CERTIFICATION OF DOCUMENT ACCURACY

WITH REGARD TO

AN ADMINISTRATIVE INQUIRY INTO MONTANA STATE PRISON

BY

AN ADMINISTRATIVE DISCIPLINE REVIEW COMMITTEE

APPOINTED BY

THE DIRECTOR OF THE DEPARTMENT OF CORRECTIONS AND HUMAN SERVICES

I, Thomas L. Gooch having served as the Chairman of the above named Committee do hereby certify that the attached is a true and correct copy of the original report as submitted to the Director and other pertinent staff with the exception that all names of Prison employees have been removed to assure privacy rights of the individuals concerned. In removing names, there were minor changes in wording to assure appropriate syntax, however nothing was changed that would alter or effect the meaning or conclusions of the Committee.

THOMAS L. GOOCH

SUBSCRIBED AND SWORN TO before me this 7th day of April, 1992.

Janet B. Bauchee
Notary Public for the State of Montana
Residing at Helena
My Commission Expires: 11-10-94

AN ADMINISTRATIVE INQUIRY INTO MONTANA STATE PRISON

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AND HUMAN SERVICES

COMPOSITION OF THE COMMITTEE: The Committee was composed of three individuals with widely divergent backgrounds. It included a long-time employee of the Department, a new employee to the Department, and an employee from the Department of Administration. Tom Gooch was appointed by the Director to chair the Committee. David Ohler and Ken McElroy served as members.

SCOPE AND RESPONSIBILITY OF THE COMMITTEE: The Committee was charged with conducting an administrative inquiry into the potential for administrative discipline of staff in addition to the seven who were initially disciplined by the Warden. The Committee was charged with identifying the duty, responsibilities, and deficiencies, if any, of prison staff to include the Warden and all subordinate personnel. Much of the Committees's effort was concentrated on management personnel from Correctional Lieutenants up the chain of command to the Warden. Such duty, responsibility and deficiencies were to be identified from existing documentation such as position descriptions, performance standards as clarified in evaluation process, prison policies, department policies, and other

related written and verbal understandings which would in sum be descriptive of the function and expectancies of the employee.

The Committee was not charged with identifying civil rights violations of inmates except as such might be discovered in the investigation into any deficiency an employee could be held accountable for, and as such related directly into the carrying out of his or her assignment as known and described through the previously described methodologies designed to inform an employee of his or her established field of performance expectancy.

The Committee was also not charged with determining whether certain individuals should be disciplined, or the extent of discipline. We have attempted only to provide the Correction's Division with a factual document. We have also included recommendations for changes in policy and procedure.

In the conduct of their responsibilities, the Committee determined to utilize the NIC report "Riot At Max", as an entry document into their inquiry.
The Committee was provided with documentation given to the NIC Team and with other information and material as requested. The Committee extensively interviewed staff and familiarized itself with the prison physical plant and the prison operational procedures.

LIST OF POLICIES PRIMARILY RELIED UPON: The Committee examined all pertinent policy in the Prison policy manual and in the Department policy manual. The policies specifically identified for use were the following:

Department Policy NO. 107 EMERGENCIES

MSP Policy 01-001 ORGANIZATION AND RESPONSIBILITY

MSP Policy 01-002 POLICY AND PROCEDURES MANUAL

MSP Policy 01-003 POLICY ISSUE AND TRAINING

MSP Policy 03-008 EMPLOYEE CONDUCT GUIDELINES

MSP Policy 09-001 MAXIMUM SECURITY OPERATION GUIDELINES

OTHER WRITTEN DOCUMENTATION EXAMINED:

1. Position Descriptions of the following personnel:
   Personnel Director; Staff Development Specialist I; Correctional Officer; Correctional Sergeant; Correctional Lieutenant; Correctional Captain; Correctional Security Manager; Associate Warden-Administration; Associate Warden-Treatment; Deputy Warden; and Warden.

2. Personnel files of all of the above were examined with the exception of Correctional Officer.

3. Logs, post orders, incident reports and a variety of other information as requested and supplied by prison personnel.

GENERAL OPENING COMMENT: The NIC Team also characterized its effort as an "Administrative Inquiry". There are, however, some major distinctions between the inquiry of the NIC Team and the inquiry of this particular Review Committee. First the emphasis of the NIC Team was to "focus on circumstances surrounding the riot at Max." They based much of their findings upon interviews with the

inmate population. While they apparently interviewed a large number of staff, their perspective in both inmate and staff interviews was centered in developing a critique of the factors or failures which contributed to and perhaps caused the riot. In the course of their investigation, the NIC Team apparently interviewed few, if any, of management staff save top officials. This Review Committee intentionally did not interview inmates. It was our feeling that the inmate perspective is sufficiently represented in the NIC report. The NIC Team clearly stated that it "would not take primary responsibility for potential staff discipline", but rather leave that mission to the Department. The primary task for this Review Committee was to accept the responsibility to identify potential staff discipline in the context of the knowledges, understandings, and directives under which the staff were working just prior to and during the advent of the riot. Subsequent to the NIC report, the Prison administration conducted hearings into and determined discipline for staff considered directly responsible for the disturbance in Max. As an extension of the Prison determinations, and under the premise that it would be inappropriate for further discipline to be adjudicated at the Prison management level, the task of inquiry into the necessity for further discipline was given to this Review Committee.

