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January 2, 1992

Senator Joe Mazurek
President of the Senate
Representative Hal Harper
Speaker of the House
Capitol Station
Helena, Montana 59620

Dear Mr. President and Mr. Speaker:

With this memorandum I submit 150 copies of "Riot at Max", the administrative analysis report on the September 22, 1991 disturbance at Montana State Prison. These copies are provided to each of you and the members of your respective legislative bodies in order that you can be fully apprised of its contents.

This is the report which I requested through assistance of the National Institute of Corrections in order to independently investigate the disturbance and determine not only what happened, but why and more importantly, how we can prevent such an occurrence in the future. The report is self-explanatory with respect to the members of this team who participated in the fact finding and writing of this report. We received the report on Monday, December 30, and released it to the press on Tuesday, December 31, 1991.

These copies represent a full and complete copy of the original document received in my office with one exception. Page eight (8) has been removed because it contained a detailed floor plan of the Maximum Security unit and, for security reasons, I believe public disclosure of this information could have the potential of compromising the security of that unit.

This report was released to the press in this form and at the time of release in response to intense press inquiries which were numerous and at least daily in nature. Upon review of the report by Attorney General Racicot, the Warden, and a few members of my staff, it was determined it did not contain any criminal justice information which would be prejudicial to the prosecution of potential criminal cases against the participants in the riot; that security of the prison would not be compromised by release of security information contained in the report; and further, that individual rights of privacy of specific employees relative to

potential administrative actions would not be abridged. Considering these interests, we determined it was appropriate to release the report in this form. We believe your need for this information as members of the Senate and the House is the most critical, but want you to understand why the release to the press was made on Tuesday.

This report forms the basis for future dialogue with this department relative to the disturbance, the lessons to be learned from the disturbance, and the direction the department intends to pursue in implementing many of the recommendations made by the analysis team. We must, however, be careful about the conclusions we might draw in this instance. Understand that this is one of three investigations performed by external agencies. The Criminal Investigation Bureau of the Attorney General's Office is still investigating the potential for criminal charges yet to be brought against participants who may have committed crimes during this disturbance. In addition, the U.S. Department of Justice, Civil Rights Division, investigated to determine if crimes were committed by staff concerning events, most of which are alleged to have taken place in the aftermath of the riot itself.

Members of the department, corrections division staff, and I are available for any legislative discussion of this report that you feel would benefit your respective membership during or after this special session of the legislature.

Sincerely,

CURT CHISHOLM
Director

cc: Members of the Senate
Members of the House of Representatives
Teresa Cohea, Legislative Fiscal Analyst
Scott Seacat, Legislative Auditor
Bob Person, Legislative Council

RIOT AT MAX

An Administrative Inquiry Into The Circumstances Surrounding the Montana State Prison Riot of September 22, 1991

Conducted under the auspices of a Technical Assistance grant from the National Institute of Corrections

ADMINISTRATIVE INQUIRY TEAM:

TEAM LEADER: Jeffrey A. Schwartz

TEAM MEMBERS: Clayton Bain
Stan Czerniak
Dennis M. Luther
Lanson Newsome
John Pfaff, Jr.
Mike Schafer

December 14, 1991

U.S. Department of Justice

National Institute of Corrections

Washington, D.C. 20534

Ref: NIC TA No. 92P1013

This technical assistance activity was funded by the Prisons Division of the National Institute of Corrections. The Institute is a Federal agency established to provide assistance to strengthen state and local correctional agencies by creating more effective, humane, safe and just correctional services.

The resource person who provided the on-site technical assistance did so on a contractual basis, at the request of the Montana Department of Corrections, and through the coordination of the National Institute of Corrections. The direct on-site assistance and the subsequent report are intended to assist the Montana Department of Corrections in addressing issues outlined in the original request and in efforts to enhance the effectiveness of the agency.

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I. Executive Summary

On Sunday, September 22, at approximately 10:00 a.m., nine Maximum security inmates at the Montana State Prison ("MSP") broke out four pieces of pre-stressed cyclone fencing in the Maximum Security Unit exercise yard. This allowed the nine inmates locked in three separate cages to gather in one exercise cage where the gate had been left open by staff returning other inmates into the Unit building. The nine inmates ran into the Maximum Unit through a yard door that had also been left open. Some of the inmates attacked the polycarbonate-shielded ("Lexan") West control cage, while others ran down the corridor to the other half of the Unit, blocking open the two sliding steel corridor doors as they went. The inmates shattered the plate glass glazing outside the polycarbonate material and both cage officers, thinking that the polycarbonate security glazing had itself been broken, went up ladders and out escape hatches onto the roof of the building.

The five floor officers, including one Sergeant, were locked into one of the six housing blocks in Max by a cage officer before he exited. The inmates built fires and dragged them against the two control cages. The automatic sprinklers extinguished the West cage fire, but the other fire melted a hole in the polycarbonate material in the door of the East cage. The inmates reached in and gained access to the East cage. Inside they found keys to the West cage.

The five Floor Officers used a padlock to lock themselves into a small shower room on "C" Block, and they barricaded the grill door with a wet mattress. They remained there for four hours until rescued. Under threat of being burned-out or killed, they gave cuff keys and yard keys to the rioting inmates.

The rioting inmates used the control consoles in the two cages to open all the doors in the Max Unit, releasing all inmates. The rioting Max inmates went onto the protective custody ("PC") block and brutally murdered five PC inmates. Two other PC's were very seriously injured.

Approximately four hours after the riot began, the Prison's Disturbance Control Team ("DCT") threw tear gas from the two roof

escape hatches down into the two control cages and then, armed with semi-automatic weapons and shotguns, climbed down the ladder into the West cage. From there, the DCT members quickly took control of C Block and freed the five staff hostages, who were brought onto the roof and out of the building physically unharmed. DCT re-took the building one block at a time, with inmates ordered to strip and lie down so they could be handcuffed behind their back and searched.

When DCT had control of the building, groups of inmates were taken to the front door of Max where they were turned over to a Restraint Team of approximately 70 staff that had formed a double receiving line, or gauntlet, outside of the door of Max. The Max inmates were taken to a field outside the Max building, referred to as "No Man's Land", and placed naked on the ground, handcuffed behind their back, under gun coverage. The Max inmates were moved into the Reception Unit after they had spent five to seven hours lying in No Man's Land. A few weeks after the riot, on October 9, a group of six Maximum inmates in the Reception Unit were hogtied with steel restraints naked on the floor for 24 hours in response to inmate threats of new rioting. They evidenced serious handcuff wounds and suffered some superficial nerve damage.

After three weeks in the Reception Unit, the Maximum inmates and the surviving PC inmates were returned to the cleaned-up and repaired Maximum Unit. The following week, the Administrative Inquiry Team arrived on-site in response to a request to the National Institute of Corrections from Montana's Director of Corrections and Human Services.

The Inquiry Team concluded that the Prison had not been running well prior to the riot. Staff professionalism was not good and responsiveness to inmate needs was frequently lacking. The grievance system and inmate disciplinary system were poorly designed and inconsistently administered. The Inquiry Team noted other problem areas ranging from medical services and supervisory accountability to staff training. Policies and procedures were sometimes inappropriate and more often ignored, and MSP's mission, goals and values were not well articulated.

The riot could not have occurred were it not for staff ignoring specific warning signs. The riot would also have been impossible except for staff's chronic breach of basic security procedures and their violation of a number of institutional security policies. The Inquiry Team concluded that the riot was planned primarily in response to conditions within the Maximum Unit and that the PC murders were a secondary plan or, perhaps, crimes of opportunity. There was no evidence of any staff complicity. The Team did find evidence of improper staff use-of-force, both before and after the riot.

The Team also found that the Warden's decision to assault as soon as he received information that people within Max were being badly beaten or killed, likely saved staff and inmate lives. The essentially self-trained DCT demonstrated bravery and professionalism in successfully effecting the hostage rescue under most difficult conditions. Their actions saved lives.

MSP dealt with staff hostages and other traumatized staff and family members with exceptional care and sensitivity. However, these actions were the antithesis of the treatment afforded to Max and PC inmates after the riot. Administrative decisions after the riot served to seriously increase tensions within the Institution. Changes were not well considered and were poorly communicated to the inmate population. Most of the changes were justified as tightening security but only served to restrict or cancel inmate privileges and programs throughout the Prison.

MONTANA STATE PRISON
ORGANIZATIONAL/FUNCTIONAL CHART

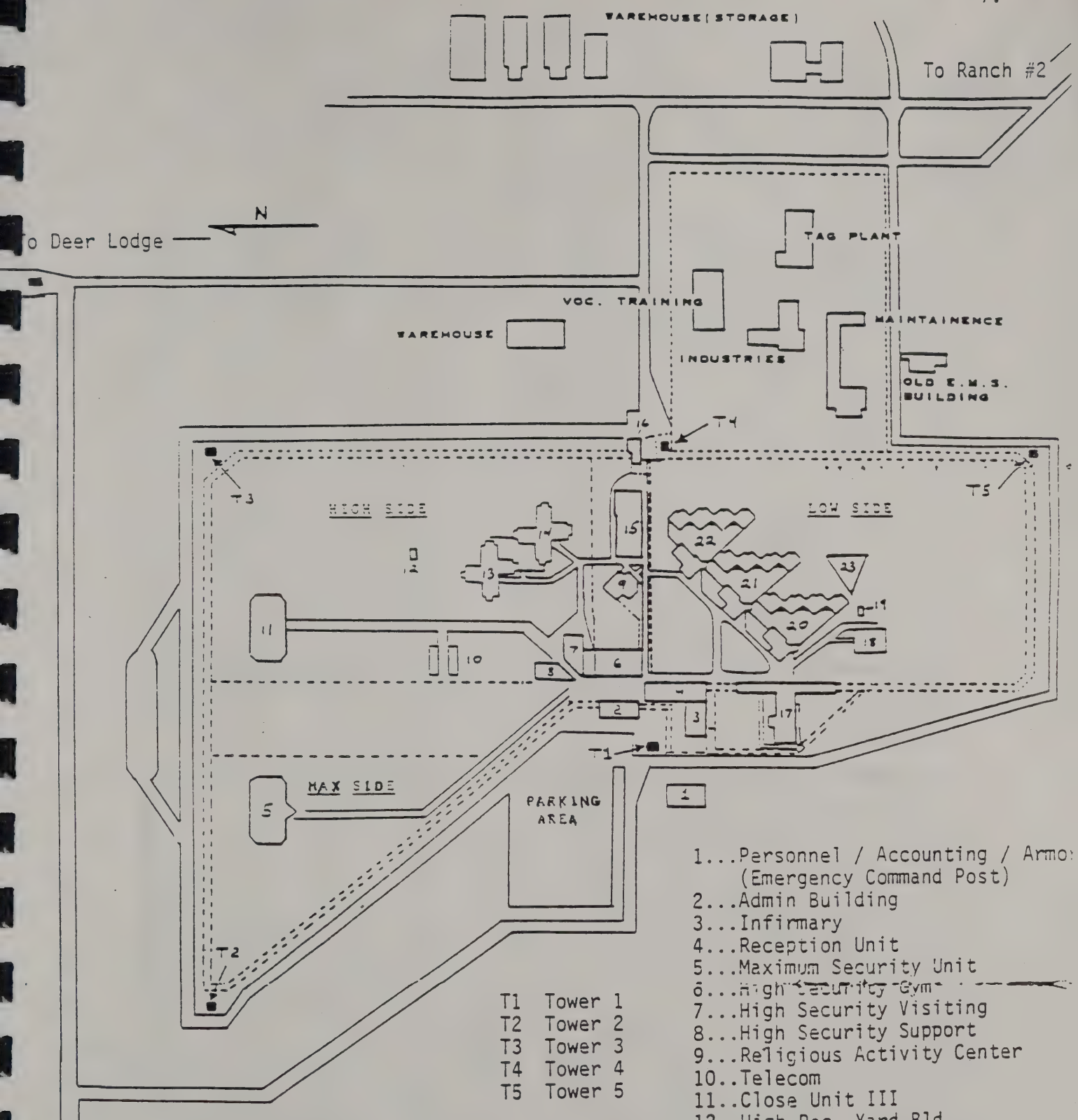
WARDEN

```
*
*---Administrative Assistant
*   ---Word Processing Center
*
*---Records
*
*---Investigator
*
*---Personnel
*   ---Training
*
*---Hearings Officer
*
*---Data Processing
*
```

ASSOC. WARDEN/TREATMENT	DEPUTY WARDEN	ASSOC. WARDEN/ADMIN.
*---Classification & Treatment	*---Security Managers	*---Accounting
---Chem. Dep. Program	*	*
	*---Captains	*---Maintenance
*---Education	*	*
---Academic	*---Lieutenants	*---Food Service
---Library	*	*
*	*---Sergeants	*---Warehouse
*---Recreation	*	* ---Canteen
---Music	*---Officers	* ---Laundry
---Hobby		*
*		*---Mail Department
*---Religious Services		*
*		*---Switchboard
*---Infirmary		

CKB/cmj

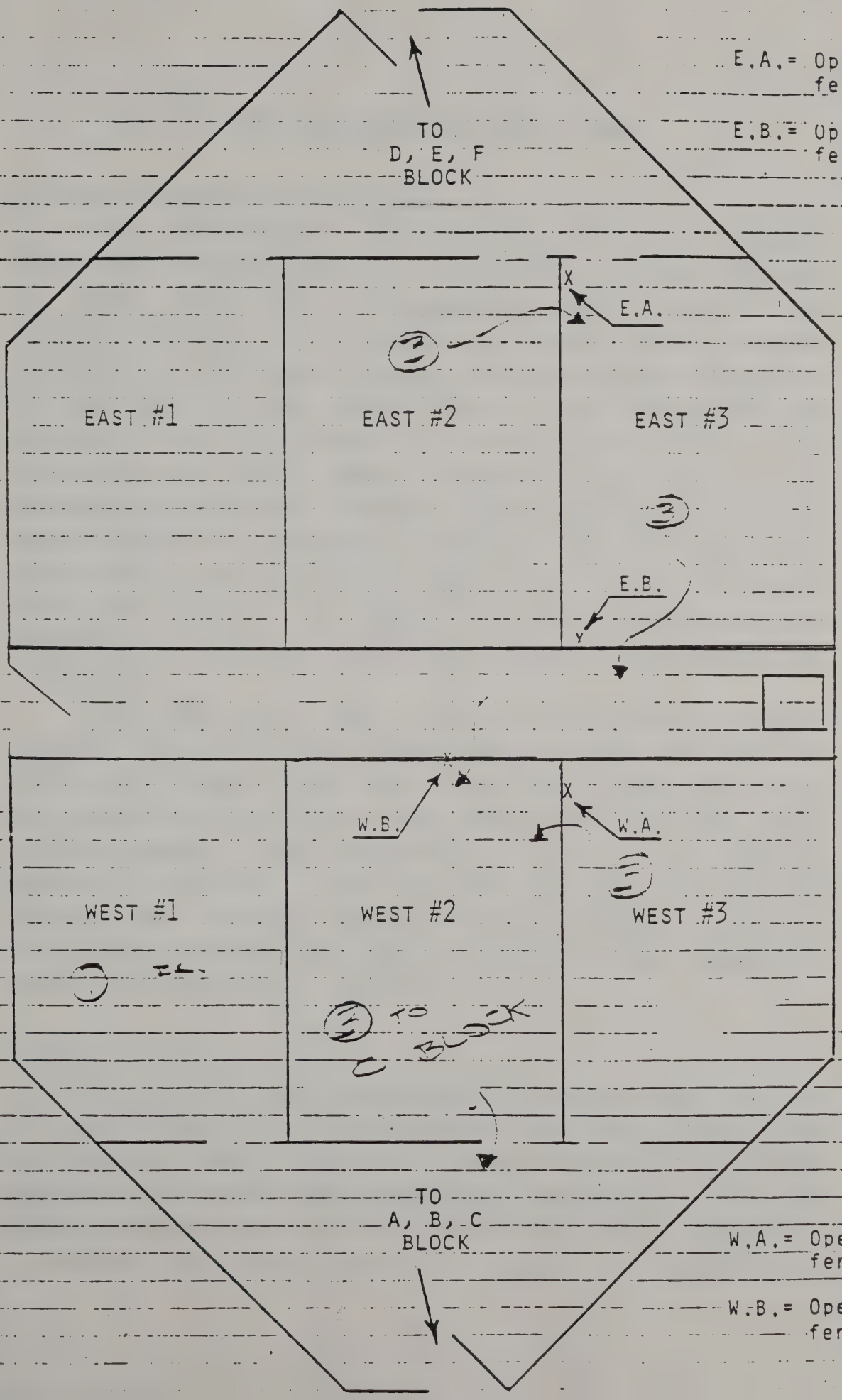
4-25-89



T1 Tower 1
T2 Tower 2
T3 Tower 3
T4 Tower 4
T5 Tower 5

1...Personnel / Accounting / Armo
(Emergency Command Post)
2...Admin Building
3...Infirmary
4...Reception Unit
5...Maximum Security Unit
6...High Security Gym
7...High Security Visiting
8...High Security Support
9...Religious Activity Center
10..Telecom
11..Close Unit III
12..High Rec. Yard Bld.
13..Close Unit II
14..Close Unit I
15..High Side Food Service
16..Guard Station
17..Low Security Support
18..Low Security Gym
19..Low Rec. Yard Bld.
20.."A" Unit
21.."B" Unit
22.."C" Unit
23.."D" Unit

To:
Dairy
Dairy Dorm
Cow Camp
Gun Range
Conley Lake



E.A.= Opening in fence 12"X30

E.B.= Opening in fence 12"X80

W.A.= Opening in fence 12"X4

W.B.= Opening in fence 12"X3

II. The Administrative Inquiry Team

A. Montana Requests Federal Assistance:

In the week following the September 22 riot, Curt Chisholm, Director of the Montana Department of Corrections and Human Services, and James Pomroy, the newly-appointed Acting Director of the Corrections Division of that Department, decided that an immediate investigation into the causes of the riot and what was done correctly and incorrectly during the riot, was a necessity. They concluded that the Department lacked the resources to conduct an investigation of the required scale and that an internal investigation by the Prison or by the Department might also lack credibility. Accordingly, they contacted the National Institute of Corrections (a branch of the U.S. Department of Justice) and requested assistance in organizing an external administrative inquiry into the riot. The National Institute of Corrections (NIC) immediately agreed to provide assistance organizing and funding the bulk of the effort.

Susan Hunter, Ph.D., Chief of NIC's Prisons Division, and Anna Thompson, also of NIC's Prison Division, began to contact potential Team members on Thursday, October 5th, in the hope that the inquiry Team could begin work the following week (October 9). That date proved optimistic because of other commitments on the part of the individuals identified for the Team. A few days after the initial phone calls, on October 9, 1991, Dr. Hunter was able to write James Pomroy and confirm that the Team would begin its' on-site investigation Sunday, October 20, exactly four weeks after the riot itself.

B. Team Composition:

NIC and the Montana Departmental administrators agreed that the Team should include out-of-state correctional experts with familiarity with riot, hostage and security issues, and that the Team should also include individuals from Montana with criminal justice backgrounds, but that the Montana members should not be from the Prison or from the Department of Corrections and Human Services. In general, NIC identified and

contacted the out-of-state members of the team, and Curt Chisholm and Jim Pomroy contacted the Montana members.

Jeffrey A. Schwartz, Ph.D. was identified by NIC as the Team Leader. Dr. Schwartz, President of LETRA, Inc., a non-profit criminal justice training and research organization in Campbell, California, had been used extensively by NIC to assist in the aftermath of other jail and prison disturbances. He is a nationally recognized expert in emergency preparedness and emergency response for prisons and jails with over 20 years experience working with police and correctional agencies.

Three other out-of-state corrections experts were selected: Stan Czerniak is the State-wide Security Administrator for the Florida Department of Corrections. Mr. Czerniak is responsible for Security Audits and the management of the Security Program at 48 State prisons through-out Florida. Prior to joining the Florida system, Mr. Czerniak had over 20 years experience in the Illinois Department of Corrections with responsibilities ranging from Classification and Treatment to Security and Institutional Management. Mr. Czerniak is a Certified Public Manager and holds a Masters Degree in Administration. He has also consulted for the American Correctional Association.

Dennis M. Luther is currently Warden at the Federal Correctional Institution, McKean County, Pennsylvania. He has been with the Federal Bureau of Prisons since 1971 and was appointed Warden at the Chicago Metropolitan Correctional Center in 1979. He was also Warden of the Federal Correctional Institution at Danbury, Connecticut for approximately five years. Mr. Luther has a Masters Degree in Correctional Administration, as well as Post-Graduate training in Public Administration and Management. He also teaches at the University level.

Lanson Newsome is currently the Deputy Commissioner for the Georgia Department of Corrections. As the Deputy over the Operations Division, he supervises Wardens through-out the State. Mr. Newsome's history includes a wide variety of institutional assignments and a long tenure in prison management. Like the other out-of-state members of the Team, Mr. Newsome has first-hand familiarity with riots, disturbances, and hostage situations and his correctional expertise is nationally recognized.

The three Montana members of the Team include: John Pfaff, Jr., M.D., Clayton Bain, and Sheriff Mike Schafer. John Pfaff is a retired Forensic Pathologist from Whitefish, Montana. The in-state members of the Team are extremely well known through-out Montana's criminal justice system and Dr. Pfaff is no exception. He was very active nationally in forensic pathology professional associations during his career and was also Acting Medical Examiner for the State of Montana at one time.

Clayton Bain recently retired from his position as Director of Montana's State Peace Officer Standards and Training agency. Mr. Bain had an earlier and illustrious career as a Police Officer, culminating in his job as Chief of Police in Great Falls, Montana. Clayton Bain has worked with every element of the criminal justice system within the State.

Mike Schafer is Sheriff of Yellowstone County. Sheriff Schafer is widely respected throughout Montana, and his jail operation in Billings is acknowledged to be one of the most modern and sophisticated in Montana, if not in the several state area. Sheriff Schafer also brought to the Team a close familiarity with every sector of Montana criminal justice.

