

- In your groups decide:
  - What 5 Personal Characteristics are most important in defining leadership?
  - Display them daily!
  - Make sure your staff are on board!

Know Your Stuff!

- What knowledge, skills and abilities are most important in making you successful?
- Make sure you have these
- Make sure your staff have these
- Know why you do things

Be on the lookout!

- There will always be someone else who wants the resources you have been given.

Benefits

- Ultimately what we want to have the ability to do is influence people when change is needed. We want to have:
  - Produced results
  - Been reliable
  - Been helpful
  - Been trustworthy
  - Helped people do their job better
  - Improved the system
 Costs of Failing to Market

- Irrelevance
- Extinction