IDENTIFICATION OF PROBLEMS AND PROCEDURE OF THE COMMITTEE: The Committee determined to categorize the allegations of the NIC Team into five major topics. 1. Security; 2. Policy; 3. Training; 4. Administrative; and 5. Staff professionalism. These topics will be addressed independently throughout this report. The Committee then examined position descriptions to determine the responsibility areas for staff with reference to the five topics identified. An initial visit to the prison was made wherein the Committee met with the Warden and

the Personnel Director. Subsequent visits were made to the prison to interview other prison staff. Structured interviews were conducted with correctional officers and less structured interviews with other staff. Some interviews were conducted three-on-one with all Committee members present while others were conducted one-on-one. Results of the one-on-one interviews were later shared in group discussion of the Committee.

FINDINGS OF THE COMMITTEE:

SECURITY: The allegations concerning this topic are as follows:

A. Warning signs of an impending riot were ignored.

B. There was a chronic breach of basic security procedures and institution security policies by staff.

A. Warning signs of an impending riot were ignored.

Discussion: The signs which preceded the riot were the following: 1) a kite dated August 3 from inmate Brown received on first shift warning of a riot in Max; 2) On August 3 a different inmate in Max informed 2nd shift Sergeant of an impending riot in Max; 3) On August 4 a Sergeant reported that the bolt locks on the entry gates to the yards were defective; 4) On September 14 a piece of fencing was retrieved from trash deposited by inmate Ritchson; 5) On Sept 19 an inmate reported to an officer that something was going to happen, but when the officer was asked what his days off were, the inmate stated he wouldn't be bothered; 6) On September 20 a church sponsor alerted a High Side officer that

a riot was coming during the week; 7) Information from an inmate recently released from prison.

1) The kite from inmate Brown was given to a Max Sergeant on first shift, who in turn wrote an incident report. The incident report is co-signed by a Lieutenant as having been received. A written cc: indicates that the information was copied to the Associate Warden of Treatment, the Deputy Warden, a Security Manager, a Correctional Treatment Specialist, a Max Sgt, and command post. The information indicated that the riot would start in the yard.

2) On the same day, August 3 a Sergeant received information from a different inmate that a riot was to occur in the next couple of days, and was supposed to happen "when yard is out". Inmate Ritchson was mentioned as a co-conspirator in the plan.

3) On August 4, a Max Sergeant reported that the locks on the entry gates in the yard are defective.

Management Response to 1), 2) and 3) above:

On August 4 four officers were assigned to shake down "all the yards and fences in the Max Bldg.". The result of the shake down was the discovery of the defective bolt locks on the entry gates to the yard. A Sergeant wrote an Incident Report dated August 4, 1991. The Incident Report was received by a Lieutenant. CC's were sent to the Warden, Deputy Warden, the Associate Warden of Treatment, Security Managers, Command Post, and

the Investigator. The Duty Officer ordered the Max yard closed until further notice. A work order was put in to fix the locks. The locks were timely fixed.

4) On September 14, inmate Ritchson was observed passing a paper sack on his lunch tray to an inmate swamper to dump into the trash. Two Officers observed the event and later retrieved the paper sack.

Management Response to 4) above:

Officer (1) wrote an incident report as did Officer (2). Upon examination of the contents of the sack the officers found two pieces of wire, one about 3 or 4 inches long, and one about 5 or 6 inches long. A Sergeant ordered an immediate check of the yard, but nothing was found. Officer (2) wrote a Class II on inmate Ritchson. The wire was submitted to Command and the Committee learned in interview that a Lieutenant received it. September 14 was a Saturday so the reports and the wire evidence stayed in Command until Monday the 16th. On September 16 the Class II report on Ritchson and evidence were picked up by a Hearings Officer. He told the Committee that he did not look inside the paper sack at the wire evidence. He took the evidence to his office and put it into an evidence locker. He stated that such was the normal procedure unless the infraction involves drugs. He stated that he scheduled Ritchson for a hearing on the following Friday September 20. At the hearing, Ritchson requested a weeks' postponement to enable him to gather witnesses. The Hearings Officer stated that he granted the week's extension which would have scheduled the hearing for September 27. The riot, of course, occurred on Sunday September 22. He

further commented that he knew the sack contained wire, but thought it to be a tie, and didn't put any particular import to it, because of the many instances of finding ties.