C. Methodology:

Team members were initially identified and contacted the weeks of October 2 and October 9. As Team Leader, Jeffrey Schwartz discussed plans for the Team's on-site work the week of October 20 with Curt Chisholm and Jim Pomroy. The Department prepared packages of background data and other information about the Montana State Prison as well as some summary data about the riot. These were distributed by mail to Team members so they could digest as much information as possible before arrival in Deer Lodge.

All members of the Team arrived in Deer Lodge by late afternoon, October 20, and an informal dinner meeting was held between the Team and the Department, represented by Curt Chisholm, Jim Pomroy and Jack McCormick, Warden of the Montana State Prison. A review of the Team's mission proved crucial at that meeting as some sharp differences in expectation emerged. Most Team members had believed that their charge was to investigate the causes of the riot, what was done

correctly, what was done incorrectly, what recommendations might be justified, and to identify lessons that could be learned from the experience. Team members expected that the criminal investigation (of inmates responsible for major crimes during the riot), and pursuit of potential staff disciplinary actions (for negligence or misconduct) were being conducted separately from the Team's inquiry. It became clear that the Team's expectations about the former were correct, but that the latter issue was the subject of misunderstanding. That is, the State Attorney General's office did have a major investigation underway of inmate crimes during the riot; however, the Department did not have any investigation initiated into potential staff misconduct and the Department officials believed that the seven member Administrative Inquiry Team would identify such areas which the Department would then pursue independently. After a lengthy discussion it was agreed that the Team would not take primary responsibility for potential staff discipline, but that the Prison and the Department would wait until the Team had finished its' on-site work and then decide how to proceed in that area.

The entire Team spent the next five days on-site in Deer Lodge, departing on Saturday, October 26. Monday, October 21, was devoted to an informal briefing from the Attorney General's Criminal Investigation Branch (CIB) regarding criminal investigation and prosecution, a press conference introducing the seven member Team and explaining the Team's mission and procedure, and a detailed tour through all three compounds of the Prison accompanied by the Warden.

Beginning Tuesday morning, October 22, the Team typically split into three working groups of two or three people each and pursued different assignments. There were, however, tasks for which the entire Team would assemble because of the critical nature of a particular task. The Team conducted individual interviews with staff and, on a few occasions, group interviews. Some of these were formal, scheduled interviews in a conference room but many of them were spontaneous as Team members toured various areas of the Prison. In a similar fashion, Team members interviewed a large number of inmates, some formally but most informally. Again, these included individual and group interviews.

Individuals were interviewed on a confidential basis and names of staff are not used in this Report, with the exception of staff members whose administrative positions are such that anonymity is not possible. Since the Team had neither prosecutorial authority or powers, and because the Team's inquiry was administrative in nature, it was decided not to tape record or otherwise transcribe interviews. Most of the inmates and staff interviewed were identified by Team members either because of their roles in the September 22 riot or because they constituted a cross-section of typical staff or inmates. However, the Team disseminated information through the Counseling staff that any inmate wishing to speak with the Inquiry Team could request an interview and the Team would attempt to accommodate as many of these as possible. To the best of the Team's knowledge, every request for an inmate interview received until noon on Friday, October 25, was accommodated. Similarly, a small number of staff members specifically requested to talk with the Team and all of these requests were accommodated during the week. These interviews were conducted in the Prison or, in the interest of confidentiality, at the motel where Team members were staying.

The Team reviewed voluminous documents from the day of the riot and also requested and reviewed a variety of other documentary information as the week progressed. Requested items ranged from specific policies to training records, the inmate handbook, inmate grievances, disciplinary reports, classification documents, etc.

It must be emphasized that the Team did not restrict its' inquiries to the Maximum Security Unit nor did it restrict itself to the events of September 22, 1991. It was the consensus of Team members that it was crucial to understand the manner in which the entire Prison functioned, its' culture, values and procedures if the Team was to make judgments about the origins of the riot or the status of the Prison at the time of the riot. For example, Team members interviewed staff and inmates in the housing units on the Low Security compound as well as those who had been in Max at the time of the riot. Similarly, Team members looked at the Vocational Training programs and the Treatment programs as well as reviewing the Armory and the actions of the Disturbance Control Team.

This task was approached in part by attempting to assess the current status of the Prison and then work backwards through changes made since the riot to identify pre-riot conditions. In short, the Team attempted to gain a comprehensive picture of the Prison and then to focus very specifically on circumstances surrounding the riot at Max.

D. Limitations:

First, it should be emphasized that this was an administrative inquiry, and not an investigation where testimony was taken under oath or recorded. However, Team members did not feel impeded by lack of subpoena power or by an inability to take testimony under oath.

Second, the Inquiry Team could not place conditions at MSP in any meaningful historical perspective. That is, while the Team might conclude that certain procedures or conditions had been problematic prior to the riot, the Team could not determine--and did not attempt to determine--whether that situation represented a dramatic improvement compared to years past, whether it was a deterioration from two, or five or ten years before, etc.

The most serious limitation the Team encountered was a lack of time. In spite of a long and intense week, Team members encountered as many new questions as answers. By mid-week, the enormity of the task weighed heavily upon the individuals involved in the inquiry and decisions had to be made about those avenues that would be pursued and those that would not. It was not possible in one week to interview all key staff or all inmate participants or inmate witnesses. There was also little time to cross-reference the available reports and other documentary evidence or to correlate them with interview data where minor contradictions existed. It was not possible to expand the Team's on-site time for several reasons, including personal commitments of Team members and NIC funding, which was finite rather than open-ended. This Report does attempt to identify areas in which available information was inconclusive.

The conclusions, findings and recommendations in this Report are unanimous, supported by every member of the Team unless otherwise stated within the Report. However, at the end of the week on-site, there were interviews that would have been useful, documents that could have

been reviewed and many areas of the Prison that could have been examined in more depth. It is stressed that none of these were possible because of time constraints.

III. The Montana State Prison (MSP)

A. History:

The first Montana State Prison in Deer Lodge, Montana was one of the original Western Territorial Prisons, along with legendary institutions such as the Prison at Florence, Arizona and Colorado's Old Max in Canyon City. The current facility opened in 1977, a few miles from the old prison that was in the heart of downtown Deer Lodge.

B. Description:

MSP includes three primary compounds within the perimeter fence. These are referred to as the Low Security Compound ("Low"), the High Security Compound ("High"), and the Maximum Security Compound which includes but a single building ("Max"). There are 58 acres inside the perimeter fence and the Institution includes 838 cells. There are an additional 40 inmates in dormitory housing, all in one dorm. The Institution sits on thousands of acres of State land and includes a dairy farm and ranch operation outside the fence.

The single Maximum building is divided into two sides ("East" and "West") and each side includes a Unit Control Room ("cage") and three 16 cell, 2 level podular living units (referred to as "A", "B", and "C" for the West side and "D", "E", and "F" for the East side). The High Security Compound includes three 96 cell housing units which are called "Close I" , "Close II", and "Close III". The Low Security Compound includes housing units "A", "B", "C", and "D" all of which are 96 to 98 cell buildings. There is one small, crowded Low Security dormitory.

The Institution's perimeter is secured by a double fence topped with razor ribbon and five towers staffed 24 hours per day. The Industries area is outside this double-fenced perimeter and is enclosed by a single fence. Only Low custody inmates are approved for this Industries area. The

Reception building is adjacent to the Administration building, but within the double-fenced perimeter.

In theory, inmates do not leave their own compound except to go to the Infirmary or Religious Activities Center. The High side Food Service building has the Institution's main kitchen and bakery and most food is taken to the Low Security Compound dining room ready to serve. Max inmates are fed in their cells from food taken to the Max Compound on insulated carts.

Staff, official visitors and inmate visitors all use the same single entrance to the Administration building and are searched at the front of the first floor of that same building.

At the beginning of the Team's week on-site, the census was just over 1100; there were 62 Maximum Security and PC inmates, 418 High Security, 582 Low Security, 28 unclassified inmates in the Reception building and 2 inmates carried on the Infirmary census. The average age of the inmate population is 29 years and the average sentence is 28 years. The racial characteristics of the population are primarily White and Native American, with Black and Hispanic inmates each accounting for less than two percent (2%) of the population. Native American inmates constitute between 18 and 20 percent of the total population. MSP had not been accepting inmates from county jails for the four weeks following the riot (because the Reception/in take unit was unavailable for new inmates. MSP moved the Max inmates there after the riot). Thus, the population was atypically low (by perhaps 50 inmates). It had been running between 1,150 and 1,196 prior to the riot.

The total number of staff positions authorized at MSP is 428, including 404 inside the main institution and 24 positions at the ranch or in industries. 275 of these positions are uniformed Security staff. The inmate to staff ratio in 1990 was 2.76:1, up slightly from 1980 when it was 2.7:1. There are six or seven Hispanic staff, but no Black staff. MSP management initially told the Inquiry Team that there were no Native American staff, but later contacted the Team to report that a records check had shown that there were four Native American or part Native American staff. There are 14 female Correctional Officers on staff, including one at the rank of Sergeant. Staff turnover for Fiscal 1991 was

just over 19%, and somewhat higher for Civilian staff than for Security staff. The beginning salary for a Correctional Officer is $15,563 per year, which is at least 15% below National Average. Correctional Officers are not entitled to Hazardous Duty Retirement or Line of Duty Death Benefits, although both of these accrue to State Law Enforcement Officers, such as the Montana Highway Patrol.

C. Organization:

The Prison is headed by the Warden, a Deputy Warden and two Associate Wardens - one for Business and Administrative Services and another for Treatment. The Associate Warden for Administration is responsible for food service, accounting, maintenance, the warehouse, the canteen, laundry, mail and the switchboard. The Associate Warden for Treatment supervises the infirmary, religious services, recreation, academic education, classification and treatment. Two Security Managers report directly to the Deputy Warden. One is in charge of the Low Security Compound and the other is responsible for the High Compound and Max. Below the Security Managers are the typical uniformed ranks of Captain, Lieutenant, Sergeant and Correctional Officer, with the Captains and Lieutenants also serving as Shift Commanders. There is also a Duty Officer system and five top managers (Warden through Security Manager) rotate that duty evenings and weekends.

D. Status at the Time of the Team's Arrival (October 20):

The Team found the Prison angry and unsettled. A long lock-down had been imposed immediately after the riot and the Prison was still in the process of coming off that lock-down. For example, although the High Compound inmates were once again eating in the Food Service building instead of in their cells, education had remained suspended and only began to be phased-in during the week the Team was on-site. A number of other changes had been made in policy and procedure, with most involving the restriction or elimination of inmate privileges. The majority of these changes were seen by staff as long-needed increases in security

or as beginning to follow policies that had been ignored in practice; they were not viewed as temporary post-riot measures.

These changes were superimposed on an institution that had serious systemic problems long before the riot. Staff professionalism at MSP is not good. Some staff regularly swear at, with and about inmates. Taunting and demeaning behavior are not uncommon. Many staff make no attempt to maintain a professional appearance. There is little supervisory accountability at any level. Staff and the Institution itself, are generally unresponsive to inmate needs. The inmate grievance system is unmanaged and ineffectual; it lacks credibility with the inmate population. The inmate disciplinary system is poorly designed and inconsistently administered. There are not enough program opportunities or paid jobs for the inmate population and, beyond the idleness that results, additional problems are created with earned good time and parole eligibility. Staff salaries are unrealistically low, staff turnover is somewhat high and staff training is inadequate; there is no lone item in the budget for training. Medical services is a source of widespread dissatisfaction and anger among the inmate population exceeded only perhaps by the Parole Board process. Important policies and procedures are inappropriate, contradictory or lacking (for example, MSP has no use of force policy) and other policies have been regularly ignored. Security is inconsistent and, in many cases, far from rigorous (Serious security lapses were frequent during the week of the Inquiry Team's visit). Perhaps most importantly, staff have no shared understanding of the institution's mission, goals or values.

The combination of the emotional trauma of five inmate murders during the riot, the long lock-down after the riot, the dramatic change in inmate rights and privileges and a number of ongoing problems at MSP that had been present long before the riot and were still apparent a month afterward, combined to create a tense, angry and emotional climate. The Team was so concerned with what it interpreted as a high probability of additional inmate violence that an informal meeting was requested with Curt Chisholm, Jim Pomroy and Jack McCormick in order to discuss the situation. A meeting was organized for Thursday evening, October 24. The Team conveyed its' concerns regarding the current status at MSP. It

should be noted that most of this discussion was outside of the Team's mandate to look into the riot, and the Team's preliminary impressions, conclusions and findings about the causes of the riot and the events surrounding the riot were not presented that evening. A very positive footnote is that the top administrators regarded the Team's concerns about the stability of the Institution with the utmost gravity and Team members were gratified to find that by the beginning of the following week, the MSP management staff were taking steps to relieve some of the pressure on the inmate population and to decrease the distance between staff and inmates.

IV. The Riot

A. Prelude:

Conditions in the Prison were quite tense prior to the September 22 riot. This is widely acknowledged by staff and inmates alike although most staff believed that any trouble would be in the High Compound. At least three significant events that occurred earlier had each served to ratchet up the tension at MSP.

First, in September, 1990, an inmate named Pileggi was beaten to death by a group of inmates using baseball bats on the High Compound exercise yard. Several aspects of the Pileggi murder are particularly relevant. Pileggi apparently was not an informer but he was a sex offender who had problems in the general population because of the nature of his offenses. The Inquiry Team received contradictory reports of why and how this inmate was initially sent to Max. According to one version, Pileggi acquired what is known as a "snitch jacket" (reputation as an informant) and went to Max as a PC although he evidently had not informed. There was also an unconfirmed report that he got caught up in a conflict over control of inmate drug trafficking while he was working in the kitchen. In any case, Pileggi reluctantly returned later to the High Compound mainline population (from PC in Max) which may have been a choice between program availability and personal jeopardy. Pileggi's murder took place within 100 yards of one of the Prison's staffed gun towers but no shots were fired and Pileggi's body lay in the yard for 45

minutes before being discovered by yard officers. (This time estimate was from AG's investigators; Msp management had no idea of the length of the delay in finding Pileggi.) Inmates blamed staff for failing to intervene in the assault.

Prior to the Pileggi murder the Prison had already been very tense. This tension, by some accounts, was due to inmate maneuvering for control of the drug trafficking within the Prison. MSP management do not believe that to be a credible hypothesis and the Inquiry Team drew no conclusions in this regard.

The baseball bat attack was actually the second plan to get Pileggi. The first plan involved an inmate named Davison whom inmate leaders had convinced to bury several weapons in the High Security yard, which would then be retrieved and used to kill Pileggi. Davison told staff about this plot and staff, unfortunately, went out to the yard immediately after talking with Davison and dug up the four buried weapons while much of the inmate population watched. This forced Davison to immediately become a Protective Custody inmate. Shortly thereafter, Pileggi was murdered anyway and Davison became a key witness in the murder cases against some of the Pileggi assailants. The two inmates indicted for the Pileggi murder were being housed in Max at the time of the riot as was Davison. They were scheduled to go to trial the week after the September 22 riot, with Davison as a key witness. Davison was one of the five inmates killed during the riot.

Second, in April, 1991, there was a Montana government-wide strike and 400 of the 450 staff at MSP walked out and stayed out for six days. The bargaining unit includes Correctional Officers, Counselors and Sergeants. The Management staff (approximately 50) ran the Institution the first day of the strike. The National Guard was then activated and ran the Prison for the next five days of the strike under partial lock-down conditions. The Prison staff was the last element of State Government to return to work. The strike was not seen as generally successful in accomplishing labor's goals. Thus, there has been an undercurrent of resentment and antipathy from MSP staff towards Montana State Government since the strike. A primary sticking point for MSP staff is the Hazardous Duty Retirement system for which Prison staff do not qualify.

One of the ways in which the negative labor climate manifested itself was that staff made comments to inmates with some regularity about their belief that a riot or other serious violence might help them secure Hazardous Duty Retirement benefits. A number of inmates interviewed by the Team believed that staff were trying to goad them into violence for that purpose and many of those inmates were afraid of the consequences if violence were to begin. Similarly, when a full box of .22 caliber cartridges was discovered in the Food Service building (a few weeks before the riot) inmates said to the Team that they had been told by two staff that other staff had planted the shells.

The third clear pre-cursor to the riot was the suicide of inmate Brown on August 16, 1991. Brown knew as early as the beginning of August that there was going to be a riot in Max beginning in the exercise yard. He warned staff (August 3) verbally and went so far as to write a detailed letter about the upcoming riot at the request of one of the Maximum Unit Sergeants. On August 16, Brown committed suicide by hanging himself. It is not known whether his communication with staff about the upcoming riot had leaked to the other Maximum Security inmates, or whether his suicide was in part a reaction to pressure or threats from those inmates. What is known is that Brown was found hanging in his cell, and staff were on the scene but would not go into the cell and cut him down for a long time because of a policy that requires night shift Unit Staff in Max to wait for back-up from outside the building before they open any cells. When back-up arrived and staff entered Brown's cell, he was dead. A number of inmates have said that Brown was still moving and choking when staff first observed him hanging. The perception among the inmate population is that staff could have saved Brown's life had they entered immediately upon finding him hanging. There is anger in the general population over this incident and Brown's suicide apparently accelerated the plans for the riot in Max. Management told the Inquiry Team that the delay from the time the Floor Officer realized Brown was hanging, until help arrived and they cut him down, was six minutes. Based on staff and inmate interviews and available reports the Inquiry Team concluded it was substantially longer than that, although the Team was unable to specify the length of this delay.

(It may be instructive to briefly review the kinds of information available on the Brown suicide as a microcosm of the situation confronting the Inquiry Team more generally. In mid-July Brown was taken to Max for assaulting another inmate. There are several staff reports documenting Brown's culpability. There is no disciplinary hearing report or other documentation indicating how long Brown is to stay in Max, or whether he has been reclassified (as opposed to disciplined). On July 20 Brown requested to make an urgent personal phone call. A counselor refused his request and Brown said that he would do something to himself. The Max Day Shift Sergeant wrote a memo that Brown refused breakfast and lunch that day and the next. No suicide watch was started and if anyone was sent to evaluate Brown, there is no record of it. On August 14 Brown wrote a kite to the Max counselor saying that he has to see him as soon as possible, that he thinks his (Brown's) wife is in jail and that he is going crazy not knowing what is happening to her. There is no indication of any response and this counselor evidently was never asked to write a report after Brown did commit suicide. In early August, Brown also sent a note to the Chaplain which is a desperate cry for help. There is no indication of whether Brown was suicidal at that time. On the night of the suicide, there is a report from the Shift Commander who received the call from Max requesting assistance, and reports from the Sgt. who responded to Max with two other officers and the nurse who responded from the Infirmary. There is no report from the Cage Officer in Max, the Floor Officer who initially found Brown or the two Correctional Officers who responded with the Sgt. Later that day there are several staff reports detailing angry inmate accusations that Night Shift staff initially ignored inmates who were yelling that Brown was hanging himself and then later stood by and took no action before summoning help. The Inquiry Team was troubled and perplexed by the lack of documentation and the apparent failure to investigate the inmate allegations or conduct a thorough inquiry into the suicide.

One of the reports documenting the inmate allegations is from a Night Shift Correctional Officer who also notes that another inmate had been maced earlier (it was probably Inmate Capstun) and at one a.m. this inmate was requesting to talk to a Sgt. so he could be moved to another

cell because he was having trouble breathing due to the presence of mace in the cell. The Floor Officer told him he would not get the Sgt. and that he would not be moved. The Officer made no attempt to find out if the inmate had been allowed to wash his face and eyes or to see medical staff, both of which are required by policy. The Inquiry Team did not follow-up on this incident because it was not directly related to the riot, but it was symptomatic of much of what the Team found at MSP.

Management suggested that there was a fourth specific major source of stress prior to the riot: the loss of a number of staff to Operation Desert Storm and subsequent problems with staffing and overtime. The Inquiry Team did not regard this as an important contributing factor because MSP, by national standards, is not understaffed.

In addition to the three specific events outlined above, the riot was also a result of the way in which the Maximum Unit was operated, and conditions inside Max. Although "Maximum" is intended to be a classification level at MSP, the Team concluded that the Maximum building was functionally a large segregation unit with none of the due process protections or regular reviews that have to be accorded to administrative segregation or disciplinary segregation inmates. Criteria for being classified into Max were not understood by the inmate population and were, at best, subjective for staff. The criteria for getting out of Max were equally ambiguous.

When the Team asked for a small number of randomly selected inmate files in order to review the Maximum classification process, the first inmate record revealed a Native American inmate with a non-violent history sentenced for a property crime and initially classified as Minimum I, MSP's lowest security classification. This inmate received a bunk restriction as the result of some infraction in a Minimum Dormitory and subsequently left his bunk to watch T.V. in a day room. When a staff member told him to return to his bunk, the inmate replied "Fuck you and your rules". The response to this behavior was to re-classify the inmate as "Maximum" and send him to the Maximum Unit. It is noteworthy that this same inmate now shows every indication that he has learned to be a "real" Maximum inmate.

The Team interviewed inmates who had been in the Maximum building continuously for four years or more with essentially no program, no activities and 23 hours per day of in-cell time. It is accepted correctional practice that long-term administrative segregation inmates will be given psychological assessment on a regular basis in recognition of the serious depression and other profound psychological deterioration that can result from prolonged isolation. There is no such procedure or practice at MSP in the Maximum Unit. Some inmates in Max appeared to be mental health cases receiving essentially no mental health services. The use of phenothiazines and other psychotropic medications was described by the nursing staff as much higher for Max inmates than for the general population. That is inconsistent with a Unit that has no mental health treatment for those individuals.

Other conditions within Max can only be described as harsh. Inmates are allowed one phone call per month and must turn in a form to staff two days before they wish to place a call. Upon entering Max, an inmate must have 30 days without a write-up in order to earn his phone call, and after a write-up phone and recreation are suspended for 30 days. An inmate may be placed in a restricted area of Max or on "temporary lock-up" (TL) at the discretion of the Unit Sergeant if he "is determined to have an attitude not conducive to a less restrictive environment" or if he "becomes disruptive". The inmate is in that case entitled to a hearing within five days (72 hours plus weekend), although inmates alleged in interviews that staff can suspend disciplinary due process for Max inmates.