PROBLEMS WITH THE ABOVE EVENTS: Max policy clearly states in 09-001 on page 7, Subsection 33, that any inmate tampering with or climbing on the fence in the yard will lose his yard privilege immediately and will receive a Class II. Half of the policy was followed in that Ritchson received a Class II write up. A Lieutenant, stated that he could have suspended Ritchson's yard privileges but did not because he felt the evidence was circumstantial. The reporting sergeant could have considered the discovery of the wire as a "dangerous contraband" incident and suspended Ritchson's yard privileges but did not. The Hearings Officer stated that in his opinion Ritchson's yard privileges could not be suspended in the absence of a hearing. The Hearings Officer did not think Command had any responsibility to enforce the Max policy on removing Ritchson's yard privileges, but did feel the Unit Sergeant had the responsibility. There is no procedural policy outlining a method of how a Hearings Officer should handle evidence. After the riot, the Hearings Officer became concerned about the contents of the sack. On Monday September 23 he examined the sack's contents, ascertained it was a piece of fence (not a tie), and then took it to the Warden, obviously too late for any appropriate action.

The Committee was able to confirm the existence of the first four warning signals. The fifth was not confirmed by anyone interviewed, nor was the

seventh. The warning which came from a church sponsor was confirmed, however, it clearly had to do with High Side and not Max.

In addition to the seven warning signs cited by the NIC report, the committee discovered that there was other information regarding an impending riot. The failure of the NIC report to discover these other pieces of information is attributed to the fact that the NIC team interviewed few, if any, management personnel when it conducted its investigation. Parenthetically, the NIC report is nicknamed the "Inmate Report" by prison personnel because of the teams extensive inmate interviews and the teams failure to interview a large segment of prison personnel.

In addition to the warning signs found by the NIC team, the committee was advised of the following additional information:

1. A Lieutenant stated that he was aware of concerns by a a number of correctional officers of an impending riot in Max, and that he was aware of other incident reports warning of a riot in Max during the summer of 1991. He was unable to remember whether these incident reports were those of Brown and the other inmate in August, or were different reports altogether.

2. A Captain stated that the Deputy had told him he had been getting kites from Max, and that the Deputy advised him that he had specific rumors about a Max riot.

3. A Lieutenant stated that he was aware of rumors that "Max was going down".

4. Permanent correctional officers in Max indicated that they were concerned that there was going to be a riot in Max. These concerns were confirmed by a relief officer who worked the day prior to the riot. He stated that correctional officers advised him that they were concerned about a disturbance. The committee was uncertain whether and how these concerns were communicated to management personnel.

Except for confirmation of the correctional officers concerns, none of these additional warning signs were confirmed by any other individual other than the person who relayed the information to the committee. However, the committee concluded that some weight had to be given to them, given that they were relayed to the committee by management personnel.

The committee concluded that there were at least four warning signs of the riot known to a number of personnel at the prison. In addition, there appeared to be other rumors and discussions indicating that Max may be subject to a riot.

The lack of a clear chain of command and a clear comprehension of the person responsible for Max is illustrated by who knew and who didn't know about the five specific warning signs. The defective gate latches appear to have been common knowledge. The existence of the Brown kite was known to a Captain and a Security Manager, along with officers on the first and second shift in Max. The

existence of the second shift memo was not professed by any management personnel, except perhaps by the pre-mentioned Captain, who remarked that the kites on the riot were "common knowledge". The extent of knowledge of the church sponsor tip appears to have been limited, as no one indicated that they had direct knowledge of that fact.

The discovery of a piece of fencing from inmate Ritchson was known by the correctional officers and sergeant in Max. It was taken to the Command Center, and given to a Lieutenant. He stated that he either told or informed the Security Manager about the fence. The Security Manager stated that he knew about the fence through the grievance filed by Ritchson, and did not indicate that he was told of it by the Lieutenant. He did specifically state that he did not tell the Deputy about the fencing. The fencing was discovered on a Saturday, and was subsequently picked up by the Hearings Officer and placed in his evidence locker.

When the committee inquired why a significant event like the discovery of a piece of fencing in the possession of an inmate seemed to be ignored, it was met with several alternative responses. First, many individuals commented that the ties which hold the cyclone fence to the posts are routinely removed by inmates, and they assumed that it was simply a tie, not a piece of fence. Another typical response was that pieces of fence "float" in Max for years. This conclusion was associated with the response that the Max yard was "shook down" immediately following the discovery of the fence, and no piece was missing. Another related response was that pieces of fence are routinely discovered missing around the prison, and the fencing could have come from anywhere.

Testimony from several individuals who actually saw the fencing indicate that it was unmistakably a piece of fence, not a tie. A photocopy of the wire viewed by the committee clearly indicated that it was fencing and not a tie. The comment that fencing is routinely found in the prison was not borne out by the testimony of the Hearings Officer. Since possession of fencing would lead to disciplinary action which he would be aware of, any other instances of fencing in the possession of inmates would be known to him. He stated that he has presided over numerous hearings in which the inmate was found in possession of a tie. Except for the Ritchson episode, he has never presided over a hearing involving possession of fencing.

The committee was not able to reach a conclusion on whether the fencing discovered in Ritchson's possession was missing from the yard fence or was a "floater". The committee believed that the yard was shaken down twice after the fencing was found. One officer who conducted the shakedown stated that he did a thorough job. The committee has not formulated an opinion on the thoroughness of that shakedown.

The principle issue raised by these pieces of evidence is the lack of knowledge by management of these incidents, and in particular the security manager and deputy warden who are primarily responsible for the security of the institution. The only piece of evidence which the Deputy stated he was aware of was the defective gate latches. He had no knowledge of any other warnings with respect to Max. His statement is contradicted by a Captain's comment that he discussed warnings with the Deputy Warden.

The failure of the Deputy and Security Manager to know of these warning signs may be attributed, to some extent, to the lack of a clear chain of command. It is likely that a clear understanding of chain of command and responsibility for Max would have ensured that these warning signs were routed to the appropriate person or persons. The failure of management to have a centralized intelligence information officer is also a factor in the breakdown of the chain of evidence.

A footnote is appropriate at this point. A number of management personnel indicated that they receive rumors and other information about riots all the time. They fault the NIC report for second guessing their failure to recognize the reality of the warnings about the riot at Max. Most individuals who made this statement also further conditioned their remarks by stating that, "of course we have to take all warnings seriously and investigate them."

The committee's concerns regarding the warning signs at Max were that they did not appear to be adequately investigated. The committee is unaware of any follow-up to the Brown kite and the memorandum written by second shift staff. No management personnel, save a Lieutenant who ordered a second shakedown of the Max yard, appears to have looked at, let alone investigated, the unusual discovery of a piece of cyclone fencing.

B. There was a chronic breach of basic security procedures and institution security policies by staff.

Discussion: There are several, specific incidents of policy violations which are directly attributable to the riot. These policy violations either permitted the riot to occur, or contributed to the scope of the riot. The increasing scope of the riot

led to the deaths of the five inmates. If the riot had not escalated to the point that the cages were breached, the five inmates may not have lost their lives.

The policy violations which occurred are:

1) Leaving the yard cage door open at the same time the door to the yard itself was opened. This permitted the inmates free access to the interior of the Max Unit.

2) Permitting both corridor doors to be left open at the same time. This permitted the inmates access to the East Block of the Max Unit.

3) The failure to double-lock the control cage door. This permitted the inmates to more quickly gain access to the control cages and subsequently unlock the doors to the protective custody inmates.

There is no dispute that the policy violations outlined above occurred on September 22, 1991. Management personnel must bear some responsibility for these violations if 1) their duties included ensuring that prison policies and procedures are followed, and 2) they were aware of the policy violations, or 3) the policy violations were frequent enough that they should have known.

Management personnel who bear a responsibility for ensuring that policy and procedure are followed and that personnel are alert and diligent include the Warden, Deputy Warden, Correctional Security Managers, Correctional Captains, and Correctional Lieutenants. This group constitutes those personnel who may

have potential responsibility for the breaches of 9/22. Based upon the committee's investigation, it was determined that the Low-Side Security Manager has no contact with the Max Unit. He therefore is not responsible for the policy violations in Max.

The second factor which would directly lead to management responsibility is if these management personnel knew about the policy violations. The committee was unable to discover any management personnel who were aware of the policy violations on September 22, 1991. In addition, almost uniformly, those potentially responsible management personnel interviewed were not aware, either directly or indirectly, that these policy violations occurred. The one exception was a general comment by a Captain that policies were violated "all the time".

A couple of Max Correctional Officers indicated that management personnel were likely in the Max Unit, at one time or another, when one or more of these violations occurred. No specific individuals or instances were identified, however. Any specific knowledge of policy violations by management was not found by the committee.

Absent specific knowledge of the policy violations, responsibility may be imputed if management should have known of the violations. Responsibility would require that the policy violations were not isolated incidents, but were pervasive.

With respect to the three policy violations identified, the committee found that the improper operation of the corridor doors as a sally port was common. The committee is convinced that the practice was pervasive enough, and was not

considered improper by almost all staff, that management personnel must have known of this practice. Because of the almost uniform belief that there was nothing wrong with the practice, it is unlikely that staff would have attempted to cover-up the improper operation when management personnel were in the Max Unit.

With respect to the improper operation of the yard doors and the cage doors, the committee found that, while it was not pervasive, these policy violations occurred more than occasionally. The improper operation of the yard doors appears to have been common with some Max sergeants, and uncommon with other Max sergeants. The failure to double-lock the control cages appears to have been dependent upon the predilection of the officer in the cage and on whether the Max sergeant enforced the policy. The committee concluded that the policy violations were pervasive enough that management should have known about them.