The Team's spot-check of several food items found that hot items are consistently served cold in Max. The Team found no temperature checks or other procedures that would assure that hot food items are served hot. Inmates who want to shave are given an electric razor which is passed from cell to cell. It is supposed to be disinfected between every use, but this is frequently not done and while some inmates object generally to the bad hygiene, all inmates interviewed were acutely aware of the potential AIDS danger from passing the electric razor around. What is referred to as "yard time" was an hour to an hour and one-half in one of six adjacent "dog cages". (The term used most often by staff to refer to

small outside areas enclosed on all sides and top by cyclone fencing within an open courtyard created by the interior walls of the Maximum building.) It is significant that Max yard time was not supervised nor observed by MSP staff. Recreation is more limited than necessary as there is no recreation equipment of any sort in the yard areas nor is there any provision for inside exercise or recreation during the long winters or extreme weather. It should be noted that even the highest security institutions and housing units in this Country have traditionally provided weights, basketball hoops, hand ball or some other forms of simple outdoor recreation, as well as board games and game tables as alternatives to outdoor recreation.

If the description above paints a picture of a Unit in which it was hard to "do time", then that is accurate. Two other important aspects of the Maximum situation cannot be ignored. First, one of the six housing pods within Max was used for the Institution's PC inmates. (Another of the six pods is for death row inmates.) These PC inmates were used as the Unit Orderlies (called "swampers"). The Team did not understand the rationale for placing inmate informants, those with gambling debts and others with serious need for protection into a housing unit with the most dangerous, aggressive and predatory inmates in the Institution. Using the PC inmates as swampers guaranteed that they would be in frequent contact with the Max inmates. Also, some staff were often careless about maintaining confidentiality regarding inmate informants and some staff would loudly tease inmates about being "snitches" or "rats".

The final factor that contributed to the highly charged, negative atmosphere in Max was staff use of force. Inmates housed in the Maximum Unit at the time of the riot, and inmates who had been housed there during the past few years but were no longer housed at Max, described a pattern of physical abuse by staff. It should be emphasized that what was described were not life-threatening or frequent beatings, but rather an occasional practice of entering the cell and roughing up an inmate, or hitting an inmate while the inmate was handcuffed or showering. Even the most experienced correctional professionals find it difficult to reach conclusions based solely on uncorroborated inmate allegations because inmates will sometimes embellish, lie, or plan to agree

with each other about an allegation about staff. It is also true that inmates are sometimes candid, truthful and precise in what they say. In this case, the frequency and consistency of the allegations created an uneasy feeling among Team members that was confirmed when a staff member who worked in Max verified that this kind of physical abuse had taken place in the Maximum Unit prior to the riot and that he had first-hand knowledge of such incidents.

The usual administrative checks and balances against improper use of force were essentially inoperative. There was no procedure specifying management review of use of force incidents or reports and the inmate grievance system provided no relief and great cynicism. The Inquiry Team reviewed one inmate grievance from Max in which the inmate complained that he had been beaten by staff during the riot without reason; the Unit Counselor wrote as an answer that it had been an emergency situation and that the inmate had been "treated accordingly". There was no investigation, interview of the inmate or other follow-up. The total response to a most serious allegation was a single sentence, written without any knowledge of what actually transpired.

Conditions, then, in MSP's Maximum building prior to September 22 had led to angry, frightened, frustrated, and perhaps desperate inmates. Inmates described to us how they had tried to talk to staff, use the Institution's grievance system, write to administrators of the Department in Helena and, in one case, write to a Member of the Montana State Senate. None of these efforts resulted in any serious consideration of conditions within the Maximum Unit and most of these efforts garnered no response whatsoever (or responses designed to stifle inmate complaints). The combination of intolerable conditions, anger at staff, poor staff supervision of inmates, and close proximity to inmate "snitches" provided more than adequate motivational fuel for the riot.

Inmate accounts of the planning of the Max riot are not consistent. Some inmates reported that "getting the snitches" was a primary goal from the outset. There are also credible inmate reports that the initial plan was to simply take over the West side of Max (and East if possible) and to perhaps take some Floor Officers hostage. This latter version centers on an inmate goal of getting media attention and negotiating over a list of grievances. This version was bolstered by the recovery after the

riot of a written list of grievances intended as a basis for negotiations. According to this view of intent, the inmates did not expect to gain access to the control cages and the murders of the PC's were crimes of opportunity more than a result of careful planning.

B. Warning Signs of the Impending Riot:

A riot at Max originating in the yard was planned at least as far back as late July. It is likely the idea was being actively considered as early as May or June. Inmate discussion of a Max riot was common by the first days of August, 1991. On August 3, Inmate Brown told one of the Correctional Officers working the floor in Max that there was going to be a riot and that it would start in the yard. While rumors of disturbance and escape are relatively frequent in prisons and staff quickly learn that most such rumors are bogus, this story was specific enough and credible enough that the Officer asked his Sergeant to interview Brown. Brown told the Sergeant (in some detail) about a plan for a take-over of Max beginning in the yard. The Sergeant was sufficiently concerned that he asked Brown to put the information in writing (a "kite"), which he did. The Sergeant gave the inmate "kite" directly to the Deputy Warden. That afternoon, a different inmate provided essentially the same kind of information to the staff on the Second Shift, about a riot planned to start in the yard and take over Max. The Second Shift Sergeant wrote a memo detailing this information and emphasizing that it was from a different inmate than had spoken to the First Shift Sergeant earlier that same day. Both of these memos went to the Warden, the Deputy Warden, one or both Security Managers, the Command Post (the Shift Commander's office) and others. (One of the Max Sergeants kept a file with all of this information, and copies of these memos, in the Sergeant's office in Max. During the riot, the inmates had open access to the Sergeant's office and read through the information to see who had been informing.)

The following day, August 4, several Second Shift Officers did an examination of the Max exercise yards. They found that the locking mechanisms for each of the six "dog cages" could be operated from inside the caged area with a plastic knife or similar flat instrument. The rec yard

was closed immediately pending modification and repair of the gate locks by the locksmith.

At MSP, the Deputy Warden holds a monthly meeting with the Maximum Unit Sergeants and minutes are kept of these meetings. At the August 7 meeting, the Deputy Warden mentioned "rumors of trouble at Max" and warned the Sergeants that they should "keep their eyes out for trouble". The minutes are consistent with staff descriptions of that meeting and there was neither detailed examination of the inmate information obtained earlier in August nor any reviews of the physical plant, policies or procedures.

Between early August and September 22, there were other clear signals of a planned disturbance within the Max Unit. The cyclone fencing in the Max yard had been a problem for years and one staff member told the Team that a section of the fence wire was found broken off and missing on at least one occasion in the few months before the riot. On September 14, a Maximum inmate was seen placing a paper bag on his food tray as he passed the tray out to the Unit swamper after feeding. The two officers who alertly observed this retrieved the paper bag from the trash and found that it contained at least two pieces of fence wire with the diamond pattern of the cyclone fence clearly visible in the pieces found. The inmate was given a write-up (disciplinary violation) which was signed by a Lieutenant and forwarded to the Disciplinary Hearings Officer. The inmate was not placed on temporary lock-up nor did he lose recreation privileges as required by policy and, rather incredibly, no one showed any concern for pieces of cyclone fencing found in an inmate's cell when the only cyclone fencing in the entire Max Unit is that which encloses the exercise cages in the yard. This physical evidence clearly confirmed the kites and informant information received in early August by staff but no one noticed, in part because the early August information had not been taken very seriously.

This incident involving the inmate with pieces of fencing received a great deal of attention in the weeks after the riot because of the obvious failure to uncover the riot plot. As with most of the central questions, however, there was no systematic investigation. When the Inquiry Team asked why this inmate had not been on restricted status because of the

Class II Disciplinary write-up and why he had been allowed recreation and why he had not had his disciplinary hearing on September 21, as scheduled and noticed, there were no ready answers. Administrators later told the Team that his hearing had been postponed at his own request and that the paperwork had not been included with the offense report and notice of hearing that the Team did receive. The Team was also told that inmates on restriction do not lose recreation. However, the "Maximum Security Housing Unit Rules and Guidelines for Inmates" states (p.3, under "Maximum Security Restricted Status) "Inmates on a restricted status will have phone and yard privileges suspended." It appears this inmate was never placed on restricted status although the same document states "If there is a Class II offense involved,...then he will be placed in the restricted area until he is reviewed by the Disciplinary Officer." There are parallel statements in the MSP Policy Statement "Maximum Security Operational Guidelines". Thus, the answers provided to the Inquiry Team were inaccurate, and these important questions remain unanswered.

An inmate who had been at MSP in Max at the time of the riot but who had subsequently left the Institution was contacted by phone and told the Team that he had given kites to two different staff members during the period of September 10 to September 15, warning staff of an impending riot starting in the yard. The Sergeant named by this inmate said he does not remember receiving any such kite and there are no records of either kite that can now be located. (The Team was concerned that there is no central repository of intelligence information and no single person responsible for coordinating intelligence across shifts or across areas of the Institution. There was no clear answer to questions about where kites containing such important intelligence information might be found. The suggestions from staff included: "it could be in the inmate file", "perhaps on the Command Post clip board", "try the Deputy Warden", "perhaps the Institution's Investigator has it", and "I don't know".) The Team found the story about the two kites warning of the riot within a week to ten days prior to its' occurrence credible because the Team originally heard about the kites from inmates in Max and then checked with the inmate who they said had authored the kites and he corroborated the story with detailed information. The inmates who

originally talked with the Inquiry Team could not have reached this other inmate to warn him of the pending inquiry.

On September 20, two days before the riot, a High Side Correctional Officer was asked by a Church Sponsor if he, the C.O., was nervous about the riot that was coming during the next week. The C.O. also received a note from the Church Sponsor talking about the coming riot. The Correctional Officer properly detailed his description of the incident and his incident report was signed by the Shift Commander and routed to all of the top managers at the Institution. The Inquiry Team found no evidence that anyone had responded to this report. The day prior to this, September 19, a Correctional Officer was told by an inmate that something was going to happen and asked the Correctional Officer what his days off were. The inmate then said, "good, you won't be bothered". The inmate reiterated that there was going to be violence. The Correctional Officer properly wrote the details of this interchange as an incident report which was signed off by the Shift Commander and routed to the Warden, the Deputy Warden, and the two Security Managers. Again, there is no evidence of response or reaction on anyone's part.

On September 22, the day of the riot, a Maximum inmate wrote a kite to staff warning that there was about to be trouble. The inmate evidently dropped this note into the corridor just before the riot began. It was found in the search of the building after the riot was over.

Other strong signs of the impending riot had to be present within the Maximum Unit itself. The fence had been worked on over a matter of weeks or perhaps months by a number of different inmates in order to prepare it for immediate breakthroughs in four separate locations all at the same time. It is also clear that inmates on both the East and West side of the Maximum building were involved in the planning and preparation because some of the fence breaches were prepared on the East cages and some on the West cages.

The most poignant evidence of what was widely known to be coming was that some of the PC inmates had taken extraordinary precautions in order to protect themselves during a riot. They believed they would be primary targets for the rioters. Two inmate swampers had

actually measured the Laundry Room (off the main corridor) and pre-cut a broom stick to the proper size so they could jam the broom stick between the washer and dryer, with one against the door to the Laundry Room and the other against the back wall. They also pre-planned the use of laundry bleach in spray bottles as a way to keep inmates from forcing the door to the Laundry Room. These precautions apparently saved their lives during the riot. Another PC inmate had experimented with red hobby paint and knew how to mix it with water in his cell to a consistency that would look like blood. He placed this mixture on his face and clothing during the early part of the riot. The inmates attacking the PC's initially believed that this PC was bloody and dead. (He was later badly beaten but did survive the riot.)

Inmate interview data was consistent with a conclusion that almost all of the inmates in the Maximum building knew that a serious riot was imminent and that it would start in the yard. Not all of the inmates knew exactly how it was planned to occur. The day of the riot was <u>not</u> widely known and may have been moved up in response to the Brown suicide. It is also possible that once all of the fence pieces were ready to be broken off and everything else was in place, the inmates were simply waiting for the right set of conditions, and that these conditions presented themselves on September 22 during the First Shift. (In retrospect, it appears that these conditions were present most of the time.)

C. The Riot Begins:

On Sunday, September 22, four Floor Officers and the First Shift Sergeant put the first group of Max inmates into the Max yard at approximately 7:30 a.m. One of the three East cages was left empty and one of the three West cages had a single inmate in it. The other four cages were each filled with three inmates. At approximately 10:00 a.m. the five Floor Officers (including the Sergeant) began to "bring the yard in". The three inmates in the middle cage on the West side were handcuffed through the handcuff slot and then removed from the cage through the middle cage gate and taken back into the Max building through the yard door. The cage gate and yard door were both left open.

As the five Floor Officers took the three inmates back to C-Block, nine of the ten inmates left in the yard cages broke off pieces of fence in four separate locations, allowing all nine inmates to get together almost immediately in the center cage on the West side. Since the gate to this cage had been left open by the Floor Officers when they removed the three inmates exercising in this cage, and the yard door to the West side of the Max building itself had also been left open, the inmates had clear access to the inside of the building and all nine rushed in. (The fence had been worked on for a substantial but unknown period of time before September 22 and four portions of the fence had been worked back-and-forth and pre-stressed. They were ready to be broken off at a moments notice. The four holes created in the fence ranged from one foot by two and a-half feet to one foot by six and a-half feet (1'x2-1/2' to 1'x6-1/2').

The nine inmates entered the building and rushed the West control cage with a few of the inmates splitting off and running down the corridor towards the East control cage (the satellite cage). Two swampers were out at the time and working the corridor. The two sliding corridor doors, controlled from both cages, had been left open as was the practice on the Unit when the swampers were cleaning. The inmates from the yard used plastic buckets that were left full of sand to put out cigarettes to jam both of the sliding doors so they could not be closed. These buckets were regularly left in the corridor, so they were likely part of the inmates' initial plan. The East Cage Officer tried unsuccessfully to close the corridor doors but they had already been blocked with the sand buckets by the rioting inmates. By this time, the nine inmates from the yard had control of the corridors and the floor area around the cages. They could not get onto any of the six living units ("blocks") and the five Floor Officers had been locked onto C Block (by the West Cage Officer) and were simply watching the rioting inmates. Almost immediately, the inmates from the yard, grabbed metal fire extinguishers and portable telephones and began attacking the cages themselves.

At this point, there is one report that one of the Floor Officers told one of the Cage Officers to get out of the cage. Within a very short period of time the inmates had broken the plate glass glazing that protects the polycarbonate security material (Lexan) from scratching.

The Cage Officers had no training about the design features of Max and did not understand the construction of the control cages and did not know, in particular, that there was glazing on the outside of the Lexan. When the plate glass shattered, the Officer's believed that it was the Lexan itself giving way and that they were about to be taken hostage by the rioting inmates. Both Officers climbed the ladders in the two cages that lead to escape hatches on the roof. At the top of the ladders is an open padlock that is intended to be taken outside onto the roof by any Officer escaping the cage so that the hatch may be secured from the outside and inmates cannot follow the Officers. One Officer accidently dropped this padlock back down onto the floor, left it, and exited through the roof hatch. The other Officer was able to lock his hatch.

Both Cage Officers report that they radioed the Command Post that there was a riot in Max before leaving their control cages. The Shift Commander on duty that Sunday morning was a Lieutenant who only remembers one of those two transmissions. He reported that the transmission was garbled and that the Officer failed to state his name or Unit so the Lieutenant was uncertain about the location of the problem being reported. The Lieutenant remembers it as being of the "It's going down! Send help!" variety. There is some difference among memories and reports about the length of time before the two Cage Officers went out through the roof hatches. It was certainly very fast, and perhaps a matter of a minute or two after the initiation of the riot. A Tower Officer saw two staff emerge from the roof hatches and his radio report was heard widely and clearly. Everyone seems to have recognized immediately that "two Officers on the roof of Max" could only mean very serious trouble within the Maximum building.

As the five Floor Officers locked into C Block observed (they could see the West side of Max, but not the East), the inmates built fires from inmate clothes and blankets and moved those fires against both control cages. The fire at the Main control cage (West) was extinguished by the automatic sprinklers, but the inmates managed to shield the fire at the satellite (East) cage and it burned intensely against the East cage door and window. There was some earlier suggestion that the inmates used powdered non-diary creamer as a heat intensifier, but the Team could not

independently verify that report. The fire melted an area of the window in the East cage door and the inmates then made or enlarged a hole in the partially-melted window using, it is believed, a broom handle. The inmates then reached through this hole to the control cage keys which had been left in the inside of the door-lock. The control cages were designed with two separate keys and locks controlling access through the control cage doors. Common practice in the Unit was to leave one of these two locks (the outside lock) in the unlocked position and to leave the keys to the other (inside) lock in the door so that it was as easy as possible for staff to let someone in or out of the cage. Once the inmates entered the East cage they quickly found a set of emergency keys which allowed them access to the West control cage as well.

It is not clear how long it took for the riot to proceed this far. It appears that it took between 30 and 45 minutes for the inmates to gain control of the two cages, with most indications suggesting that it was closer to 45 minutes than 30. The condition of the Maximum building was deteriorating rapidly. The sprinklers remained on so that water on the floor was ankle deep in some places; smoke from the fires was getting thicker in the building and the smoke evacuation system had been inoperative since early February, although this fact was unknown to most staff.

Once the inmates were inside the two control cages, they had access to every living unit and every cell in the building. This should not have been the case. The electric consoles in both cages that operate all of the doors are built with a power-off override switch with a key lock. Had the Cage Officers turned the power off and taken the console keys with them when they exited, then it would not have been possible for the inmates to operate any switches even with full physical control of the two cages. It is unfair to place primary blame upon these two Cage Officers, however, because they had not been trained in emergency exit procedures nor had they been instructed in the design of the Maximum control cages. The control cages were frequently assigned to new officers, to officers with little familiarity with Max, and some staff suggested to the Team that the cage positions were sometimes assigned to staff who had incurred the disfavor of a superior officer. In any case,

it is undisputed that there was no mandatory or even customary instruction for a new officer assigned to Max and this state of affairs was true even for a Sergeant who was assigned a relief shift there and was unfamiliar with the Unit. Finally, the Post Orders for the control cage positions were completely inadequate. They did not specify what to do in an emergency situation. The Post Orders that the Team reviewed were disturbingly generic rather than having been crafted for individual positions. Even if the Post Orders had been explicit about emergency responses, it would almost certainly not have mattered because there was no expectation that staff either read or become familiar with Post Orders. The Team found this to be true in Max even at the time of the inquiry, four weeks after the riot.

There are additional security safeguards that should have prevented an inmate take-over of the entire Maximum building but did not. It has been mentioned that the smoke evacuation system had been inoperative since February. The reason is that the smoke evacuation fans and sensors were part of a sophisticated electronic fire alarm system in the Max building. An additional part of this same system are other power override switches that are located in the Shift Commander's office. These switches were designed to allow the Shift Commander to cut the power to the East and West cage consoles. Two logic boards in the fire alarm system failed on February 4, 1991, and the Maintenance staff were unable to get the contract service firm to fix the electronics. There was some history of bad feeling between this contractor and the Prison prior to the February failure of the alarm system. The Prison staff made repeated attempts to get the contractor to fix the equipment, but without response. They contacted the manufacturer of the equipment, an Ohio firm, and were told that the current contractor was the only franchisee authorized in the State of Montana. In May, the facility Maintenance staff asked the Warden for assistance; he immediately wrote a strong letter to the manufacturer and the contractor. No response was forthcoming and the Prison took no further action. As a result, the Maximum Security building was without a fire alarm system from February 4 until the time of the riot, and the auxiliary features which were a part of that system were also disabled. These included the smoke evacuation

system, the Command Post power override switches for the control consoles, an intrusion alarm system monitoring the status of the three roof hatches and three external doors at the Maximum building and an auto print system which allowed the Shift Commander to monitor and receive a hard copy of the status of all of those systems and alarms.

There are two aspects of this situation which the Team found beyond explanation. First, within two days after the riot the contractor had been out to MSP and fully repaired the fire alarm system and its' auxiliary sub-systems. Second, with the exception of attempts to contact the contractor, the Prison staff never reacted to the security system break-down in any way, even though it was obviously life threatening. Most Security staff were unaware that the system was inoperative and those who knew thought that the break-down was only in the fire alarm system itself. The facility Maintenance staff told the Team that they believed everyone knew the implications of the equipment failure, but the Security staff, including the Shift Commanders, did not know. Forgetting about the intrusion alarms and the power override switches, the Team could not understand why no back-up safety procedures were instituted to compensate for the loss of the fire alarms and smoke evacuation devices. In fact, if there had been a serious fire at Max instead of a riot, there is a high likelihood that many more lives would have been lost than were lost in the riot.

Parenthetically, it is not apparent that if the system had been working it would have been used properly. At the Command Post, each of the two power overrides (one for the East control console and one for West) has a separate switch with a key lock. During the riot, a Maintenance person was asked to throw the power override switch and he turned the one available key to the "off" position for one of the consoles. He then realized that he did not know whether the power would go back on if he turned the key back to the "on" position to remove the key so that he could turn off the other console. An hour to an hour and a half later this Maintenance employee was again asked to use the power overrides to disable the consoles. He went to the Armory so he could get a second key and put both switches in the "off" position and leave them there. It is apparent that this critical security system had

never been tested under conditions simulating an emergency. The equipment was not understood by Security staff and at least by some facility Maintenance staff. There were no existing emergency procedures in the Shift Commander's office that would remind the Shift Commander to disable the consoles in the event of an inmate disturbance. It is also not possible to conclude that the initial attempts to use the power override switches were early enough in the disturbance that they would have prevented the inmates from opening all of the doors inside the Maximum building. It appears, based on staff interviews and the report of a Maintenance employee, that the initial actions would have been in time to stop the spread of the rioters (had the equipment been working). However, the Team could not reach a firm conclusion on this point.