Before discussing the responsibilities of the differing levels of management for the failure to discover policy violations, the common reason cited by all management personnel for this failure should be presented. All management personnel charged with visiting Max and enforcing policy, from the Warden to the Lieutenants, stated that it was impossible for them to discover policy violations because there is, "no way to sneak into Max". Management believe that staff have a grapevine similar to that of the inmates, and it is impossible for management to enter Max without someone alerting the staff that they are coming. This supposedly permits any policy violations by staff to be corrected before management arrives.

While the committee recognized that this could indeed happen, it disbelieved that the grapevine was so thorough that violations could never be discovered. In fact, a couple of correctional officers in Max commented that they had been "surprised" on a number of occasions by management visits. Further, as already discussed, the corridor door policy violation was so accepted it is unlikely that there were attempts to cover that fact up. Finally, the committee questioned whether management, which was aware of the grapevine, should have made some concerted attempt to perform surprise visits. The committee believes that there are a number of possibilities available to ensure surprise visits are possible in Max. No attempts were apparently made by management in this regard.

It should be noted that the committee is unaware of any instance when management was specifically informed by Max personnel that possible violations were occurring. Thus, there may have been no individualized suspicion which would lead management to believe it needed to perform a surprise inspection.

Lieutenants and Captains man the Command Center. Their duties are routinely shared, and their responsibilities are co-extensive. Both are charged with routine inspections of the facility and personnel. They also perform administrative functions while in the command post. Their administrative functions take from 50 - 75% of their time. These functions necessarily limit the time they are able to perform tours of the facility.

The extent of these officers visits to Max varies with the individual. One Captain stated that he visited Max once a week. A Lieutenant responded that he

did not go to Max much. The committee concluded that tours of Max were limited, and occurred at most once a week, and as little as once a month. This in contrast to the Deputy Warden's expectation that Lieutenants and Captains visit Max once a day. Several officers commented that they did not visit Max enough. Statements by Max correctional officers indicate that visits by management, including Lieutenants and Captains occurred, "not very often". Other comments indicated that the visits were often cursory and brief.

The committee believes that the expectation of the Deputy Warden probably was not communicated to the officers. Further, the expectation is unreasonable in light of the manpower available at the Command Center and the extent of their administrative duties. One officer commented that he did not visit Max because it was the Deputy Warden's turf, and he had differences of opinion on the operation of Max with the Deputy Warden. Failures of Lieutenants and Captains to discover the policy violations is mitigated by these circumstances.

The Warden has overall responsibility for the prison. This responsibility includes ensuring that policies and procedures are followed. It is not, however, a primary function of the position. The responsibility of the warden is limited. His primary duty is administrative, and much of his time is spent in activities other than tours of the facility.

It is also much more likely that the warden's visits to Max are more visible, and his arrival is probably always preceded by notice to the Unit. Thus, his ability to discover policy violations is probably limited.

The committee noted that the warden maintains a presence throughout the facility, and toured the prison much more than his predecessor. This activity was commented upon with favor by a majority of the staff. The warden is to be commended for his willingness to spend time with staff and inmates.

The committee felt that any responsibility for failing to discover the policy violations occurring in Max rested with either the Deputy Warden, the High-Side Security Manager or both. The relative extent of responsibility is a more difficult question. To extrapolate, at this point the problems with the chain of command and the responsibility for Max need to be highlighted.

The chain of command at the prison, and staff's recognition of that chain, varies. On the low side, the chain of command is clear. That chain is from Correction Officer to Sergeant to Command (Lieutenants and/or Captains) to Security Manager to Deputy Warden to Warden. All personnel recognize this chain of command clearly. Parenthetically, the chain of command is not always followed. The Low-Side Security Manager stated that Sergeants sometimes proceed directly to the Deputy Warden. While the chain of command is somewhat less clear on the high side, it is commonly recognized as the same as the low side.

The breakdown in the chain of command, and staff's awareness of that chain, occurs when the Max Unit is discussed. At the committee's initial discussion with the warden at the outset of the investigation, the warden was asked who was responsible for the operation of the Max Unit. The warden responded that he did not know, that we would, "have to ask the Deputy and High-Side Security Manager".

The committee did ask the Deputy and the Security Manager. The Deputy Warden stated that he believed the chain of command was clear, and that the chain went from the Max Sergeant to Command to the High-Side Security Manager to the Deputy Warden. The High-Side Security Manager responded that the chain of command was from the Max Sergeant to the Deputy.

The responsibility for the Max Unit was equally unclear. The Deputy Warden believed that much of the responsibility for Max was shared with the High-Side Security Manager. The Deputy Warden had ultimate responsibility primarily for policy making. The Deputy expected the Security Manager to share equally in other aspects of Max, including inspections. Somewhat at odds with the Deputy's assertion of equal responsibility, when asked about the fencing discovered on inmate Ritchson prior to the riot, the Deputy stated that the Security Manager should have told him about it. Also at odds with the Deputy Warden's perception of the chain of command is the fact that he is responsible for assigning the Sergeants to Max, and he chairs the monthly Max sergeant's meetings. These procedures suggest that the chain of command is Sergeant to Deputy Warden, and not as the Deputy Warden characterized it.