Among the central questions asked of the Team was "Why did the riot occur and could the killings have been prevented?" The motivation of the rioters is explored above, but it is useful to review the factors which could have prevented the killings. If the cage gate and the yard door are properly operated on an "as-needed" basis, then it is unlikely that nine inmates could have rushed into Max. If the inmates in the yard were adequately supervised then some staff would have noticed nine inmates moving from cage to cage. If the corridor doors inside Max were left closed and operated as a sally port, as intended in the building's design, then the inmates could not have reached the East control cage which is the one they were able to break into. If the control cage doors were operated with both locks rather than leaving one lock in the open position, and if the one lock that was used was not left with the keys sitting in it, then the inmates could not have reached through the melted window to gain immediate access to that control cage. They might have been able to further melt the polycarbonate window material, but that might have taken them a much longer period of time. If the Control Cage Officers had turned the consoles off and taken the keys with them (When they exited through the roof hatches, they should have taken the console power switch keys and the key rings with all of the manual emergency keys; even if they had only taken the console power switch keys, that might have slowed the inmates enough to save lives.) then the inmates could not have gained access to the living units, even after

gaining access to the cages. Had the Command Post power override switches been operating properly, then the Shift Commander could have disabled both consoles and the inmates, again, would have been unable to get onto the living units or into individual cells. And had the management staff taken the multiple staff and inmate warnings of a riot in Max seriously, and responded in almost any way, they would have been likely to have discovered the inmate plan or to have stopped the security breaches that allowed the riot to develop.

There are another set of factors having to do with policy and procedure which might well have prevented the riot. The Maximum inmates should not have been allowed to exercise unsupervised. There is a fenced corridor between the three East and three West cages and that corridor is a natural post position that should have been staffed at any time inmates were in the Maximum yard. With proper supervision of recreation, the rec yard fencing could not have been compromised so easily. In theory, the Control Cage Officer was supposed to visually supervise inmates in the Max yard, but lack of visibility makes this an almost impossible task. Also, the reality is that the Cage Officer is busy operating doors for showers, inmate transportation, the Unit Counselor, and the like. It is particularly important to achieve close visual and auditory supervision in an area like the Max yard because it is such an easy opportunity for Max inmates to pass contraband and to talk, plan and scheme with inmates from other areas of the Max building.

When the Team asked about shakedowns of the Max yard, staff told us that the yard was shaken down with some regularity. When we asked why yard shakedowns were not mentioned in the Max Unit "shake down log" we were told that only cell shakes and other areas within the building were to be entered on the shake down log. In fact, the policy states clearly that the exercise cages and the yard will be shaken down thoroughly before and after each use of the yard, and that those shake downs will be listed in the Unit Log. Not only was this policy not observed, it was obviously unknown even to Supervisors working in Max. Even an occasional inspection of the yard fence would have been likely to have revealed the areas that the inmates had worked on and weakened.

A third critical policy failure had to do with escort of Maximum inmates. The policy for the Maximum Security Unit (H1 and H2, page 9) states that "inmates will be taken to and from the yard, one inmate at a time." This policy is directly contradicted by the First Shift Post Orders for the Maximum building which specify that no more than two inmates "may be run to the yard at one time". Typical practice, however, was to take three inmates at a time to and from the yard. Both the policy and the Post Orders also specify that there will be at least two officers for every inmate escorted and this was also violated regularly; the custom was to have five Floor Officers escort three inmates. One of the Unit Sergeants told the Team that he was concerned with the practice of escorting five on three and knew that it was not consistent with written guidelines. He told the Team that he specifically asked the Deputy Warden about this practice and was told that there was no problem with the "five on three" procedure. The Deputy Warden says he has no memory of this conversation.

Another policy says that inmates in Max may not pass anything to another inmate. That policy makes good security sense, but it was not followed. "Swampers" routinely gave meals to Max inmates, took trash, etc.

A final, most serious failure of policy and procedure has to do with allowing inmates into the control cages. Policy clearly forbids staff from opening the control cage doors when an inmate is in the area but this rule was sometimes ignored for the sake of convenience. Inmate swampers (PC's) would sometimes bring soft drinks or coffee to the Control Cage Officers who would then open the control cage door. Inmates occasionally talked with Control Cage Officers from the open door of the control cage and were able to get a very detailed look at the inside of the cages. Some of the PC's shared information regularly with Max inmates. Thus, prior to the riot it was common knowledge among the Max inmates that there was no defensive equipment or other armament (Capstun, batons, fire arms, etc.) in the control cages and the door controls and console layout may have been familiar to the Max inmates as well.

In summary, there were two general kinds of failures that allowed the Max riot to develop and spread. The first failure had to do with

policies and procedures which were missing, inadequate or unrealistic. The second set of problems had to do with staff failures to follow existing policies and procedures through lack of knowledge, negligence or willful disregard. It must be emphasized that the second set of failures loom much larger than the first. There were many policies and procedures that were imminently sensible, such as the requirement for daily inspection of the exercise yard and the requirement that the yard door and corridor door be left in the closed position, but these common sense security provisions were ignored with some regularity. The responsibility for this state of affairs must ultimately be placed on mid-managers and top administrators. Evidence from a variety of sources led the Team to the conclusion that there was little supervisory accountability at any level of the organization, and the Maximum Security Unit was no exception. Although managers told Team members that they visited the Maximum Unit with reasonable frequency, a check of the Unit Log in Maximum showed that the total number of visits from August 1 until the September 22 riot by anyone above the level of Sergeant (Lieutenant, Captain, Security Manager, Associate Warden, Deputy Warden or Warden) was 14. That translates to less than one time in every 10 shifts that anyone above Sergeant enters the Unit. One Shift Commander admitted that because of paperwork demands, he had not visited the Max Unit for at least six weeks prior to the riot. Worse, when Shift Commanders or top administrators were in the Unit, they did not check compliance with policy or procedure nor closely observe how the Unit was being run.

D. Staff Reaction to the Developing Riot:

It must be emphasized that this Section of the Report and the following Section that deals with the events inside the Maximum building during the riot are the areas where it is least possible to be precise. Almost all of the written reports are reconstructions rather than contemporaneous records. It is difficult to separate what inmates or staff heard from others from what they know of first-hand experience.

When the Shift Commander heard that two Officers were on the roof of Maximum, he detailed available staff into the Maximum Compound. During the next several minutes Security staff streamed into

the Maximum Compound and gathered around the Max building where the two Cage Officers were visible on the roof. These Cage Officers were yelling that the Max inmates were rioting and that they were attacking the cages. By most accounts it was a few more minutes before some of the responding officers assisted the Cage Officers off of the roof. Smoke was coming out of the roof escape hatches by the time the Officers did get down. It appears that it was then about 10 minutes after the initiation of the riot. The Cage Officers confirmed to the responding Officers that the Sergeant and the four Floor Officers were locked on C Block and at least temporarily safe from the marauding inmates. The staff surrounding the Maximum building then received a radio message from the Shift Commander to report back to the Command Post.

Did the Shift Commander recognize the information for what it was, that the trapped staff were temporarily safe and not yet hostages, but that once the inmate attempts to break into the control cages proved successful, they would then have control of the staff, the PC inmates and have the ability to release all of the other Maximum and death row inmates? If he did, then an immediate decision to put a large amount of chemical agent (tear gas) into the two control cages through the roof hatches or a decision to send officers with firearms in the front door of Max or down into the control cages (after verifying that they were not yet under inmate control) might have prevented a complete inmate take-over of the building. It appears that there was a window of opportunity for these actions which, from the time the first few officers arrived at the outside of the Max building probably lasted from 15 to 35 minutes.

It must be emphasized in the strongest terms that this kind of after-the-fact analysis is fraught with peril. First, hindsight is always "20-20" but it seldom bears much relation to how events are experienced when they actually unfold. Second, MSP policies, procedures and expectations were contrary to the kind of decision-making described above. A decision to use tear gas or a decision to take a firearm into the Compound was, by policy, only to be authorized by a Duty Officer. That policy makes little sense because of just the kind of situation that occurred. By the time the Shift Commander was able to reach the Duty Officer (by coincidence the Duty Officer at the time of the riot was the Warden) and fully apprise him

of the situation, the opportunity might well be lost. Third, a decision to control the building using firearms or a decision to use tear gas to keep the rioting inmates out of the cages, only made sense if there was reasonable certainty that the Floor Officers were relatively safe and that there were no hostages. In a developing riot information is seldom clear and seldom well corroborated. If there was doubt about the presence of hostages, the Shift Commander would have little choice but to follow a strategy of "isolate and contain". In fact, the Shift Commander was not certain about the status of the Floor Officers. Apparently, that information was not transmitted to him quickly and he did not interview the two Cage Officers, although the Warden later did. Additionally, the Team noted that the Shift Commander was experienced and had been through other inmate disturbances as a Shift Commander. The Team concluded that the Shift Commander performed admirably under the most difficult circumstances and that the Institution's failure to consider a broader range of tactical responses earlier in the situation had to do with weaknesses in planning, preparation, training, equipment and procedures rather than human error by the staff on shift.

A Sergeant initially responding to the Max building observed the scene and told the assembling officers (numbering from 10 to 25 at that point -- the Cage Officers were still on the roof of the building) "don't go in unless you're sure you can handle it". The Sergeant then ran back to the Command Post to see if he could find out what was happening from the Shift Commander. There are two obvious problems here. The order to the Officers was not well thought out and might have given license to a group of unsupervised staff to enter Max and imperil staff hostages. There was also an acute need for immediate on-scene command of the gathering Security staff. That could have been accomplished either by a supervisor on the scene taking charge or by a Shift Commander clearly identifying someone as the on-scene Supervisor. Neither was done.

The next series of events are not necessarily presented in chronological order. Shortly after the Sergeant left the Max building, the officers were assisted off the roof and there was radio communication with the Command Post. The staff around Max were directed to return to the Command Post. At about this time Administrative notifications were

begun, starting with the Warden. The Warden remembers a very short phone call in which he was told that officers were on the roof of Max and that that was enough to let him know that there was serious trouble. The Shift Commander had wisely assigned an additional officer to help with phone communications so that administrative notifications and other decisions were occurring concurrently. The other four individuals in the Duty Officer chain were notified and the next group of calls was to the Disturbance Control Team (DCT) members.

Before the order to return to the Command Post, the officers around Max had heard inmate Davison yelling through a window that the inmates were trying to break into the cages and that if they did so, the PC's would all be dead. Staff also observed one PC inmate in his cell appearing bloody and beaten. Another staff member saw an inmate trying to break into the Counselor's office and saw inmates beating on the control cage windows with mop handles and other instruments. When the group of staff reported back to the Command Post, they reported that they believed the Floor Officers were in one of the lower C cells.

The first top administrator to arrive at the Prison was the Associate Warden (AW) for Treatment, Mike Mahoney, who preceded the Warden by seven to ten minutes. Mahoney did not assume command of the Institution but appears to have worked in parallel with the Shift Commander with Mahoney concentrating on events inside Max. AW Mahoney directed two staff members to take an AR-15 rifle and a .357 revolver, go to the lower C cells of Max, break out a window of the cell where the Floor Officers were hiding and use the weapons to cover the escape of the Floor Officers. The two officers broke out a window in lower C 7 but the cell was empty. Inmates in an adjoining cell yelled to staff but could not make themselves heard. They wrote a note to the officers saying that the staff members were in the lower C shower room (which has no external window) .

Two other officers had been sent on a recognizance mission to enter the basement crawl space underneath the Max building. They found water and smoke problems on both sides of the building and screaming and hollering coming from the East side (blocks D, E, and F) although the West side (A, B, and C) was relatively quiet. At about this

time staff around the Max building heard inmates screaming that the inmates are in control of the cages and one inmate wrote a note saying that all of the inmates are out. It is difficult to establish times for these events except that they appear to be after 10:30 and prior to 11:00 a.m.

Warden McCormick arrived at approximately 10:40 and went to the Command Post. He wisely did not attempt to take charge instantly, but rather waited until the Shift Commander had a few free moments to brief him. After this briefing, the Warden assumed command clearly and decisively. In fact, the Warden's command presence throughout the rest of the incident was one of the most positive aspects of the staff response.

MSP has a siren that in the past has been sounded for short intervals in the event of escapes. The siren was turned on during the riot (apparently between 10:45 and 11:00 a.m.) and left on continuously for approximately 45 minutes. The siren proved extremely effective in alerting staff who were off duty that there was serious trouble at the Prison. The Disturbance Control Team Commander and one of the Institution's Captain's were bow hunting in the mountains a number of miles from the Prison on that Sunday but they heard the siren and realized that it was not stopping after a few minutes as it did in the event of an escape. They returned to MSP.

Shortly after 11:00 the pace of staff actions accelerated sharply and a number of initiatives were underway at the same time. The Warden asked for blueprints of the Max building and directed a Lieutenant, the Assistant Commander of DCT, to pull together his Team Leaders and other necessary staff and arrive at a preliminary plan for re-taking the Maximum building.

At about this time a Sergeant in the Command Post who had tried repeatedly succeeded in reaching an inmate in one of the cages by phone. The Sergeant was given a demand that the inmates be allowed to meet with the media and told that the inmates would throw a letter over the fence to the media (most likely the handwritten list of grievances that the inmates planned to negotiate over, and which was found after the riot). The inmate on the phone could not be identified by the Sergeant, but the inmate told the Sergeant that the Max inmates had control of the

Officers and the PC inmates. MSP did have trained hostage negotiators but they were not yet on the scene and this Sergeant was not one of them.

The negotiations continued intermittently throughout the entire incident and were important to staff in several ways. They provided additional information about conditions and events inside of the Max building; they held out the potential of a resolution without force; and they were later used to establish a diversion to help cover the approach of the Assault Team. The Sergeant who made initial contact with the inmates in Max was eventually replaced by MSP's one trained hostage negotiator but the Sergeant showed excellent judgment in his initial dealings with with inmates on the phone. He did many of the things that trained negotiators are taught to do. He told the inmates that staff would talk with them, he gave them a phone number so they could reach him, and he asked them not to do anything crazy. In retrospect, it is clear that the inmates in Max were not well organized. Precise cause and effect relationships for what transpired within Max will never be known, but this Sergeant's good, early work communicating with the inmates may have helped prevent the rioting inmates from turning their hostility toward the five trapped Floor Officers.

Medical facilities were checked and readied for emergency cases. A physician was standing by and ambulances were requested. The DCT Assistant Commander returned to the DCT assembly and dressing area in the Armory as additional DCT members continued to arrive, were briefed and outfitted themselves.

Most of MSP uses low band radios and there was concern that the inmates in Max could monitor these. The Warden organized the available high band radios and had them distributed to key staff members along with code names.

At about 11:15 a.m. the Warden assigned a Captain to try to reach Curt Chisholm and keep his office briefed. At 11:20 a.m. the negotiator called the inmates to try to play for time. He told them that it was hard to reach the media people because it was Sunday. Twenty-five minutes later the inmates called back and an inmate told the negotiator to get the Correctional Officers away from the building and the fence outside Max

or they would bring up a Correctional Officer hostage and cut his head off. Ten minute later the negotiator told the inmate on the phone that media people would be brought in to speak with the inmates provided staff could surround the building and contain the incident.

It was then approximately noon. The rest of the Institution had been locked down although the logs do not show when that was ordered or when it was accomplished. It is known that there were some particularly tense moments with the High Compound inmates soon after the riot began. It had been the practice at MSP to allow large numbers (or all) of the High Compound inmates to be out in the yard around mealtime with some heading towards the Food Service building and some coming back from eating. A large group of these inmates were returning to the Close III Housing Unit along the fence that separates the High Compound from the Maximum Compound when they saw officers around Max and smoke coming out the roof hatches of the Max building. Some of these High Compound inmates cheered and yelled with obvious excitement at what was going on in Maximum but they then continued on their way, went into Close III and were locked-down without incident. Given the tension that staff and inmates reported in the High Compound prior to the riot, it is more than fortunate that the Close III inmates made no attempt to start a disturbance themselves. The Institution would not have been able to respond to a second major problem, mutual aid had not yet been requested and there is a very high likelihood that if the disturbance had spread to the High-side Compound, the entire Institution would have been lost.

By this time in the sequence of events (approximately noon) the first ambulance had arrived at MSP. (ambulances had been held at the police roadblock nearby). Towers had already been double posted and additional high ground spotters and/or snipers had been deployed. A plan had been established for the retaking of Max by the DCT. The plan was that they would use an Institution fire truck to carry the Team to the back of the building and they would make a dynamic entry through the back door of Max. It was also planned that they would introduce a staff member into the Max compound with a video camera and tell the inmates that it was a media person, hoping that this person's approach to the

front of Max would distract the inmates from the fire truck carrying the DCT to the rear entrance. In readiness for this plan the Institution fire truck was driven to the warehouse where most of its' hoses and other equipment were removed so it could carry the DCT.

In the meantime, at the Command Post, there was a report that a beaten and bloody inmate had been seen at the Max sally port. The negotiator called the inmates and asked to arrange the removal of the injured inmate. He offered to turn off the water to the automatic sprinklers which the rioters had indicated was a problem within the building. The inmates on the phone denied the request to remove the injured inmate and reiterated their demand to talk with and get a written note to the media. They also said that the lights were failing and the ceilings were coming down in the Maximum building because of the water.

The decision to assault Max was arguably the most important judgement made by staff during this entire day. In the infamous New Mexico Penitentiary riot, inmates were seen torturing and killing other inmates but officials did nothing to stop the riot. New Mexico officials even said "no one has been killed yet," an unmistakable message that they did not equate inmate death with the death of "real" people like staff or visitors. Few actions September 22 deserve more positive recognition than the immediate decision to assault in response to clear evidence that people inside Max were being seriously injured and/or killed. It is clear that this decision was entirely the Warden's. It is not clear from the logs or from other sources at what time the decision was made, but it appears to have followed the sighting of a beaten and bloody inmate near the sallyport inside the front door of Max, just before noon, and the inmates' refusal to negotiate over releasing that injured inmate so that he could receive medical attention. (There is, however, one contradictory log entry recorded at 12:04, just <u>prior</u> to the report of a badly beaten inmate, that has the Warden saying "Out of time. If they're beating on our people, it's over." While this log entry suggests the decision to assault was not in response to inmates in jeopardy, it is at odds with interview data. Also, if the Warden believed he had reliable information that staff were being beaten, the response recorded in the log would have been exactly appropriate).

The Deputy Warden assigned a Sergeant to organize a restraint team to take the inmates (once controlled) from the Maximum building, search them, restrain them and take them to a field in the Maximum Compound known as "No Man's Land". In preparation for the assault on Max, radio call signs were reviewed and confirmed. Airspace over the Prison was restricted. DCT was reminded that they were to move directly to C Block where the staff hostages were believed to be held. The Warden had previously agreed with Curt Chisholm's office to clear any actions that might be life threatening and the open briefing line between MSP and Chisholm's office was used to discuss with Chisholm that the assault on Maximum was about to begin. Chisholm (and the Governor's Office through Chisholm) had been in regular contact and they were by then well aware of the broad parameters of the plan to retake Max. It should be noted that there was no interference with tactical decisions either from the Department level or from the Governor's Office, although that kind of problem has been relatively common in prison riots in other states.

Shortly after 1:00 p.m., all signs for the assault were positive and the plan was put into action. A few glitches developed. There was no one in the Command Post area who was a good candidate to role-play a media person because all of the staff members were known to the Maximum inmates. Jim Pomroy, the Acting Director of the Corrections Division, had been on-site for some time and was unknown to the inmate population. He was given a video camera and went into the Maximum Compound at approximately 1:10 p.m. after the negotiator called into the West cage and informed the inmate on the phone that a media person was coming in to take pictures. However, the DCT assault was delayed, first because it took longer than anticipated to unload equipment from the fire truck and then because they were unable to effect an entry on the rear of the Maximum building. DCT had sent for emergency keys to the back of the building at the last moment and thought that they had the proper keys with them. When they got to the back of the building, they found that they either did not have the proper key with them, or that there were so many keys on the emergency ring they were unable to locate the proper key under the pressure of the situation. Additionally,

they found that inmates had used belly chains, padlocks and other restraints to lock the doors shut and that the proper emergency key would still not have allowed a quick entry.

DCT had wisely arrived at a back-up plan, but that involved going down from the roof and in through the exercise cages in the Maximum yard. When DCT members got onto the roof of Max they found that Plan B was also unworkable because the yard gates and yard door had also been chained shut with restraint chains. The Lieutenant in charge of the DCT (its' Assistant Commander) was forced to improvise immediately and did so. The Team pried open the roof escape hatches (they had also been barricaded) and threw small pyrotechnic tear gas canisters, first into the West control cage and then into the East cage. Then, the DCT entry teams, heavily armed and with gas masks on, went down the ladder into the West control cage one by one with the Lieutenant in command leading the way. (Many SWAT, CERT, and similar tactical teams have procedures that prohibit the Team Commander from leading entries or other tactical missions because of the possibility that the Commander might become isolated or disabled. In the absence of such agreed upon procedures, it was in this case appropriate, courageous, and effective leadership for the Lieutenant in command of the Team to be the first Officer into the West cage, going backwards, blind, and essentially unprotected down a ladder into a tear gas and smoke-filled unknown.) As other members of DCT followed the Lieutenant down into the cage, they realized that the inmates on the loose in the West side of Max were not aware of the Team's presence in the cage. When sufficient DCT Officers had crowded into the cage, they left and went directly to C block ordering all inmates encountered to strip and lie down in place on the floor. Then, unarmed DCT members secured the inmates with flex cuffs, under gun coverage from other DCT staff. They were able to quickly reach the lower C shower room without encountering inmate resistance and they found the five staff hostages still locked in the lower C shower but physically unharmed. They tried to escort the five hostages to the front door of Max, but the tear gas was too thick for the hostages, who did not have gas masks, and the sally port area inside the front door area was also barricaded. DCT members retreated back to C block with the staff

hostages and then made sure that the way was clear to the West control cage. The hostages were taken out through the roof escape hatch.