The High-Side Security Manager expressed the opinion that Max is the Deputy Warden's responsibility, and that he becomes involved only when requested to. The Security Manager believed his primary responsibility, as far as Max was concerned, was overseeing the budget. He did not supervise Max, he responded to questions.

Upper management's confusion regarding the chain of command and responsibility for Max is mirrored by the responses the committee received from lower management. Lieutenants and Captains expressed a wide range of opinions on both the chain of command and the person responsible for Max. Conversely, Max sergeants appeared clear that they were to report to the Deputy directly. This understanding may explain the Low-Side Security Manager's complaint about sergeants foregoing the chain of command on the low side, since sergeants rotate throughout the facility.

Some of the confusion regarding chain of command and responsibility may be explained by what appear to be recent developments in management. The Maximum Security Policy MSP-009 states that the Max unit is the direct responsibility of the Deputy Warden. This policy was apparently initiated under the preceding Warden, and has been the historic method of supervising Max. The committee received several comments that the High-Side Security Manager's increased activity in Max are a recent occurrence.

The committee ultimately believed, with respect to the failure to discover the policy violations which were occurring in Max, that the ultimate responsibility rested with the Deputy Warden. He was recognized by the Unit Sergeants as their supervisor, and was historically the management person responsible for Max. Any changes to that historic responsibility are recent, and the confusion of staff indicates that any changes that were made were not communicated to staff properly. The Deputy Warden remains the ultimate authority for policy in Max.

It appeared apparent to the Committee that the Deputy Warden does not communicate effectively with his subordinates. There were a number of specific instances commented on by lower management that critical decisions by the Deputy Warden were not communicated to staff. The Deputy Warden's express expectancies of lower management did not appear known to staff members. The Committee believes that this failure of communication resulted in confusion over the Max chain of command and responsibility for Max.

The lack of a clear chain of command and a clear statement of who is responsible for Max must rest with the Deputy Warden and the Warden. The committee was surprised at the lack of definition of responsibility for Max, if for no other reason than this is the most critical security area in the prison.

The Warden, as the person ultimately responsible for the operation of the prison, bears some responsibility for this confusion. The committee concluded that the Warden's management style, which delegates a lot of responsibility to lower management, was partly to blame. The committee was reluctant to criticize the Warden's management style, partly because it is a function of the individual personality of a manager, partly because overall it appears to work well for the prison, and partly because the committee itself believed it to be a desirable goal. However, the committee felt it necessary to point this factor out, given the critical nature of the Max Unit.

Confusion over Max command is not, in and of itself, necessarily a cause for considering discipline. However, the Committee believes that this confusion contributed to the failure of management to recognize the warning signs

preceding the riot. Thus, the confusion regarding command of Max indirectly may have contributed to events of September 22, 1991.

In addition to what the committee has termed direct causes of the riot and its escalation, certain acts or events were "indirect" causes of the riot. They include:

1) Escorting the inmates from the yard with 5 correctional officers per three inmates (5 on 3), instead of 2 on 1. Had this practice not been utilized, the availability of only 5 floor officers would have required that one inmate remain in the yard cage, which in turn would have required the yard cage door to remain locked.

2) Failure to adequately train cage officers. The lack of knowledge of the existence of glass on the inside and outside of the Lexan and the perception that their security had been compromised forced the cage officers to leave their posts prematurely and enabled the inmates to reach the protective custody inmates sooner. Lack of training in emergency exit procedures may have contributed to their failure to shut off the control consoles.

The committee found that the practice of escorting 3 inmates with 5 officers was commonplace. It was done by at least two separate Max Sergeants.
This policy violation is indirectly responsible for the riot at Max. There are only five floor officers and there are typically three inmates to a cage. In order to meet the policy of transporting one inmate with two guards, one inmate would

have had to remain in the cage while the other two were moved. This would have necessitated the officers following the policy which requires that the cage door be locked when the yard door was open. Thus, it is likely that the inmates would not have been able to enter the building on the day of the riot.

A second concern is the human tendency that the failure to enforce one policy leads staff to disregard further policies. That appears to the committee to be what happened in this case.

The committee also was concerned that the Deputy Warden may, in fact, have authorized the 5 on 3 policy without formally changing the written policy. The committee was left uncertain whether the Deputy Warden had informally changed the inmate movement policy.

The Deputy Warden stated that he had discussed the 5 on 3 policy with the Max Sergeant on duty when the riot occurred. He stated that he did not approve the change in policy, but rather told the Sergeant that if he felt it was a secure procedure then he should bring it up at a Max sergeant's meeting. The policy could then be considered for change. The Deputy Warden's statement was supported by the comments from a number of other individuals.