When the identity of the staff hostages had earlier been confirmed at the Command Post, immediate efforts had been made to notify the families of the hostages and a family staging area had been set-up on the perimeter of the Institution for hostage families that wanted to drive to the Prison. As soon as word reached the Command Post that the hostages were rescued and safe on the Max roof, that message was relayed to the hostage families that had been reached. The establishment of a family staging area, the immediate notification of hostage families and the early notification of the hostages' safety were the first in a long and complex series of steps organized by the MSP Administration to deal with the staff hostages, staff trauma and the families of traumatized staff. The entire sequence of steps was characterized by extraordinary thoughtfulness, sensitivity and professional competence and it stands as a model for other correctional agencies that must confront violence, death and trauma.

As a side issue, one has to have substantial sympathy for the plight of the Acting Director of Corrections, Jim Pomroy. He had been appointed Acting Director less than a week and a half before the riot began and his background was in Community Corrections, so that he had little familiarity with MSP. He had barely arrived at the Prison when he was given a video camera and told to enter the Maximum compound by himself and walk towards the front door in order to provide a momentary diversion. The "momentary diversion" was not quite accurate as the delays in the assault left Pomroy in front of Max for more than 30 minutes. It is interesting to speculate what might have been going through his mind about his new job as he walked around by himself in front of a building filled with 70 rioting Maximum security inmates, and waited for a staff assault that did not seem to be coming.

Inside Max, the DCT members assaulted and secured one block at a time in proceeding to regain control of the building. "Assaulted" may be a misnomer although it is the DCT term that is used in the Logs; no inmate resistance was actually encountered. The only incident of note occurred when one inmate refused a staff member's order to strip and lie on the

floor. The staff member reports repeating the verbal command three times and then, according to three different staff witnesses, the inmate took a step towards the DCT member who then fired a warning shot into the inmate's cell door with his revolver. The inmate then complied with the order and was restrained on the floor. As far as the Inquiry Team could ascertain, that was the only shot fired on the day of the riot.

As the DCT cleared the West end of Max (A, B, and C blocks), inmates said that the PC's had been killed. The officers moved to the East side of Max and immediately found dead bodies on D block. There were four obviously dead inmates lying on lower D and one additional body on upper D along with a surviving PC inmate who was in very serious condition with a cut throat and one who had barricaded himself into his cell.

In many situations like this, subsequent criminal prosecutions have been severely compromised because of failure to maintain the integrity of the crime scene. All indications are that the DCT quickly recognized the importance of the integrity of the crime scene and identified a Command level staff member to secure the scene. In the meantime, DCT was finishing the job of controlling and searching the remaining areas of Max. As inmates were stripped and flex-cuffed on each block, they would be taken out in a group to the front door of Max and given to the Restraint Team waiting outside the front door. The DCT found two PC inmates barricaded in the Unit Laundry Room. They had used the washer and dryer to barricade the door and, when marauding inmates attempted to force the door, they had sprayed them with laundry bleach from spray bottles. They were unharmed. The inmate who had used red hobby paint to simulate blood on his face and clothing was found badly beaten, but alive, just inside the front door of Max. Inmates had initially thought he was dead in his cell and he managed to not react when they poked him with a broken mop handle. When they later returned and checked for breathing, he could not hold his breath forever and he was dragged out of his cell and badly beaten. He managed to get to the front sally port area where he made a loud show of trying to talk an officer outside the window with a gun out of shooting him. Even though the officer left

shortly after the inmate began this behavior, the inmate continued and it apparently saved his life.

E. Inside Max During the Riot:

In addition to the limitations presented at the beginning of the preceding Section, the Administrative Inquiry Team recognized that the responsibility of sorting out who did what to whom inside Max and how and when, lay with the Criminal Investigation Branch of the Montana Attorney General's office. The Attorney General had committed staff and resources to this investigation beginning the day of the riot itself, and there was no need to work at cross-purposes with those efforts or duplicate them. The question of which inmates did what to which other inmates during the course of the riot is simply not germane to the Administrative Inquiry.

Issues having to do with the staff hostages are important for the purposes of this report. Had the Floor Officers initially tried to fight with the inmates from the yard rather than isolate themselves on C block, a number of things would have been very likely to occur, all of them bad. First, the officers were outnumbered 2:1 and they may have thought initially that there were more inmates involved than that. Second, it is probable that many of the inmates had fashioned some sort of weapon for the assault, and the officers had no defensive gear whatsoever. In addition to the high probability that some of the Floor Officers would have either been injured or killed in the initial resistance, the end result would have been that the marauding inmates had staff hostages in hand rather than isolated. It would have placed extreme pressure on the two Cage Officers and it cannot be predicted how they might have reacted. It would certainly have foreclosed the options of the staff on the outside and it might have rendered an assault so risky to the lives of the hostages that a long-term siege would have ensued. There is no indication that things would have been any different for the Protective Custody inmates except that, with more time, it is very likely that more of them would have been killed.

When the Floor Officers saw that the inmates were gaining control of the cages and retreated into the shower, they took an inmate mattress

and dragged it through the water on the floor and then used that to provide a barrier between the open grill of the shower door and the marauding inmates. That mattress was intended as a barrier against fire or home made weapons, but it may have been far more important as a psychological barrier that kept the rioting inmates from focusing their attention on the group of five staff hostages. It was a very good idea. There is no dispute that had the inmates wanted to get at the staff hostages they could have rather quickly broken the padlock off the shower door using something like one of the heavy fire extinguishers or they could have set a fire against the shower as they threatened. As it was, with the hostages partially blocked from visual access by the mattress, inmates hung a blanket or curtain in front of the Lower C shower and further obscured the hostage view of the inside of Max. The available evidence suggests that the five staff hostages performed admirably. They avoided rash actions and they avoided panic, either of which might have provided the impetus for the inmates to attack them. On the two occasions when the inmates requested keys from the hostage staff, the officers tried low level verbal resistance until the inmates began to threaten to burn the officers out of their shower room. At that point the officers quite correctly cooperated but it should be emphasized that their cooperation was entirely under duress and that they cooperated only enough to prevent being attacked.

It will come as no surprise to anyone familiar with prison riot situations that a substantial number of inmates, when given the opportunity, chose not to come out of their cells or get involved and that the number of inmates actually involved in the homicides upon the PC inmates was much smaller than the number of rioting inmates. It is also no surprise that no matter how horrible a situation actually is, rumors in an Institution will have it much worse. In this case, there were persistent rumors among the Prison population a month after the riot about acts of mutilation and dismemberment. The Inquiry Team established that such acts did not happen.

F. After the DCT Assault:

Events after the DCT began to regain control of Max can be divided into what was going on within Max and what transpired outside of Max. Inside, there were groups of inmates lying on the floor secured by flex cuffs and under gun coverage. Most were naked although some inmates had ignored the first part of the order to "strip and get on the floor face down". The front door to Max could not be opened immediately because of barricades at the inner sally port doors and then because of problems with keys. (It had also been left closed to avoid problems with potential cross fire). In addition to water, smoke and tear gas within Max, the corridors were thick with broken glass that had been shattered from various interior windows.

As the groups of mostly naked inmates were led to the front door, many inmates suffered glass cuts on the bottoms of their feet. There have been many inmate complaints and allegations about the infliction of these cuts from broken glass. However, the actions of the DCT were in this regard proper. Moreover, they were necessary for the safety of all concerned. The inmates did need to be stripped naked as quickly as practical to ensure against hidden weapons, particularly since there were a large number of inmates that had unsupervised access to potential weapons and they were being restrained with flex cuffs rather than steel restraints. The staff also needed to get the groups of inmates out of the Max building as quickly as possible for several reasons. First, when the first three or four groups of inmates were coming out of Max, the last two or three cell blocks had not yet been cleared or controlled and it was not known whether or not the staff were about to meet armed resistance. If there were to be fighting or shooting, the fewer inmates in Max, the safer for staff and inmates alike. Second, the building needed to be thoroughly searched and there might be individuals in hiding who were gravely injured. The search had to be conducted quickly. Third, the building itself might not be safe. It is well documented that conditions within Max by the end of the riot were nightmarish and it was not possible to be certain that there were not life-threatening conditions due to gas, electric or mechanical problems.

Available alternatives were simply impractical. It did not make sense to bring other staff into the building with shoes or blankets and compromise the integrity of the DCT assault force. it also did not make sense for the DCT Officers to sweep or otherwise clear the corridors because the required time was a luxury they could not afford. As a final note, adrenaline levels among staff and inmates were so high and the conditions within Max so bad that DCT staff did not realize that inmates were cutting their feet on the broken glass. Many inmates also did not realize that they had received cuts until they were outside and had been lying on the ground in No Man's Land for some time.

There are also inmate allegations that DCT Officers beat, kicked or used batons on inmates who were being taken out of Max under restraints and who were offering no resistance. The Administrative Inquiry Team could neither verify these charges nor could they disprove them. The full DCT has two video operators attached to it, which is an excellent idea. Many tactical situations in jails and prisons result in allegations of improper use of force or other improper staff conduct and management must take cognizance of these recurring problem situations. Video is an excellent tool in this regard as it will document what is actually done and what is not done, although video is far from a perfect answer to documenting every situation. Video does have at least two other salutary effects. Video is a deterrent for many (but not all) inmates because they do not like to be identified or photographed during transgressions. Video is also a deterrent against staff misbehavior in that it can change staff comfort levels just enough that a staff member may not do what his or her emotional impulses may suggest.

The problem in the instant case is that the Entry Team video tape is so poorly filmed as to defy description. It will show staff or inmates within Max for a fleeting second or a few seconds and then it will focus on the floor or the ceiling for long periods of time. There is an unfortunate correlation between the audio track and the video: it seems as though most of the time screaming or yelling is heard, the camera pans to the ceiling. Bad video taping is certainly not evidence of staff malfeasance but it does raise more questions than would be raised if there were no video tape whatsoever. Even with a gas mask on one's face and

the chaotic conditions inside Max, it is difficult to understand how a video operator could have lost track of his primary mission.

The staff reports from DCT members are similarly not helpful in resolving the allegations. With the exception of the single incident in which a warning shot was fired, there is no DCT report that provides any level of detail about force used in taking inmates out of the Maximum unit. No reports mention pushing inmates along to hurry them or lifting inmates off the floor if they were reluctant to move after being restrained. If the reports are taken at face value, inmates were told to get up off the floor and walk out the front door of Max in groups and they did so. That is far too sterile a description to be believed by anyone familiar with such situations. With the exception of the few PC inmates who were found gravely injured, none of the DCT reports mention any inmate injuries although a substantial number of inmates were treated later that day for injuries other than cuts to the feet, and some of those injuries should have been apparent to at least some staff inside Max. Short staff reports lacking in detail do not prove inmate allegations anymore than does a video tape of the floor and ceiling but both may create skepticism.

(The incident in which a correctional officer fired a warning shot into a cell door on B Block was promptly reviewed by a 3 member fact-finding panel on September 26. They exonerated the officer and recommended that he be commended for his actions. The Inquiry Team did not interview the principals or witnesses and reached no conclusions regarding this incident. It was noted that some inconsistencies in the witness reports were not addressed by the fact-finding panel report.)

Outside the front door of Max was a large contingent of MSP staff. More than an hour earlier, a Sergeant had been assigned to assemble and coordinate a Restraint Team. By the time DCT entered Max, this group of officers had grown to 60 or 70 in number. Helmets, batons, handcuffs and other restraints were passed to this group although not every staff member received every item. That is, some staff had batons and some did not. Some carried belly chains, some had helmets, etc. This large group was assembled in the courtyard outside the Shift Commander's office and when DCT brought the staff hostages onto the roof of Max

and reported that they were physically unharmed, the Warden himself led the Restraint Force as they ran into the Max compound in a double line that assembled on either side of the front door of Max. This group of staff outside the front door of Max is referred to by inmates as "the gauntlet".

The Administrative Inquiry Team received many consistent inmate allegations that the inmates coming out of Max, naked and handcuffed behind their backs, were forced to run through this gauntlet while the officers in the double receiving lines hit, kicked, tripped or swung batons at the inmates. Most inmates said clearly that not every inmate was abused in this way and that some inmates were allowed to move through the gauntlet without trouble. The staff members initially interviewed by the Inquiry Team said that there was no excessive or unnecessary use of force whatsoever. They did say that there was some confusion because it had not been well understood in advance whether an inmate coming out of Max would be taken by the pair of officers nearest the front door and led through the receiving lines and then to No Man's Land, or whether the inmate would walk down the receiving lines and be taken by the last pair of officers. The Inquiry Team was also told that a number of inmates were very reluctant to leave the Maximum building and had to be propelled out by DCT officers inside or grabbed by the closest staff on the outside and pulled out and that some inmates fell during this procedure. The Inquiry Team was initially skeptical that inmates would be hesitant to leave a building filled with smoke, tear gas, broken glass and perhaps fires and marauding inmates unless there were something on the outside of the building that the inmates were even more worried about. Subsequently, three separate staff members, each of whom was on duty during the riot and in a position to have first-hand knowledge of exactly what transpired in the receiving lines confirmed the inmate allegations in substance and in detail. Those staff members verified that handcuffed inmates coming through the gauntlet were in some cases kicked, punched or hit with batons. One Officer who admitted to watching as naked and restrained inmates were kicked stated that this was justified as it was "morally correct". Another Officer described how he "drop-kicked" an inmate in the head who had fallen down in front of him. He further stated that he

didn't do serious damage to the inmate because he was wearing his soft-toed shoes. He also said that he was now sorry, but that at the time he had been "pumped up". Two less obvious abuses were described that can be extremely destructive. If a person who is handcuffed behind his back is walking or running and is then tripped, the person has no ability to break his fall and will pitch face-first into the ground. Very serious injuries can result. The second abuse also has to do with the handcuff position. If someone is handcuffed behind the back, and the handcuffs are grabbed and lifted up sharply, it may feel like both shoulders are being dislocated and great pain is inflicted. The Administrative Inquiry Team concluded that these abuses did in fact occur and that the reports and interviews of the staff on the scene represented a systematic cover up. The gravity of this conclusion was fully recognized by the Team.

When the inmates were taken to No Man's Land, they were placed face down, handcuffed behind their back. The small number of inmates that were still dressed were stripped at this point and those inmates who had flex cuffs on had them replaced with steel handcuffs. There is nothing inherently wrong with the idea of the twin receiving lines, with the plan to escort inmates leaving Max two-on-one to No Man's Land, or the idea of placing the handcuffed inmates face down, naked on the yard under the gun coverage afforded by the Towers until alternate housing or transportation could be arranged. Unfortunately, there were again repeated inmate allegations about staff abusing inmates in No Man's Land, primarily by kicking inmates as they lay on the ground. Two of the three staff that confirmed the abuse in the gauntlet could also confirm the abuse of the inmates in No Man's Land from first hand knowledge. (The third staff member was not in a position to see the inmates in No Man's Land, but reported that he was told by a staff member that he worked with and who was a good friend that he had seen a particular inmate being kicked by staff in No Man's Land.) One staff member told the team that he had not seen inmates being kicked in No Man's Land, but "we sure screwed them into the ground pretty good when we got them there". The Inquiry Team concluded that improper and unnecessary force was used upon some inmates in No Man's Land.

Other problems occurred in No Man's Land. Inmates were on the ground there for six to seven hours, beginning shortly after 2:00 p.m. and ending between 8:00 and 9:00 p.m. when inmates were moved to Reception. The number of inmates varied as some went to the Infirmary, but approximately 55 inmates were secured there with five or six inmates in the Infirmary and a few inmates with very serious injuries were transported out of the prison to area hospitals. September 22 was a hot day and some inmates suffered sunburn as they had no way to protect their backs, legs or ankles from the sun. Some other inmates complained about the length of time that they were left handcuffed behind their back without relief and/or that the handcuffs had been applied too tightly. When evening approached, the temperature fell quickly and inmates alleged that they were left naked in the cold until 8 or 9:00 p.m. Administrators told the Team that when it began to get dark they sent for blankets from the warehouse and that inmates in No Man's Land were each given a blanket until they were moved to the Reception housing area. The Team did not reach conclusions about the additional allegations of mistreatment in No Man's Land. Some exposure to the sun may have been unavoidable because staff had to place a large number of inmates in some location where they would be secure and under gun coverage. No Man's Land was an appropriate choice. Blankets or clothing for the inmates had to wait until the Maximum building was cleared and secured and even then, medical screening of staff and inmates was the next priority. The standard that should be applied to this kind of question is one of reasonableness, and staff cannot be faulted for failing to do everything at the same instant. They had to make sure that they were locating all seriously injured individuals; they had to isolate and secure a multiple homicide scene; they had to coordinate with the mutual aid agencies that were on-site; they had to care for the staff hostages and their families; they had to make arrangements for where to house 60 Maximum security inmates and they had to make sure that the rest of the Prison was attended to. Nevertheless, it is reasonable that after some period of time, the staff would be able to turn some attention to the welfare of the inmates in No Man's Land. Unfortunately, there are no log entries in the Command Post Log that document when or if blankets were

sent to No Man's Land. There are no entries that indicate an order to check inmate restraints or check the condition of the inmates in No Man's Land. The Team was unable to find any staff reports that would shed light on these questions. Ultimately, staff who were interviewed believed that the treatment of the Maximum inmates was reasonable and most of the inmates interviewed did not. The Inquiry Team's findings on a wide range of issues and incidents does suggest that what some staff at MSP believed to be reasonable treatment may fall well short of contemporary national standards in corrections, and the plain fact is that some staff's lack of concern with the welfare of the Maximum inmates after the riot stands in stark contrast to the truly exceptional care and concern afforded to traumatized staff which further supports the Team's contention that staff and inmates were extremely polarized prior to the disturbance.

V. The Aftermath

A. Debriefing:

Debriefing is here distinguished from medical and psychological screening. There are two kinds of debriefing that should be mandatory following a major incident. The first is the report writing and interviewing that should take place as soon after the conclusion of the incident as is possible. The point of this first kind of debriefing is to provide the best possible documentation of what actually happened. It is critical that this kind of debriefing be accomplished before staff go off-duty or leave the institution at the end of the incident, although there are a few obvious exceptions to this rule (seriously injured parties, hostages who may not be in condition to be interviewed, staff with a family emergency, etc.). There are additional standards for this kind of debriefing and they too are crucial. A debriefing should be under the direction of someone who is not a key player or decision maker in the incident itself, but who is management level if possible. All written reports, taped statements and interviews should be reviewed by someone to make sure that they contain adequate detail, that important issues have not been omitted and that the substance is not contradictory to the general understanding of the

incident. When these criteria are not met, the individual involved should be asked to provide clarification or additional information. The reviewing staff member should sign the report or be identified on the audio tape and the time at which the report or audio tape was made should also be documented.

The second kind of debriefing that should be required after a major incident is a staff analysis, or "critical incident review", that looks at what was done correctly and incorrectly and attempts to identify changes necessary in policy, procedure, training, etc. The critical incident review should not be done immediately after the incident itself, but is best accomplished a few days later. The single biggest pitfall in critical incident reviews is ensuring that they do not become exercises in "head-hunting", aimed solely at finding out who will be disciplined.

The MSP staff did some of each kind of debriefing, but both were inadequate. Most of the written reports from staff are of extremely poor quality. It is apparent that no one reviewed these reports or most would have been rewritten. More bothersome is that large numbers of key staff evidently did not write incident reports at all. (The Inquiry Team was given what MSP refers to as "the riot file" and was told that it contained all available documentation from the day of the riot. Well over 100 staff participated directly in the events of the September 22 riot, yet the "riot file" contains less than half that number of staff incident reports.) There are no incident reports for most of the mid-managers and administrators who were on-scene that day. The Lieutenant who was the Shift Commander when the riot started said that he wrote an incident report. MSP cannot locate it. The Sergeant who was placed in charge of the restraint team by the Deputy Warden did not write an incident report, nor did the Deputy Warden. There were no staff interviews or tape recorded statements that the Team was aware of. There are no indications on written reports of when they were prepared, although the Team concluded from talking with staff that most or all of the written reports were completed the day of the riot. There was no one directing the debriefing process and no one verifying that each staff member was providing a written report before leaving. No one prepared an inventory of

logs, notes, incident reports and other documentation. None exists to this day.

As is true with many aspects of this situation, the DCT members seemed to have done a substantially better job with debriefing than the rest of the staff. Most of the DCT staff submitted incident reports while most of the rest of the staff did not, and the DCT did conduct a thoughtful critical incident review, under the direction of the Warden. There is no evidence that the staff in the Command Post during the incident, the Medical Staff, Plant Operations, or other groups of staff that figured importantly in this incident conducted any critical incident review. The Commander of DCT did produce an investigation report into the riot but it only attempted to identify how the inmates had been able to gain control of the Maximum building.

Two points must be emphasized about debriefing. Without good debriefing it can be almost impossible to later answer important questions about an incident. Times, locations, decisions reached, and staff members involved can all be lost. Because of poor or missing documentation, the Inquiry Team found itself in a maze without road signs on too many relevant questions. The second point is that after a serious incident there are strong pressures on staff to leave, get home to families and to begin to try to unwind. Without preplanned procedures and strong training about emergency situations, it is the rule rather than the exception that debriefing will be handled badly.