On the other side, at least one Max sergeant other than the Sergeant immediately aforementioned stated that he utilized the 5 on 3 policy, and that the Deputy had approved of the policy. The committee concluded that, at the very least, the Deputy Warden had again failed to adequately communicate his expectations to staff.

With respect to the cage officers, the lack of training may have led to the premature abandonment of the cages and the failure to adequately shut down the control panels. Knowledge of the glass layers on the Lexan windows is not common knowledge. The only persons with prior knowledge of that fact are employees who were stationed in Max when the glass was installed. That knowledge is not imparted to officers during pre-service training. What they are told is that the cage glass is bulletproof. It is understandable that the sight of "bulletproof" glass shattering led to the abandonment of the cages.

Outside of DCT training, there is little, if any, emergency training of any kind at the prison. Such procedures are commonly acquired not by training, but by "common sense". The lack of emergency training in general was cited by numerous employees, and there appears to be a strong desire by personnel to receive such training.

Despite the problems of lack of training, the committee did not feel that this was sufficient cause for discipline. It is however, an area which needs to be considered in the future. The committee is also aware that management has consistently requested funds to enhance training at the prison. Management has recognized the need in this area for some time, and cannot be faulted for the lack of funds.

POLICY: The allegations concerning policy are as follows:

C. Important policies and procedures are inappropriate, contradictory or lacking, and other policies have been regularly ignored.

D. The exists no Use of Force Policy.

E. Post Orders for control cages are completely inadequate.

F. There is no expectation for staff to read or become familiar with post orders.

G. There is no Suicide policy.

H. There is no Emergency Procedures Plan.

C. Important policies and procedures are inappropriate, contradictory or lacking, and other policies have been regularly ignored.

Discussion: The determination of whether or not important policies were inappropriate, the Committee believes is a matter of frame of reference. The NIC Team was comprised of individuals with considerable experience and expertise. Within their frame of reference, it is certainly possible they may have found what they considered to be inappropriate policies. Perhaps the best indication of the NIC Teams's conclusions on this matter lie on page 94 of their report under the heading "C. How the Riot Occurred". Therein we find in #3. "Post Orders in Max were either completely missing or written so inappropriately as to be ineffectual". Under #8 we find "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".

First, it seems obvious that the NIC Team limited their criticism to the Max unit. Presumably, this could mean that they found post orders in other areas at least adequate. This Committee found no evidence from our interviews of Max personnel that post orders were "completely missing". Some staff stated that

they thought the post orders were insufficient, while others considered them to be acceptable. The Committee examined the post orders in Max and considered them barely adequate. Had the post orders been followed, the disturbance on September 22 probably would not have occurred. Post orders were at least sufficient, if followed, to have created procedure that would have precluded the riot event. The Committee did not consider the post orders to be "ineffectual" as critiqued by the NIC Team. However, Post Orders had need of and are being revised and rewritten.

Secondly, the NIC Team found that policies and procedures were "routinely violated" by officers. It was clear to the Committee, that it had become commonplace to violate or ignore some of the Max policy. There were violations of policy on September 22. The Max staff on duty that day were guilty of several violations of written policy. The most pervasive of those violations was permitting the corridor doors to be both open at the same time. This had apparently been done on a regular or routine basis by a number of staff. The Committee believes that the yard door was frequently left open for ventilation when the inmates were locked down. We also believe that it was not an uncommon occurrence for it to be left open for convenience, when inmates were being moved from the yard back to cells.

The failure to double lock the control cage doors also seemed not to be an uncommon occurrence. When the Max structure was built, the double lock system was not in place. It was installed later as a security addition. Perhaps some of the complacency arose from the fact that it was not initially required. Clearly, however, at the time of the riot it was a requirement that was violated by the

officers on duty. It was difficult to determine whether or not "supervisors and managers" ignored those violations on a regular basis. If the terms supervisor and manager as used by NIC refer to Sergeants, the Committee agrees that such was their finding. If it refers to those higher in the chain of command, such was not admitted to, and it would be difficult to substantiate one way or the other. It was clear that those higher in the chain of command knew that the policies violated the day of the riot were in force and were expectancies of management. The consensus of those interviewed was that had they noticed such violations in a visit they would have been corrected.

It is appropriate to note at this juncture, that the Committee concluded that the prison relied almost exclusively on the sergeants for enforcement of the policies, post orders and rules that did exist. Clearly, if a Sergeant was deficient, derelict, or "soft" in his enforcement, the whole unit was "soft". In many instances, and clearly on September 22 in Max the prison had a supervisor who was derelict and did not enforce the security provisions of Max policy and procedure. This condition existed in significant part, because of the inability of Command personnel to make frequent and regular visits to the units.