B. Medical:

The Warden was very careful to make sure that Medical Staff were on-site and mobilized as close to the Maximum unit as possible before the assault took place. That was an important and proper decision. As inmates came out of Max after the riot, there were several very seriously injured individuals. At least some staff and some rioting inmates had mistakenly thought that the inmate who was found on the upper level of the PC block with his throat slit next to a dead inmate, and the inmate who was very badly beaten and found near the front door of Max, were dead. Gurneys were brought up near the front door of Max as these seriously wounded inmates were brought out and it appears that they

were on the gurneys and in route to area hospitals as promptly as possible. Inmates with less serious injuries ended up in No Man's Land and were taken from No Man's Land to the Infirmary. The most serious of these cases stayed in the Prison Infirmary and the less serious were seen and/or treated and then returned to No Man's Land. It is not clear how inmates were selected from No Man's Land to be taken for treatment. Rather than any systematic review of each of the inmates in No Man's Land, it appears that those who were asking for medical attention or those who were seen by staff as needing treatment were taken to the Infirmary on a continuing basis. The Inquiry Team did not attempt to determine the quality of medical care provided to inmates on the day of the riot; similarly, no conclusions were drawn about the promptness of medical care, in part because of the recurring problem with poor documentation. It is obvious that medical treatment was made available to serious injured inmates and the Team did not receive inmate allegations about withholding care from anyone on the day of the riot.

Fortunately, there were no serious staff injuries. That outcome, however, could not be known prior to the assault and DCT members or the staff hostages might have emerged with serious injuries. It appears that the staff had made thoughtful provisions for that possibility.

On negative side, ambulances should have been called out almost immediately because it was impossible to predict when injured individuals might be recovered or need attention. Fortunately, this mistake proved irrelevant. Some contact also should have been established early on with local hospitals, particularly after the report of a badly beaten person near the Max front door.

C. Psychological:

Psychological screening was provided on the day of the riot by MSP staff psychologists or other members of the Treatment and Counseling staff. The seven staff hostages were seen first and then all members of the DCT had individual clinical interviews as did any other staff member who observed the dead bodies, the killing scene, or who gave any other indication of being traumatized. In times past there was a code in corrections that said that seeing a mental health professional was a sign

on the guidelines and in rules to area hospitals as currently as [illegible]. Inmates with less serious injuries ended up in Mo's Land were taken from Mo Man's Land to the Infirmary. The most serious of [illegible] stayed in the Prison Infirmary and the less serious were sent [illegible] and then returned to Mo Man's Land. It is not clear how inmates were selected from Mo Man's Land to be taken for treatment or there any systematic review of each of the inmates in Mo Man's [illegible] It appears that those who were seeking for medical attention or those who were seen by staff as needing treatment were taken to the Infirmary on a continuing basis. The Inquiry Team did not attempt to determine the quality of medical care provided to inmates on the day or on any similar day. No conclusions were drawn about the proportion of inmates, during the past because of the recurring problem with overcrowding [illegible]. It is obvious that medical treatment was needed to serious injured inmates and the Team did receive inmate allegations about with holding care from anyone on the day of the riot.

Fortunately, there were no serious staff injuries. That person however, could not be known prior to the assault and DCT members or the hostages might have emerged with serious injuries. It appears that staff had [illegible] the [illegible] ful provisions for that possibility.

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[illegible]

[illegible] psychological screening was provided on the day of the riot by [illegible] psychologists or [illegible] members of the Treatment and Counselling [illegible]. The seven staff hosts [illegible] were given first aid and then all members of [illegible] interviews as did any other staff member [illegible] gave any other

of weakness, even for a staff member who had been held hostage. Some vestiges of that "macho" code remain and the proper management response is to make psychological screening mandatory when there is any question of need. MSP did exactly that. It was but another in the series of steps that MSP took to try to deal positively and sensitively with the effects of inmates deaths and staff hostages on the psychological well-being of staff members and their families. MSP's performance in this area was remarkable for its sophistication, thoughtfulness and effectiveness.

Every staff member sent for psychological screening was seen a minimum of twice. This is excellent procedure because delayed reactions to trauma are relatively frequent and a Correctional Officer who was doing quite well the day of the riot might find that two or three weeks later he or she was experiencing nightmares, anxiety attacks, or other symptoms of post-trauma reaction.

Approximately one week after the riot, the treatment staff organized a meeting for families of staff. The meeting (October 3) was well-announced in advance, and approximately 75 people attended, a remarkably good turnout. At this meeting, spouses were able to talk about their fears that a husband or wife would be killed in the Prison and feelings were also explored about the inmate deaths and the staff hostages. Additionally, the riot was so heavily publicized and talked about in the small towns surrounding MSP that no one could avoid the topic, including young children. Thus, there was some attention at the meeting regarding how to discuss something like the riot with young children. Staff and families were most appreciative. The meeting appeared to help pull the staff together in the aftermath of the riot. It seems to have been an extremely good idea, conducted extremely well. Perhaps as a result of the very thoughtful management of staff reactions, only two staff quit in the wake of the riot, a very low number as these kinds of events go.

Another crucial aspect of dealing with these kinds of tragic situations has to do with planning for the rehabilitation of staff who do suffer serious psychological trauma. Again, MSP has done an outstanding job. When staff have been held hostage, some agencies will give no time off unless staff demand it, or they may offer a day or two of

administrative leave. Experience has shown that expecting hostages to remain on the job is not a good idea and may have dire consequences for the hostages' ability to successfully recover and work productively. On the other hand, a small number of correctional agencies have established equally destructive expectations that any staff member held hostage should be off work for a period of months. No answer is perfect and no plan will guarantee that a particular staff member will be able to return to work or will fully recover from a traumatic incident. However, what seems most effective is to give staff a long enough period to compose themselves and to find out whether there are severe delayed reactions. Operationally, this means from one to several weeks. It is also important that staff members are being seen regularly during this time and that they are brought back to work carefully and with a plan for monitoring their adjustment. MSP did all of that. The staff hostages were away from work for approximately three weeks and during that time they had counseling regularly. When they returned to work they did not go back to the Max unit and they started with non-inmate contact positions, such as the Towers. A group counselling session was established for all of the seven staff hostages to talk with each other about their adjustment, and as the Administrative Inquiry Team completed its' work, the plan was for that group counseling to continue once a week for the near future.

It is sometimes found that a major reason that staff held hostage do not return to work successfully is because of the negative, if subconscious, reaction of non-hostage staff to the hostages when they return. To counteract this, and also to deal with staff members who might not have been identified as traumatized but could nevertheless be suffering, the Psychology, Treatment and Counseling staff wrote and distributed a few memos to all staff dealing with grief, death, fear, hostage situations and the like. The Inquiry Team found these to be most effective. They were very practical in that they identified some of the more frequent kinds of problems that staff or family members might be experiencing, therefore, giving staff license to acknowledge those problems. The sensitivity and values demonstrated by talking about the difficulty of dealing with death and grief without distinguishing between inmate death and staff death was not lost on the Inquiry Team.

The Inquiry Team concluded that MSP actions in coping with staff trauma could well serve as a model for other correctional agencies nationwide.

D. Hostages:

Much of the care afforded to the hostages has been described in the preceding section of this report. There are, however, additional factors that are relevant to these hostages and to hostage situations in general.

It should be noted that the Inquiry Team interviewed some, but not all of the hostages. The Team did not want to interview hostages who were reluctant, particularly since they were just returning to work and a detailed review of the incident could be very difficult for them. Thus, the Team was most grateful that a few of the hostages did freely volunteer to be interviewed. There remained, four weeks after the riot, substantial anger and emotionalism among the hostages. That should be a surprise to no one. There were also some clear signs of guilt about the inmate deaths and about the riot generally. That, too, should be no surprise. Those guilt feelings may have been exacerbated by the hostages' knowledge of the common sense procedural errors that allowed the riot to develop, and the fact that they had not been held accountable for those errors. It likely would have been easier for some of the hostages had they been quickly and decisively disciplined after the riot while still acknowledging their exemplary conduct as hostages.

MSP staff made an excellent decision in identifying seven staff as hostages, rather than five. They could have defined the five Floor Officers as hostages and treated the two Cage Officers, who escaped at the beginning of the riot, in the same way in which they treated the rest of the staff. However, it was obvious that the two Cage Officers were deeply shaken. It was humane to group them with the five Floor Officers and it also helped allay unvoiced suspicions from some staff that the riot could have been stopped had the Control Cage Officers remained in their cages.

E. The Step-Down Plan:

As with debriefing, there are usually two parts to a Step-Down Plan. The first part is deciding how the Institution will operate in the 24 to 72 hours after a major emergency. The second part is the longer term strategy for returning the Institution to normal operation. MSP did not do well with either of these.

Some jails and prisons treat Step-Down Plans as a minor annoyance, ("Where do you want to stick the Dorm 1 inmates until we get most of the tear gas out of the dorm?"). Failure to treat the Step-Down Plan carefully, with thoughtful attention to detail, can have severe consequences. Among the recent, highly publicized prison insurrections in this Country in the last ten years, the New Mexico riot, the disturbances at Jackson, Marquette, and Ionia in Michigan in 1981 and the 1989 riot in Pennsylvania at Camp Hill all provide examples of situations in which it wasn't over when it was over. In the Michigan situations and the Pennsylvania riot, the initial disturbances were nowhere near as serious as what ensued in the next one to two days. Tensions in any correctional institution run high after a major incident and a sloppy or poorly conceived Step-Down Plan can lead directly to further violence. Step-Down Plans are also inherently difficult because of the circumstances in which they are forged. Top staff may have been on duty for a day or more without sleep, Subordinates are emotional and conditions chaotic. It is tempting to make a few snap decisions and go home.

The short-term plan arrived at in the late afternoon and evening of September 22 was very basic. It was to move the new intake inmates (the "fish") out of the Reception building and use the Reception area for the 50 to 65 Max inmates who had been displaced when the Max unit was rendered unusable. Since the rest of the Prison was already locked down and since MSP had experience in running under lock-down conditions, there was little question but that the Institution would remain on total lock-down for the near term.

There were a number of elements that should have been considered in the short term plan and were not. No command level staff person was left in the Reception Unit as a precaution against staff retaliation, nor

were any other preventative measures taken. While some inmates with relatively serious injuries continued to go to the Infirmary during that first night, medical screening should have been planned for all of the Max inmates, if for nothing else than to document their condition after the riot and limit the State's exposure to future liability judgments. A basic informational release about the outcome of the riot could have been made available to the general inmate population, where the wildest rumors continued to flourish. By late afternoon on September 22, it would have been possible to assign a few mid-managers to divest themselves of other responsibilities and begin to outline the short-term Step-Down Plan. However, there was neither training nor procedure at MSP that would make mid-managers familiar with the concept. By default, the Step-Down Plan became the answer to the question, "where shall we put the Max inmates?".

The longer term Step-Down Plan arrived at over a period of days or weeks was a matter of considerable fascination for the Inquiry Team. It was apparent almost from the time the Team began touring the Prison that the Step-Down Plan was not working. It was intended to increase security rather than to return the Prison to normal operations, but the Inquiry Team concluded that it was having the paradoxical effect of decreasing security.

After the riot, staff had seized the situation as an opportunity to re-establish controls that many staff felt should never have been relinquished to inmates in the first place. For example, the Prison outlawed a number of items of inmate personal property, such as Rugs and large containers of smoking tobacco that had previously been allowed, and had even been sold in the inmate canteen. A limit was placed on the number of audio cassettes that an inmate could keep in his cell (24) and the number of allowable in-cell hobby crafts was changed from two per inmate to one per inmate. For inmates on the High security compound, recreation was reduced from approximately four and one-half hours per day to approximately an hour and fifteen minutes per day and education time was reduced from about fifteen hours per week to three hours per week. Some paid jobs were eliminated. High compound inmates had visiting days reduced from five a week to three per week.

The reaction to these changes from High compound and Low compound inmates alike was "Why are we being punished when we didn't have anything to do with what happened in Max?". It was not just the restrictive nature of the changes or the fact that they were announced as permanent rather than temporary changes that angered the inmates. They were also carried out badly. Inmates received inadequate notice or no notice at all that many common inmate possessions were being disallowed and would have to be shipped out of the Prison, to someone on the outside. Some of these items were required to be shipped at the inmate's expense and if an inmate had no one on the outside to send things to, or had no money on the books, then personal possessions which the inmate had saved to purchase and which had been acceptable for a long time might well be thrown in the trash by the staff. If these changes had been superimposed upon an institution that had been functioning smoothly prior to the riot, it would have been one thing. That was not the case at MSP. Staff - Inmate distance was excessive prior to the riot and, as might be expected, rather worse after the riot.

In the aftermath of the riot, it would have made excellent sense to improve security, particularly since so many security failures contributed to its' occurrence. However, the Step-Down Plan did not substantially change security, with the exception that more inmates were locked up more of the time. Some benefits were realized in fire safety because of the decrease in personal possessions kept in inmate cells, although the Inquiry Team still rated fire safety as alarmingly poor at MSP.

It should be noted that a number of the changes, such as those affecting in-cell property limitations, actually involved reimposing and enforcing existing policy that had gone unobserved for a long time (or perhaps had never been enforced). Management regarded this as an important distinction. The Inquiry Team did not. The Inquiry Team was more concerned that the management implications of the various changes had not received the careful analysis appropriate to the situation. Rather than imposing restrictions, the emphasis should have been on adherence to existing security procedures and development of additional security procedures where lacking.

The Step-Down Plan was arrived at through a succession of changes in inmate regulation, rather than as a single, comprehensive change. This added to the difficulty of the situation because inmates felt that each successive change added to the pressure on the population. The Administrators at MSP worked to get supervisory participation in the changes and they also took steps to make sure that the various changes were well communicated to the living unit staff. In spite of these good efforts, the process broke down at some point and most inmates received incorrect information, or no information about the changes. Inmates were unable to make a connection between the Step-Down Plan and security, and could only regard it as retaliation.

There is a very positive footnote to this discussion. After the Thursday evening meeting with Chisholm, Pomeroy and the Warden, at which the Inquiry Team communicated its concerns with the high tension level in the Institution and with the nature of the changes that had been made, the Warden almost immediately began initiatives designed to inform and reassure the inmate population about the temporary nature of some of the more restrictive changes, and also to increase staff responsiveness to inmate needs. By the time this report was completed, recreation for High Compound inmates had been increased to 2 1/2 hours per day and education restored to its' original three hours per day. Most, but not all, paying jobs had been restored for High and Low side inmates. Almost all inmate programs had been restored. (AA is an exception, but is expected to be operational by early January, 1992).

What has not yet been discussed are the Max inmates and the surviving PC inmates and how the Step-Down Plan dealt with them. It appears that there was no plan as such beyond keeping the Max inmates in the Reception building until the Max building was ready to reoccupy. The rest of what happened in Reception seems to have been created on an "as needed" basis. In retrospect it is obvious that a thoughtful, detailed Step-Down Plan should have been carefully developed and carefully administered. What did happen in Reception between September 22 and October 15, the date on which the Max inmates were returned to the Maximum building? In part, the Inquiry Team does not know. The Team received inmate allegations of mistreatment in Reception

towards the end of our week on-site. There was little time left to re-interview staff and inmates and review new documents. As indications of the issues in Reception began to emerge, it also became clear that it would take a separate comprehensive investigation to answer all of the questions and charges that were raised about those three weeks in the Reception Unit.

Inmates alleged that they were left for the first several days in Reception without clothes and without mattresses; that they were fed two meals a day and denied hygiene items (toothbrush, toilet paper, Kleenex, etc.) and denied showers; that Capstun (similar to mace) was used on inmates who refused to talk with the Attorney General's investigative staff; that for weeks they were denied phones, mail, visitors, legal material, and lawyer contacts; and that some inmates were left for extended periods of time on the floor, naked and hog tied (handcuffed behind their backs with leg irons on and the leg iron chain passed up through the handcuffs so that they were bent over backwards).

A unit log was kept in Reception from the September 22 until October 15. Unfortunately, this log is less than reliable. There are a number of entries where inmates are taken off the unit without an entry documenting the inmate's return, even though it is obvious from the subsequent day's count that the inmate did return. Similarly, staff are sometimes logged into the unit but then not logged out of the unit. The most frequent problem with the log, then, seems to be that significant events that occurred may not have been logged. That became a critical issue with some of the inmate allegations; reliance on the unit log would lead one to conclude that most of the inmate allegations were accurate, in that events like showers do not appear in the logs. It may be, however, that the events in question did occur but were not recorded.

The Inquiry Team was able to confirm a number of serious allegations. Inmates were fed two meals a day, consisting mainly of cold sandwiches. This was because of the complete lock-down. MSP could not produce regular meals without inmate workers in the kitchen (even the Treatment staff was put to work making sandwiches in order to feed 1,100 inmates and the improvised kitchen staff worked 12 hour shifts. This seems like a poor allocation of staff resources because a lock-down

always creates sharp tensions and the counselors would have been more valuable out in the units talking with the inmates than making sandwiches.) Feeding cold meals may be a necessity immediately after a riot and perhaps two meals a day is also all that was initially possible. The problem is that within a few days there should have been ways to alleviate the problem. Certainly some minimum custody inmates could have been used in the kitchen without great risk. Perhaps one hot meal could have been substituted for sandwiches each day or perhaps minimum and medium inmates could have begun eating in the Dining Room under heavier supervision than normal. It is difficult to conclude that there were no acceptable alternatives to cold sandwiches twice a day for three weeks.

It appears from the log that the Max inmates were left naked and without mattresses (but with blankets) for four to five days. A log entry on September 25 refers to passing coveralls on the blocks, except for "Z" block. A subsequent entry on September 27 says "passing mattresses and coveralls on Z block". The first mention of towels to allow inmates to wash in their cells occurred four days after they are moved into Reception. It appears that showers were not allowed until October 15, more than three weeks after the riot. It is difficult to justify these measures. If they were imposed for punishment then that is illegal and also illogical (in that staff knew that not all inmates had participated in the riot). If they were justified as necessary for security then the argument is just wrong. What threat would coveralls pose on well searched inmates being held under complete lock-down? If there were enough staff to escort inmates to the Infirmary and to see the AG's investigators, why weren't there enough staff to safely shower inmates, even if it had to be done on a slow and staggered schedule?

On September 25, the log indicates that a supervisory staff member and some correctional officers went to take an inmate to talk with the AG's investigators. The inmate refused and the staff member used Capstun on the inmate twice, after which he complied. This likely was an imposition of corporal punishment. It may be argued that staff were within their rights ordering the inmate out of his cell and that it was this refusal that justified the use of force. However, an inmate cannot be

made to talk to investigators and to take an inmate who is resisting and in restraints out of his cell just so he can be brought back to his cell after refusing to talk face-to-face, is not a legitimate use of Capstun. The staff member who actually used the Capstun wrote no report although it is required by policy to do so. Moreover, the Deputy Warden left a standing order on that occasion with the Reception Unit staff that if the same inmate refused any further orders, they were to use Capstun on him. That order is blatantly improper. Presumably it would cover the inmate being told to stop yelling or the inmate being told to sit on his bunk. Capstun is justifiable only as self-defense or to assist in placing an inmate in restraints or bringing him under physical control. When it is used to make an inmate start doing something or stop doing something, then it is being used as punishment for noncompliance and that is not legal.

Perhaps the worst aspect of this situation is a Supervisor's testimony that this inmate was selected as the first to be taken to the investigators because on the preceding day he had said that no one would ever handcuff him again. The staff also acknowledge getting approval for the use of Capstun from the Shift Commander before even trying to talk with this inmate. If the priority was to avoid use of force situations where possible , then it would make sense to avoid this inmate until other inmates had been handcuffed and taken to the investigators without incident. For the Inquiry Team, this information raised questions about the judgment of supervisory staff, as well as their motivation. If managers reviewed the reports of this incident, they evidently found nothing amiss.

On the same day, September 25, the Deputy Warden ordered a different inmate to be stripped and put in belly chains and leg irons. It appeared as if this inmate was not hog-tied but, rather, was fully restrained standing up. There is no reference in the log to this inmate's behavior. Placing restraints on an inmate who is already locked securely in a cell may be justified if the inmate is trying to harm himself, or if he was, for example, trying to assault an inmate in an adjoining cell through the open bars. In this case, the inmate was released from his restraints exactly 24 hours after he was placed in them. It appears that he was given a 24-hour "sentence" by the Deputy Warden. This incident and the

preceding incident with Capstun underscore the importance of a well-written use of force policy and of staff training that guarantees staff understand the policy and its application. MSP has no such policy and no such training.

The Reception log shows other incidents where inmates are chained, put in restraints and/or their coveralls are taken from them. There is no indication that these inmates were suicidal and there is no other good reason for leaving an inmate naked. In these cases the various requirements of the MSP policy statement on restraints were routinely violated. Mandatory reports were not written, medical and security checks were not performed or were not logged, or both, and Treatment staff were not consulted.

Inmates in Reception were not allowed phone calls, visits, recreation, personal possessions or legal materials. Inmates reported that they were denied attorney contact during the entire three weeks in the Reception Unit. MSP and Department management said that was only true for five days and that after that an inmate could give 24 hour notice and have an attorney visit. The Inquiry Team was skeptical of this assertion because an inmate who was denied mail and phone privileges would have no way to contact his attorney, or to be contacted, to set up an attorney visit. More persuasively, the Reception unit log reflects not a single attorney visit or phone call to any MAX inmate prior to Oct 4, and only a few legal calls or legal visits are recorded during the entire three weeks in Reception. While some of these prohibitions may have been justifiable for varying but short lengths of time, three weeks was excessive for those items. The restrictions placed on the Maximum inmates after the riot were not because MSP had to, but because MSP wanted to.

During the week that the Inquiry Team was on-site, Court Orders were issued on behalf of a few inmates from the Max Unit whose attorneys had petitioned the Court claiming that the inmates were being held essentially incommunicado. The Court found no plausible security justification for the continued refusal of MSP to allow attorneys access to their clients and directed MSP to immediately let these clients see their

lawyers for unlimited lengths of time during working hours Monday through Friday.

The most serious allegation about the Reception unit was that a number of inmates were hog-tied, naked and left in that position for a long period of time. The background is that the Max inmates began to be noisy and verbally abusive by September 27 and then there are intermittent log entries about groups of inmates becoming loud or shouting obscenities scattered through the log. The most problematic location was "Z" block. On September 28, staff heard inmates talking about a hunger strike planned for October 1. On October 6, the log reflects that inmates were yelling and banging on doors on two different blocks. On October 9, the noisy, disruptive behavior was continuing and staff heard some of the Maximum inmates talking about breaking the porcelain toilets off of the wall and starting a disturbance. A supervisor believed that he could identify five of the inmates who were participating in this discussion from the sounds of their voices over the PA/Intercom. Other staff evidently identified six ringleaders. Management at MSP regarded this as a serious threat of further violence. The Warden met with four of his top staff members for approximately two hours to decide how to respond. They concluded that they had to do something preventative and decided to place a small group of inmate ring-leaders in "full restraints" for 24 hours. The Warden so ordered it. The top managers acknowledge that they understood "full restraints" to mean using handcuffs and leg-irons to hog-tie someone naked on the floor (although the MSP policy statement on use of restraints defines "full restraints" as "the use of handcuffs with belly chains and leg cuffs")

The DCT was assembled in case there was strong resistance from the inmates who were to be placed in full restraints. The six inmates were stripped, hog-tied and left naked on the floor of their cells with instructions not to move or struggle against the restraints. The Warden, Deputy Warden, the Associate Warden for Treatment and one of the Security Managers were in the Reception unit for the application of the restraints, which began shortly after 9:00 p.m. (10/09/91). No serious resistance was encountered and by shortly after 10:00 p.m., the DCT was released and left the unit. The restraints were initially left on for

between five and seven hours and after that were removed for 10 to 15 minutes at approximately three hour intervals. During one break, shortly before noon the next day (10/10/91), the restraints were apparently off for over a half hour so the inmates could eat. After about 23 hours, five of the six inmates were released from the hog-tie position. One of the inmates had wriggled in order to get his hands below the level of his buttocks, which took a substantial amount of pressure off his wrists and ankles. He may have gotten his hands below his feet, ending up handcuffed in front and with leg irons on but without connection between leg irons and handcuffs. He was reminded that he had been told not to move or change position and he was left hog-tied for an additional 24 hours.

Serious injuries resulted from the hog-tieing. One of the six inmates evidently hyperventilated, passed out, and then vomited. Staff removed his restraints and took him to medical personnel. He was revived, brought back to the block and placed back in the hog-tie restraints. When the physician member of the Inquiry Team examined four of the inmates involved it was over two weeks after the restraints had been removed. He found substantial handcuff wounds and indication of probable injury to superficial nerves on the hands of all four inmates. His prognosis was that the handcuff skin wounds would heal with no greater residual than superficial scarring and that ultimately there would probably be no irreversible nerve function impairment. However, since there still remained a possibility of permanent nerve damage, he recommended a neurological consult for each of the inmates complaining of numbness involving their hands.

The Inquiry Team was shocked by these staff actions. However, in discussions with MSP top administrators, it was clear that they did not believe there was anything wrong with what they did. They thought that their actions were proactive, that they prevented these six inmates from starting another riot, and that they set an example for the rest of the inmates that further violence would not be tolerated. The Inquiry Team concluded that the Warden and the staff were sincere but the Team remained perplexed about the methods employed. The Team could not accept that there were not safer and more humane ways to immobilize

the inmates if that is what had to be done. Even assuming, arguendo, that the use of steel restraints in this fashion was unavoidable, it would be imperative to order correctional staff to check the well-being of each individual inmate every 15 or 20 minutes and document that inspection and also to order frequent, documented, medical observation of each inmate.

These actions also violated the following MSP policies

- "A video camera will be checked out from Main Control and used to videotape the entire proceeding"
- "The inmate being restrained will be seen by a medical staff member as soon as possible..."
- "Each staff member involved in the use of forceful restraint and/or Mace will submit a written incident report..."
- "Only the amount of force reasonably necessary to control a given situation shall be used"
- "Appropriate Classification and Treatment staff will see each inmate...on Treatment Plan at least once per day..."
- ""...inmates may be physically restrained...on a written order (signed by two appropriate persons including one of)...Warden, Deputy Warden or Security Manager (and one of) Psychiatrist, AW Treatment, Psychologist, Physician or Physician's Assistant"
- "Treatment Plan: Written plan outlining goals and objectives on each inmate placed...in restraints."
- "Inmates in restraints will be checked three to four times per hour, and this will be documented in the unit log."

It must also be noted that the situation that confronted the MSP management has been faced by many jails and prisons. It is not that uncommon for a group of Maximum security inmates or segregation inmates to become verbally abusive, to throw food, feces or urine, or to threaten to start a disturbance. There are a variety of acceptable measures that staff may use, although it should be emphasized that these are never easy situations. Inmates may be moved, ring leaders may be separated, staffing may be increased, disciplinary procedures may be invoked, etc. While MSP staff justified their actions as preventative,

logic suggests that the inmates could have done the same things they were threatening 24 hours later, once they were out of restraints. The conclusion is inescapable that the actions taken were actually punishment designed to set an example for those and other inmates.

None of the top managers involved in this incident wrote a report about it. Finally, the Department Director and Division Acting Director were given a verbal report about the situation at the time that was markedly inaccurate and incomplete.

F. Criminal Investigation

The criminal investigation of the five inmate homicides and other major crimes during the riot was given to the Attorney General's Criminal Investigation Branch (CIB). CIB Investigators were called to the scene immediately after the riot and cooperation between MSP and the AG's investigation seemed to be excellent. That well-established informal working relationship between the AG's office and the Department of Corrections and Human Services also was reflected in the cooperation that the Administrative Inquiry Team received from the CIB Investigators.

The largest problem with the investigation was the sheer scope of the task. It was necessary to attempt to interview every inmate who had been housed in Max prior to the riot (among others) and there were many hundreds of items of physical evidence which had to be cataloged and analyzed. At the time the Inquiry Team was on-site in Deer Lodge, the CIB Investigators were estimating that it might be another two to three months before they reached final decisions concerning indictments. The Inquiry Team was most sympathetic with the plight of the CIB staff confronted with a complex, sprawling investigation involving multiple victims of capital crimes and large numbers of potential suspects, but lacking the staff resources that a more populous State might offer.

G. Public Information:

In general, MSP and the Department of Corrections and Human Services managed media relations and related public information functions quite competently. The information released by the Institution the day of the riot turned out to be entirely accurate. That is often not the case in

prison emergencies. The names of the five dead inmates were withheld pending a reasonable opportunity for the Prison staff to try to notify family members of the deceased. The temptation to jump to hasty conclusions about the causes of the riot were avoided. In the days following the riot, there was substantial pressure for Department officials to comment about the perpetrators of the homicides and to comment about staff actions that might have contributed to the situation. The Department and the Prison refused to respond to these pressures, and correctly so. As this report is written it is well over six weeks after the riot and there has been no hint of publicity about potential inmate suspects in the homicides that might constitute prejudicial exposure and compromise prosecution efforts.

In a similar fashion, once the Department had decided to ask for an objective, outside team to conduct an administrative inquiry, it would have been improper to air concerns or issues with policy, procedure or staff actions in the media prior to the publication of this report. Departmental Officials recognized that they were caught in a classic "Catch 22" situation: If they spoke out before the independent inquiry was completed, then their conclusions might well have been criticized as colored by bias and self interest; if they waited for the results of the independent inquiry then little information would be available about the details of the riot and they would be accused of stonewalling. They chose the latter course and the charges of stonewalling and cover-up have persisted. The members of the Administrative Inquiry Team believe that the critical and detailed nature of this report should put those particular concerns to rest.

MSP did not have a media plan for emergencies What was done with the media was developed as events unfolded. Initial media inquiries were received by MSP by phone and these occurred relatively early during the riot. They were likely in response to the MSP siren, although they could have been a result of reporters with scanners monitoring police transmissions. At some point during the riot, local police set up a road block at the top of a rise (locally called "Airport Hill") on the road leading to MSP from Deer Lodge. Neither the Department nor MSP has a full-time Public Information Officer (PIO), but MSP's Director of Classification and

Treatment has a journalism background and actually used to cover MSP when she worked as a reporter for a Montana newspaper. She is designated to handle press relations for the Prison and her media background and experience have proven most valuable. The Director of Classification and Treatment should have been one of the very early notifications because of her role as PIO, but there was no plan nor check list to guide the Shift Commander's initial decisions.

As more media people gathered at the police road-block, one film crew complained about lack of access, but the reporters were generally cooperative and understanding. Families of two of the five staff hostages had been reached by the Prison and had chosen to come into the Prison. They were being accommodated in a small log cabin-style building outside the perimeter of the Prison. At approximately 2:30 p.m. staff were able to give these families word that the hostages were rescued and physically unharmed. Shortly after that the Warden contacted the PIO and asked her to move the families out of that building and to bring the media in for a press conference. By 4:00 p.m. the Prison had been contacted by CNN and the National networks, but no information was released per the orders of the Warden. A press conference was held late afternoon on September 22. The Warden's press release at that conference outlined the riot at Max, the five inmate deaths and the subsequent retaking of the Maximum unit. It provided few details and the names of the dead inmates were still withheld pending notification of next of kin.

There were several problems with these initial decisions about the media, but none of them were severe. The reporters grew increasingly unhappy that no information at all was forthcoming several hours after the riot had begun. An initial brief press release or a few brief press updates followed by a later press conference would have been preferable. Within a few days of the riot many media outlets within Montana were editorializing about the Prison's obligation to provide public information and this was a predictable result of negative mind-sets created the day of the riot by long delays and little information.

One reporter from Helena, because of personal relationships and unusual circumstances, was informed about the inmate deaths long before

the reporters waiting at the Prison were told anything. This created some resentment and some credibility problems for MSP. Finally, the site used for the media worked well for the Prison in that the crime scene and the general security of the Institution were not threatened by reporters or film crews, but the electronic media and the photographers were understandably unhappy that they were too distant to get photos of the Max building, the smoke, etc.

The day after the riot, the Warden asked the PIO to prepare another release providing the names of the dead inmates, the current status of the institution and some additional information. That was released at about 11:00 a.m. on September 23 and again, predictably, the T.V. stations complained that a written statement was of no use to them without any visuals. In response, the Governor's office asked MSP to hold an afternoon press conference, which the Warden conducted. The information provided at that conference was still sharply limited although there was opportunity for reporters to ask about various rumors or tips that they were getting and the Warden did confirm or deny some of this information. The television reporters were at this point more aggressive in their requests to get access to the Prison so that they could film the riot scene within Max. MSP said no.

In the days following the riot, coordination of media relations was complex and rather delicate. The Governor's Press Secretary, the Department Director and the Warden all had strong views on the various media decisions that had to be made and the locus of decision-making would shift from Helena to Deer Lodge and back during the week following the riot. It does not appear that there were intense disagreements or major misunderstandings, but rather that coordination and decision-making were less than smooth. There was increasing pressure to allow camera crews into the Max unit. The Department agreed to allow a limited number of reporters, on a media pool basis, to take film and photographs inside Max on Thursday, September 26. The media pool tour was organized out of Helena rather than from MSP. It was not problematic and it did lessen some of the hew and cry for more information.

MSP properly chose not to release the name of staff hostages. In the days after the riot, one reporter did call one of the hostages at home and the staff member was surprised and caught off guard. However, when prisons are located in small towns, detailed knowledge about prison business that should be confidential often becomes common knowledge within those towns. Hostages and other staff who played key roles in high profile incidents should be informed that they or their families may be contacted by the media while off-duty and encouraged to think through how they want to respond should the situation occur.

During the next several weeks the media pressure to release information on how the riot started, and the details of what happened during the riot, continued. On October 9, Curt Chisholm issued a press release announcing that the State had requested that the National Institute of Corrections (NIC) assist in forming an Administrative Inquiry Team and that they had agreed to do so. The release went on to identify the members of the Team and October 20 as a start date of the inquiry.

The Department received a request from the Associated Press that reporters be allowed to accompany the Administrative Inquiry Team as it conducted its' work on-site and to also sit in on interviews, meetings and the like. When the Department denied this request, a formal written request followed from the Montana Freedom of Information Project, a coalition of news media from Helena. (Montana's statutes governing open meetings and freedom of information are among the strongest in the United States.) Curt Chisholm's office denied the coalition's request and explained to the individuals involved that it was the opinion of the NIC and members of the Inquiry Team that the task would be impossible if there were reporters present at interviews and meetings. It was further the position of the NIC that they were prepared to cancel the Technical Assistance grant which was funding the Team's effort if the Team was unable to conduct interviews and meetings in private. A compromise of sorts was arrived at and Curt Chisholm held a press conference the morning of the Team's first day on-site to introduce the members of the Team and discuss their backgrounds, qualifications, and the methods that they intended to use in their inquiry. A subsequent press conference was held on Friday, October 25 by Curt Chisholm and Jeffrey Schwartz, the

Team Leader. This second press conference was somewhat frustrating because the Team could not discuss findings, conclusions or recommendations until the final report was complete and formally delivered to NIC and the Department.

The following Thursday, October 31, Curt Chisholm released a statement that, based on information presented to him informally by the Inquiry Team, he had conferred with Montana Attorney General Marc Racicot and that General Racicot had requested the FBI and the Civil Rights Division of the U.S. Department of Justice to conduct an investigation into potential violations of inmate's civil rights at MSP in the wake of the riot. The following day, November 1, the Montana Chapter of the American Civil Liberties Union held a press conference and released a statement charging MSP staff with a variety of serious abuses of inmates following the riot on September 22. The charges ranged from beating inmates with clubs and chains to shooting an inmate in the head with bird shot while he was handcuffed and naked. The ACLU statement went on to charge that Montana Governor Stephens personally witnessed the brutalizing of inmates and did nothing to stop it and that some inmates developed scurvy as a result of being denied adequate food for a period of weeks. Both the State's request for a Federal Civil Rights investigation and the subsequent ACLU charges played as headlines and lead stories in Montana's newspapers and evening news programs.

VI. The Disturbance Control Team (DCT)

DCT was formed at MSP in 1982 as a reaction to a riot in the Close I housing unit. There are 33 members on the Team, all of them volunteer. They do receive overtime for DCT training. DCT is organized into two Riot Teams, each consisting of eight Officers and one Riot Team Leader, two Entry Teams of four individuals each and one Leader for those two Teams. In addition, there is a Commander, Assistant Commander and several individuals trained as Snipers/Spotters. Each of the Riot Teams includes a Video Operator and a Medic. The Team is primarily self-trained although some Officers have arranged to attend Street Survival, or Officer Safety courses when they have been presented for area police agencies.

In recent years the Mountain States Association of Tactical Teams has held an annual conference and the Commander and Assistant Commander have both attended. DCT training is usually held monthly and all DCT personnel are assigned to first or second shift at MSP.

The DCT locker room is adjacent to the Armory in the Personnel, Accounting and Training building just outside the perimeter. Each DCT member has a locker with his own equipment, including a black jump suit, a helmet with a visor, padded gloves, small flashlight and an aerosol Capstun dispenser. They do not have vests or other body armor. When the DCT Assistant Commander first began to formulate a plan for entry into Max, there were perhaps three other DCT members who had responded to the DCT staging area. By the time the actual entry into Max was effected, approximately 25 Team members actually went into the building. In the interim, Team members completed equipment checks on each other; Team Leaders participated in trying to find flaws in tentative plans as they were developed; and Team Leaders and the Assistant Commander updated the available information and briefed incoming Team members. The Administrative Inquiry Team concluded that DCT was a well-disciplined, cohesive group and that their self-training and self-preparation proved highly effective under very difficult circumstances.

There are several issues that arose with the DCT that may be instructive. First, when the DCT Commander arrived at the Institution, he found that the Assistant Commander had the Team organized and was well advanced toward establishing an entry plan. Rather than assuming command or taking a chance of creating confusion by trying to assume a support role, he chose to stay entirely away from the assembling Team and their operation. Instead he assumed command of a small Weapons Team that guarded the fence between the Max and High Security Compounds and the Assistant Commander continued to lead DCT throughout the day, even long after the hostages' release had been secured. There was wisdom in the decision not to take over command in the midst of tactical planning. The need to be fully briefed and inevitable differences in judgment about the best entry plan might well have delayed

DCT's readiness to assault, and that delay could have cost additional lives.

A second instructive note about DCT occurred during their entry into Max. As DCT members followed the Assistant Commander down the ladder and into the West cage, and then into the Unit itself, he became aware that two of his people were not doing well. One was somewhat claustrophobic and the dark, crowded, smoke and tear gas filled atmosphere combined with wearing a gas mask could not have been much worse for that condition. Another DCT member was diabetic and had high blood pressure. The Lieutenant directed both these staff members to go back up the escape hatch ladder and wait on the roof. He was concerned that it was too risky to wait and see if they had serious problems. In view of the situation inside Max at the time of the DCT entry, it was not easy to have the presence of mind to consider such factors; the Inquiry Team regarded this as excellent command decision-making.

The Prison's DCT did not have the advantage of sophisticated training or extensive resources. That did not prevent them from maintaining a high degree of readiness. When they were needed, they were able to assemble quickly, plan effectively, maintain discipline and very successfully complete a multiple hostage rescue under life threatening conditions involving large numbers of perpetrators. The success of DCT in this operation serves as a reminder that where there is a will to accomplish something, there is usually a way. Many jails and prisons have no tactical team that could be used in circumstances like those at MSP. Most of those institutions would look to local police, sheriffs or state police to provide a tactical team in the event of an emergency, but often the institution has not worked out any of the details and has little sense of what kind of assistance they could actually receive, or under what conditions. Another group of jails and prisons have spent time, money and other resources in developing a tactical capacity and then, through management inattention or negligence, allowed that tactical capacity to deteriorate to where the institution thinks that it has a team that could handle hostage rescue or riot or the like, but there is no realistic capacity remaining to accomplish a tactical mission.

At the review conducted by the Warden several days after the riot, several factors emerged. DCT members were grateful that their commanders had made them practice and train wearing full gear, including gas masks. They wanted more training time and they did express the need for body armor. Had "flash bang" grenades been available to the Team prior to the riot, they might have chosen them to cover the dynamic entry rather than tear gas. Riot team members expressed a belief that they should receive as much training as the entry teams. The Team had followed FBI minimum physical standards for selecting individuals as Entry Team members or Snipers, although there were no physical requirements for the two Riot Teams. These requirements were also discussed during the Warden's debriefing of DCT. In general, the sentiment of Team members was that they had been reasonably well prepared and they were pleased with their performance.

As a final note, there is a sharp philosophical difference among tactical teams in terms of anonymity and appearance. Some tactical teams (SWAT, CERT, etc.) wear clothing with names or identifying numbers stenciled prominently front and back, and/or on helmets. These teams often adopt camouflage or blue colors and eschew heavily tinted visor helmets. Other teams work to maintain anonymity of team members and have no identifying characteristics on their uniforms. These teams often wear all black outfits and tend to favor the heavily tinted visor helmets as well. The goal for these latter teams is to present a presence that is as anonymous and frightening as possible. MSP's DCT adheres to this philosophy and specifically requested that this report not divulge names of individual DCT members.

There is one disquieting epilogue about the DCT, although it reflects on management rather than on the DCT. When the Inquiry team was on site, there were t-shirts on sale inside the front door of the MSP Administration building, with the proceeds to benefit the DCT. The inscription on the shirts read " DCT TOOK IT TO THE MAX" over a picture of a dark- visored DCT member and the Maximum building. The Inquiry Team understood the staff desire to acknowledge the DCT hostage rescue but a humorous tone seemed deeply inappropriate in light of five inmate deaths. Allowing the sale of the t-shirts at the location where

inmate families and visitors stopped for sign-in was insensitive and poor judgement.

VII. Emergency Preparedness at the Time of the Riot

The Inquiry Team found that MSP had no Emergency Plan whatsoever at the time of the riot. While members of the Inquiry Team had encountered jails and prisons with emergency plans that were out-of-date, poorly designed, unrealistic or even unknown to most staff, it was more than a surprise to find that the Institution had been operating without any plans at all. This situation had evidently persisted for a long time in spite of Departmental policy that clearly mandates a detailed Procedure Manual covering at least the following types of emergencies: disturbance, fire, flood, work stoppage, escape, unnatural death and assault. The copy of this Departmental Policy received by the Inquiry Team was undated and unsigned but replaced an Emergency Policy dated 1984.

The Administration at MSP recognized this problem and began working on the development of comprehensive Emergency Plans for the Prison approximately a year ago. During the year preceding the riot, various components of the Emergency Plan were being drafted and circulated for comment among management staff by the Warden, who had taken personal responsibility for this task. During the riot the Warden detailed a Captain and the Associate Warden for Treatment to go to the Administrative offices and bring back the Draft Emergency Plan (of which there was only one copy). The Captain and the AW were unable to find the Draft and returned to the Command Post without it. The Warden said that while he was forced to work from memory, the fact that he had been working actively on the development of an Emergency Plan had been very helpful and that he was able to recall many elements of the Plan without difficulty. It is not relevant to critique the Draft Emergency Plan in any depth because only the Warden was familiar with it. Even the other top managers professed no knowledge of the Draft and the Shift Commanders interviewed were unaware of its existence. Suffice it to say that the Draft is an interesting beginning, but it is only that. It is particularly weak on issues regarding organizational structure and command, specific

procedures, documentation, staff training and use of external agencies. However, some individual elements of the Plan are very well thought-out and were actually put to use during the riot. The most obvious examples are the procedure for restricting air space over MSP in an emergency, which was done during the riot, and the psychological debriefing procedures, which were also followed in large part (although the Post-Trauma Team called for in the Draft Emergency Plan had never been developed).

The lack of an Emergency Plan at MSP for a period of years is a failure of serious proportions but it is also a symptom of the lack of readiness to respond to an emergency in other ways. With no Emergency Plan, it follows that there would be no emergency check list available to the Shift Commander. Thus, each time a Shift Commander is faced with crisis conditions, he or she must attempt to remember and/or invent all of the proper things to do, and the priorities to be afforded each step. The obvious solution is for management to agree upon a general emergency check list that can be followed by the Shift Commander, who can also modify the steps called for as needed depending on the specific situation. In this riot, the Lieutenant who was Shift Commander was no further ahead than he was almost 10 years prior when he had been on duty at the start of a riot in the Close I housing unit. A wide variety of other procedures and preparations, ranging from mutual aid agreements to availability of hostage negotiators, to debriefing procedures are usually driven by an institution's Emergency Plan and were here absent.

VIII. MUTUAL AID

The term "mutual aid" is used here in a broad sense to include police and correctional assistance as well as civilian agency assistance. Conclusions about mutual aid are limited because of a dearth of documentation. There are no log entries indicating which agencies were called for assistance, or when or by whom they were contacted. There are also no copies of reports completed by staff of those outside agencies.

Both the Sheriff's Department and the ambulance service played important roles in the September 22 riot. There is one reference in the logs to police securing the perimeter and another to the Warden asking for the Sheriff to be brought into the Command Post for a briefing prior to the assault on Max.

It appears that the Sheriff's Department was contacted quickly and that the working relationship between MSP and the Sheriff's Department was very good. Ambulances should have been called almost immediately but were apparently not contacted until later in the riot. Fortunately, there were no adverse consequences. (The Inquiry Team was originally told that ambulances were not called during the first hour of the riot and it is well established that he first ambulance to drive up to the Prison gate arrived just before noon. Management later told the Team that ambulances had been mobilized much earlier but held at a staging area near a police roadblock on a road approaching MSP. That does not square with documentation showing that when the ambulances were called up, there was a delay of about 20 minutes after the first ambulance before the second arrived at the gate.) Similarly, the local Fire Department should have been called very early but was not. Other agencies that might have been needed on-site include the telephone company and the local utilities company. The absence of a Command Post Emergency Checklist meant that there was nothing to remind the Lieutenant in charge to call all of these agencies, no 24-hour phone numbers for the managers of the civilian agencies and no inter-agency agreements.

As with the ambulance question, there was -fortunately- no life threatening situation that developed and was dependent on mutual aid staff or equipment. That is not to say, however, that such a scenario might not have developed. Had the fire and smoke gotten worse, then the immediate availability of portable smoke evacuation equipment could have been a life or death matter. maintaining the negotiations could have been dependent upon the phone company. DCI might have needed equipment that the Highway Patrol or a local law enforcement agency could have delivered to MSP. In short, mutual aid was not central t other resolution of this crisis but it was an area in which MSP was poorly prepared.

IX. General Security Considerations

In addition to the security failures described early in this report that contributed directly to the development or spread of the September 22nd riot, the inquiry team found additional security problems that were frequent and serious. What was most disturbing was that some of the kinds of security problems that might have prevented the loss of life during the riot had still not been corrected one month later.

Doors that were designed to be operated as sally ports, both within buildings and outside buildings, frequently would be opened and closed together. In other locations one of the two control doors is simply left open, effectively eliminating the protections that were built into the institution as a matter of design. Inmates on the High Compound and Low Compound yards often appeared to be completely unsupervised.

Tool control and key control were generally poor, and in both cases there was a lack of policy as well as a lack of written procedure. Similar problems existed with control of caustics on the living units. Inventory/control procedures in food services for knives and for yeast were inadequate. Most of the chemical agents in the institution are in a location that is not secure, and they are uninventoried and kept in an unlocked refrigerator. Much of the supply is beyond the recommended shelf life of the manufacturer. Some weapons are in locations that are not secure and are in plain sight of, and potential access to , inmates. The armory inventory and armory control procedures for weapons and ammunition were seen as inadequate. Three staff members have armory keys and all three work day shift and take the armory keys home with them. If staff need to get into the armory evenings or weekends, they call one of those three staff to come in to the Prison. There is supposed to be an additional set of emergency keys to the armory, but staff on duty could not locate those keys for the Inquiry Team. The three staff members who carry armory keys are often in the compound or in living units, where those keys could be taken by inmates. Thus the two basic issues with armory keys, that they be accessible at any hour to staff and that they be secure from inmates, are both defeated.

Perimeter security is substantially compromised by razor ribbon that is improperly installed. The ties that anchor the wire coils to the top of the exterior fence are very light gauge wire that can be untwisted by hand.

Some security issues were attended to after the riot. For example, prior to the riot, metal detectors were not used regularly to screen inmates returning to the Low Compound from Industries, nor were those inmates always searched, but those procedures were in force at the time of the Inquiry Team's visit.

In interviews, some staff raised questions of MSP's responsiveness to staff complaints or suggestions about security problems. The Inquiry Team heard a number of detailed anecdotes about written security complaints that were transmitted to managers and went unanswered.

In general, staff do not appear to be held to a high standard in performing security duties; expensive and potentially effective systems that have been designed into the Prison are rendered useless through staff negligence or ignorance about these systems.

XI. Findings and Conclusions

A. Causes of the Riot:

1. The riot was planned primarily as a result of conditions within Max, which the inmates perceived as unnecessarily harsh.

2. The Max Unit was run badly and living conditions for inmates were unreasonable (cold food, lack of recreational opportunities, lack of programs, etc.). There was a pattern of improper and unnecessary use of force by staff against Max inmates.

3. Criteria for sending inmates to the Max unit, or for releasing inmates from Max to the general population, were poorly defined, overly subjective, or entirely unspecified.

4. Functionally, Max was a large segregation unit rather than a classification level. The operation of the Max Unit raised questions of Constitutionality with the Inquiry Team.

5. Conditions generally at MSP prior to the riot were not good. The tension level was very high.

6. Several specific events contributed to the tensions within the Max Unit before the riot, including: the suicide of an inmate a month earlier which inmates believed staff could have prevented; the murder of a High Security inmate with baseball bats in full view of a nearby gun tower approximately a year before the riot, and the upcoming trial of Max inmates for that murder, with one of the PC inmates in Max scheduled to be a star witness; a six day long strike by Correctional Officers, Sergeants, and Counselors six months prior to the riot, with subsequent talk about how a riot might goad the State Legislature into better staff benefits.

7. The suicide of inmate Brown in the Max Unit on Aug. 16 was handled poorly and may have been preventable.

8. The Protective Custody inmates should not have been housed in the Max Unit in the first place.

9. Managers seldom visited Max and did not actively supervise or review when they were in the Unit.

B. Warning Signs of the Riot:

1. There were clear signs and signals of the coming Max riot. These warnings came to staff from a variety of sources for at least six weeks prior to the riot. Some warnings were specific and in writing.

2. The warning signs were essentially ignored by staff. Management staff must bear most of the responsibility for this since some front line staff and supervisors did send detailed intelligence to management.

3. The September 22 riot was planned by a relatively large number of inmates. The specifics of both breaking out of the caged exercise areas in the Max yard and of taking over the floor of Max were planned for at least two months, and may well have been planned for twice that long.

4. Most Maximum inmates in the Max Unit, and at least some of the PC inmates, were aware of the plan to start a disturbance in the Max yard.

5. If front line staff, supervisory staff or management staff had responded to the warnings, the September 22 riot could not have occurred.

C. How the Riot Occurred:

1. Staff security failures allowed the riot to develop and then additional security failures allowed it to spread to the entire Maximum building.

2. The staff security failures were not a one-time occurrence, but rather were chronic mistakes which had gone unattended by supervisors and managers for a long time. They had become part of the expected method of operation of the Unit.

3. Post Orders in Max were either completely missing or written so inappropriately as to be ineffectual. Where Post Orders did exist there was no expectation that staff would read or comprehend those Orders.

4. There was no staff training or orientation for the various positions within Max, including the Sergeant's position.

5. With reasonable Post Orders and staff training, there is a high likelihood that the two Cage Officers would have prevented the rioting inmates from gaining control of the cage consoles and the keys and that the Floor Officers and the PC inmates would have remained safe.

6. Day shift staffing in Max was inadequate to accomplish the required tasks and still provide acceptable levels of inmate supervision.

7. There was no evidence found of any staff complicity in this riot, nor was there anything that suggested that as a viable explanation.

8. Policies and Procedures concerning the Max unit were routinely violated by officers, and supervisors and managers ignored those violations on a regular basis. In addition, some security policies were contradictory and other crucial policy areas were covered by no written policy at all.

D. Staff Hostages:

1. The five Floor Officers trapped within Max comported themselves admirably. They cooperated with the rioters only to the extent that they had to, and entirely under duress. Their ingenuity in

locking themselves in a shower room and barricading themselves with a mattress may have saved their own lives.

E. Staff Response to the Riot:

1. The Institution had no Emergency Plan at the time of the riot.

2. The Cage Officers were justified in very quickly using the roof escape hatches.

3. There was a period of time ranging from 30 to 45 minutes after the onset of the riot during which an armed intervention by staff into Max would have put down the riot before the Max inmates could get at the staff hostages or the PC inmates. However, Command staff on the outside did not have good enough information to know that this opportunity existed or that the five staff trapped inside Max would have been safe in the event of such an armed assault.

4. The initial staff response to the riot was uncoordinated, although the Shift Commander was quite effective given his lack of resources, training and preparation. The response included a number of excellent technical moves: early attention to the perimeter, double posting towers, deploying high ground spotters and, later, restricting air space over MSP prior to an assault.

5. The failure to establish on-scene command was a serious flaw in the initial staff response.

6. From the time of the Warden's arrival and briefing, he provided clear, decisive and effective leadership and command presence.

7. The hostage negotiations were unplanned but were conducted thoughtfully and to great advantage for the Commander and his decision-making.

8. The staff response was severely hampered by the inoperative fire alarm system in Max, and by the earlier failures to inform staff of the system breakdown and agree upon alternative procedures.

F. DCT and the Assault on Max:

1. The Warden's early decision to direct DCT to develop contingency plans for an armed entry of Max was a crucial element in the later successful hostage rescue.

2. DCT proved to be a well-prepared and effective tactical unit in spite of being essentially self-trained and limited by few available resources.

3. The Warden's response to information that the rioting inmates were apparently killing or torturing individuals within Max was to order an immediate assault. That decision probably saved staff and inmate lives.

4. DCT assault planning was practical and well done. It could have been improved, however, by better use of intelligence information and more detailed contingency planning about potential problems that might be encountered with the planned entry.

5. The DCT actions in regaining control of Max and quickly rescuing the hostages demonstrated bravery, professionalism and exceptional effectiveness. The Lieutenant who led the Team on this mission deserves particular commendation for his leadership in this regard.

6. If the riot had been allowed to last another 30 minutes to two hours, it is extremely likely that other inmates would have been killed and that some staff would have been murdered.

7. There is no evidence that the Max inmate perpetrators attempted to mutilate or dismember any of the PC inmates.

8. The DCT actions in ordering inmates to strip and lie on the Max floor and then later in moving the inmates in groups, naked and handcuffed through tear gas and over broken glass to get them out of the Max building, were reasonable and justified.

G. The Aftermath:

1. Management should have anticipated the possibility of staff retaliation and should have taken steps to prevent it.

2. A Command-level staff person should have been placed in charge of the restraint team that received inmates coming out of Max after the riot, and in charge of the situation in No Man's Land.

3. When inmates were taken out of Max, they were run through a double receiving line of staff (the "gauntlet"). The inmates were handcuffed behind their backs and most were naked. Some inmates were subjected to improper and unnecessary use of force by some staff in these receiving lines, including being kicked and hit with batons.

4. Some inmates were kicked by staff in No Man's Land while the inmates were lying naked and handcuffed on the ground.

5. Some senior staff had to have witnessed some of the abuse of inmates in receiving lines and in No Man's Land, or to have heard about such abuse from other staff and inmates. Senior staff made no attempt to investigate these questions and the Inquiry Team concluded that it was confronted with a systematic cover-up.

6. The Institution had video tape equipment available and was remiss in not using video tape to film the inmates coming out of Max, the situation in No Man's Land, and the later situations in the Reception unit after the Max inmates were moved there.

7. The Maximum inmates in the Reception Center were treated with a number of punitive measures that were unnecessary from a security standpoint and unjustifiable on any other grounds. Examples ranged from improper use of Capstun to leaving the inmates naked and without mattresses for several days.

8. As a result of conditions in the Reception unit, Max inmates began to talk about starting another riot. In response, the Warden, with concurrence of four of his top managers, ordered six inmates to be hog-tied with handcuffs and leg-irons and left naked on the floor for 24 hours. Management believed this action to be reasonable and preventative. The Inquiry Team found it to be unnecessary and unjustifiable corporal punishment.

9. These staff actions (hog-tying the six inmates) violated at least seven or eight separate policy provisions of the MSP "Use of Restraints" policy statement.

9. The hog-tied inmates suffered painful physical injuries and may develop some permanent, although minor, neurological impairment.

H. Debriefing/Psychological Screening and Treatment:

1. Report writing and other documentation was substandard throughout this incident. Many key individuals did not write reports; many of the reports written were of very poor quality; what appear to be key documents are in some cases after-the-fact reconstructions rather than contemporaneous records of events.

2. MSP decisions and actions concerning the staff hostages were extraordinary, thoughtfully planned and carefully followed through. The hostages were dealt with with sensitivity, sophistication and care.

3. The same qualities that made care of the hostages so exceptional were also evident in MSP's work with other staff who might have been traumatized, and with their families. These actions were sensitive, caring and most effective.

I. The Step-Down Plan:

1. Management should have developed a comprehensive, short-term (one to three day) Step-Down Plan before deactivating the Command Post on the night of the riot.

2. The longer term Step-Down Plan was unreasonable and unnecessarily harsh for inmates in the Low and High Security compounds. It seriously increased tensions in the Prison.

3. MSP management was unaware of the specifics of how the Step Down plan was being accomplished and of its' impact on the population.

4. The kinds of wide-spread security lapses that were common before the riot and contributed to the riot were not appreciably improved after the riot.

5. The decision in mid-October to move the surviving PC inmates back into the Max unit was inhumane and unjustifiable.

J. Departmental Support:

1. The Director of the Department and the Office of the Governor offered support to MSP without interfering in the tactical decision-making necessary to rescue the hostages. A charter flight to the Prison by the Governor and the Department Director immediately after the re-taking of Max underscored the State's stance that the five inmate deaths would not be taken lightly.

K. Public Information:

1. Public information about the riot from MSP was unusually accurate, though limited. MSP and the Department created a public and media perception that MSP was stonewalling about the riot by not releasing information earlier the day of the riot and then by waiting several days before allowing media into the riot site in the Max building.

L. General Organizational Issues:

1. MSP has not communicated a clear understanding of the Institution's Mission, Objectives or Values to staff or inmates.

2. There has been no effective oversight, audit or other external review of MSP operations.

3. Staff professionalism is generally low at MSP.

4. Supervisory accountability is lacking at every level of the organization and staff disciplinary procedures are seldom used to enforce regulations.

5. The chain of command at MSP is unclear, even to supervisors.

6. Executive Staff involvement and visibility on the living units has been very low.

7. Written policy and actual practice are substantially different on many issues. Some policies are routinely ignored and others are unfamiliar to staff. These problems are not limited to security issues.

8. MSP has placed little emphasis on female and minority employment issues.

9. By national standards, MSP is neither understaffed nor underbudgeted.

10. The inmate Grievance System and the inmate Disciplinary System are both poorly designed and poorly carried out. Neither has credibility with the inmate population.

11. Medical services at MSP is a source of substantial dissatisfaction and anger for inmates.

12. The Parole Board Procedure is ambiguous, manipulated by inmates, and inconsistently administered. For many inmates it is the single largest stressor in the environment.

XII. Recommendations

A. Riot-Related:

1. That PC inmates be moved out of the Max unit permanently. (Note: Already accomplished after Inquiry Team's visit.)

2. That restrictions imposed on the general population after the riot be re-examined for necessity and purpose. (Note: partially accomplished after Inquiry Team's visit.)

3. That the State Attorney General's office, or the Federal Department of Justice, be requested to investigate possible staff violations of inmates Civil Rights. (Note: Federal Department of Justice and FBI investigation requested by Department Director and State Attorney General on Thursday, October 31.)

4. That a neurological consultation be arranged for each of the six inmates who was hog-tied in the incident in the Reception Unit.

B. Organizational Considerations:

1. That the Mission and Goals of the Institution be carefully considered, articulated, and thoroughly disseminated.

2. That the organizational structure and chain of command issues be clarified and thoroughly disseminated.

3. That a study be commissioned comparing correctional staff salaries and benefits in Montana with those of comparable States with comparable costs of living.

4. That the State Legislature give serious consideration to extending Hazardous Duty Retirement to correctional staff and that correctional salary levels be brought to the median of comparable States as disclosed by the salary study.

5. That a comprehensive plan to increase staff professionalism be developed.

6. That an Office of Inspector General, attached to the Department Director's Office, be developed to conduct Management and Security audits on a regular basis from that Office. That Office should also conduct or oversee Internal Affairs investigations for the Department.

7. That MSP Consider a Unit Management System for running the institution.

8. That the Department seek a review of Unit Determination for the Bargaining Unit to find out if supervisors can be removed from the Bargaining Unit representing non-supervisory staff.

9. That MSP develop a realistic plan to employ and promote more Native American and female staff, and to ensure that the work environment is not hostile to these groups.

C. Operations:

1. That technical assistance be arranged for an analysis to determine whether the inmate population is generally over-classified.

2. That managers and supervisors be involved in reviewing and rewriting policies, procedures and post orders.

3. That the inmate Grievance System be redesigned with appropriate checks, balances, controls and safeguards. Hold staff accountable to administer the new system with scrupulous fairness and consistency.

4. That the Inmate Disciplinary System be re-written so that offenses are objectively defined. Serious and minor offenses should constitute different offense categories. Review several other State disciplinary systems as models. Develop a plan to eliminate inmate back-log awaiting space for a lock-up.

5. That the Departmental administrators, the Parole Board and the Governor's Office work to change Parole Board policies and inmate perceptions of Parole Board Hearings.

6. That staff be disciplined for taunting, swearing, demeaning or otherwise engaging in clearly unprofessional conduct with inmates.

7. That a thoughtful, complete Use-of-Force Policy be developed. Train all staff, security and civilian, in its meaning and application. Develop a review procedure for use of force incidents.

8. That minimum standards for Executive Staff and management visits to living units and other areas of the Prison be developed.

D. Emergency Preparedness:

1. That MSP develop simple, basic Emergency Plans as quickly as possible to be used on an interim basis until comprehensive emergency preparedness can be completed.

2. That at least five additional hostage negotiators be trained in order that a minimum of two negotiators will be available by phone or pager at any time. As with other key emergency functions, track sick leave and annual leave for these sensitive positions.

3. That DCT be maintained and their capacities enhanced with additional defensive equipment. Bring a tactical expert to Deer Lodge to provide the entire team with State-of-the-Art tactical training.

4. That specific inter-agency emergency agreements be developed.

E. Security:

1. That the institution engage a security expert to conduct a full-scale security audit. (Note: Security Audit began November 19.)

2. That specific Post Orders be developed for all key security posts throughout MSP. These Orders must include Emergency Procedures. Mandate staff familiarity with Post Orders prior to a staff member beginning an assignment to any new post and develop controls to ensure that staff have mastered the Post Orders (oral quiz by Supervisor, written test, etc.).

3. That some person or method for coordinating intelligence across shifts and across living units be developed.

4. That a policy be developed that requires video taping of any Critical Incident or Use-of-Force situation in which time allows video tape equipment to be brought into position. Make the use of the video tape a Supervisory responsibility.

5. That, at a minimum, two air packs be purchased for each of the three Compounds and the two DCT air packs be moved to the Shift Commander's office. Either train all staff in the use of air packs or train a substantial number of staff on each of the three shifts.

6. That if the Security Audit currently underway does not include a thorough review of fire safety, such a review be conducted as a separate enterprise.

7. That supervisors supervise and that front-line living unit staff spend the majority of their time on the floor interacting with inmates and not gathered in small staff groups or in the Sergeants' offices.

8. That recreation be actively and regularly supervised for Max inmates.

9. That technical assistance be arranged for an analysis of post positions and staffing needs.

10. That separation of High and Low Compound inmates be improved, particularly at the Religious Activities Center.

11. That a psychological autopsy of any inmate suicide be mandated.

12. That an appropriate analysis of every serious security threat or violent incident be prepared, even it if is a criminal act for which the AG has primary investigative responsibility.

F. Inmate Programs/Services:

1. That the amount of individual counseling time available to inmates within the living units be increased.

2. That more inmate pay jobs for maintenance and clean-up be organized, both inside and outside the living units.

3. That a medium-ranged strategy to increase inmate programming opportunities and decrease idleness be developed.

4.That a thorough audit of MSP Medical services be conducted using outside medical experts.

5. That the Food Service operation be reviewed with particular attention to sanitation, the food preparation area, presentation and temperature standards.

6. That inmate visit procedures be improved with particular attention to treating inmate families with dignity and attending to privacy needs of visitors where possible without compromising security.

7. That increased mental health programming be provided; develop medium-range plans for housing and services for special needs offenders, e.g., geriatric inmates, physically disabled inmates, etc.

8. That MSP plan to provide programming for Max inmates.

9. That the institution provide inside recreation space within Max (perhaps on the various blocks) and provide some recreation equipment or games that can be used for outside recreation.

10. That the possibility of building additional Max outdoor recreation areas adjacent to the Max building, under tower coverage, be reviewed.

G. Training:

1. That a line item for Staff Training be included in the Budget.

2. That agreements be forged with the Union to allow non-uniformed staff to relieve Security Staff in Post positions for training purposes.

3. That some minimum amount of corrections-specific supervisory training and management training be established as mandatory for those two groups of staff.

4. That the Correctional Officer Basic Academy be expanded to five weeks and that the curriculum be revamped to include, among other topics, legal issues, emergency procedures, use of force, suicide prevention and correctional standards.

5. That MSP provide some agreed upon minimum number of hours of in-service training for all correctional staff each year.

6. That training for experienced staff be provided on day-to-day low level informal communication with inmates, as well as on areas like Conflict Resolution, Crisis Intervention and Suicide Prevention.

7. That Supervisors and Mid-managers be trained in report writing and other documentation requirements.

H. Media Relations:

1. That Department officials, Governor's Staff and MSP Staff involved in dealing with the media should review media relations during and after the riot in order to achieve better pre-planning for media relations in emergency situations and improved coordination between Deer Lodge and Helena.

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