The Committee found there were some contradictions in procedures used to carry out policy. The requirement for "2 on 1" versus "5 on 3", has been discussed. This was seen by the Committee as a contradiction, evidently not in written policy, but a contradiction nonetheless.

There were other more subtle contradictions. There were complaints that the Deputy and the High-Side Security Manager would at times give contradictory orders, lending confusion to the staff.

The management of incident reporting has contradictory elements. There was no prescribed routing of information at the time of the incident. Since the riot, the incident reporting form has been revised and provides for routing. In the instance of the piece of fencing connected with inmate Ritchson, the Hearings Officer picked up the incident report, and the evidence, and locked it away without even examining the evidence. Such a practice, if concurred in by upper management, is certainly contrary to the maintenance of good security. This would suggest a lack of policy. There should be a clear method of handling incident report and evidence, centrally coordinated, to provide for the central repository concept, and of course the critical assimilation of information. Of note, however, is the fact that prison staffing to provide for this essential service is totally lacking if not non-existent.

D. There exists no Use of Force Policy:

Discussion: This Committee believes that it is not appropriate to characterize the prison as having <u>no</u> use of force policy. It would be correct to state that there is no uniform Use of Force Policy applicable to the entire institution. It is important to note that Max Policy does contain a nominal use of force policy. Policy 01-009, Section F. is titled "Use of Force", and does contain at least a minimal procedure for the use of force in Max. The obvious limitation that imposes is that staff may construe such to mean that Max is the only area of the prison the policy applies to

which with respect to holding staff accountable to use of force standards is unacceptable.

E. Post Orders for Control Cages are completely inadequate.

Discussion: While the post orders in the control cages leave a great deal to be desired, the Committee did not believe them to be "completely inadequate".

It is clear in retrospect, that had the cage officers complied with the existing post orders, that the rioting inmates could not have gained access to the cell houses and consequently would not have had access to the PC inmates. The cage officers in Max the day of the riot had both been through pre-service training which exposed them to the operational features of the control cage. They knew that their doors should have been double locked. They knew that upon exiting, they should take their keys with them. The West or Main cage officer knew about the power shut down feature of the cage, but did not perform it upon leaving. Had the East cage officer simply taken the keys with him, it is unlikely that in the time they had, that the rioting inmates could have gained access to the cage. What was inadequate was the understanding that the officers had received through training of the features of the Lexan shields. Had they known of the glass covering, which shattered, the officer on duty in the East cage on the day of the riot would likely have remained in the cage at least long enough to have performed the exit procedures correctly.

F. There is no expectation for staff to read or become familiar with post orders.

Discussion: The Committee interviewed extensively on this subject. What we found that there indeed was a general expectation to read the post orders. Officers stated that they knew the expectancy from at least two sources. First

they were instructed to do so in pre-service training. Secondly, most said they were instructed to read post orders by their Sergeants. In some instances, officers stated that they were instructed to read post orders by senior, more experienced officers. The Committee also found an occasional officer who stated that he was never asked to read a post order except in pre-service training. These officers, however, knew that they should, but simply reaffirmed what has been stated previously, that "soft" Sergeants did not instruct them in that duty. Interviews with the Sergeants, confirmed that they understood that it was their duty or train, orient, and make certain that officers knew the expectancy of their assigned post.

G. There exists no Suicide Policy:

Discussion: The NIC team faulted the prison for its lack of a suicide policy. The lack of a policy relates to the Brown suicide, which the team felt was a major factor in the inmate's decision to riot.

There is no suicide policy at MSP. With respect to discipline, the question then becomes whether the lack of such a policy lead to the disturbance at Max. That requires a determination of whether the Brown suicide was a motivating factor in the riot.

The Committee questions whether Brown's suicide was a factor in the riot. A number of employees stated that Brown was disliked by the inmate population at Max. Committee member Ohler attended the inquest concerning the Brown suicide. His attendance at the inquest, and subsequent report to the rest of the Committee leads us to believe that Brown's suicide had no particular effect on the

inmates who planned the riot in Max. Three inmates testified at the inquest, William Grey, Steve Ritchson, and Chester Bower. Ritchson was evasive when asked whether the inmates had discussed what had happened. Ohler believes he was evasive because he did not wish it to appear that the inmates were fabricating their stories. Bower, who appeared to be a credible witness, testified that the Max inmates attempted to fabricate a story. There was also testimony from officers present at the scene that the inmates were enthusiastic and happy that Brown had committed suicide.

Grey and Ritchson were not believable witnesses. Both testified that they were awake. Both stated that they could hear Brown choking. Both expressed shock and dismay at Brown's suicide. Yet neither stated, nor did any officers state, that they made any attempt to notify the officers of Brown's suicide attempt. Ritchson was further not credible, because he stated that Brown passed him a magazine an hour prior to his suicide. However, the cell between Brown and Ritchson was unoccupied.

We conclude that the Brown suicide was not the motivating factor in the riot. We also believe that it probably was not a factor at all. However, it must be stressed that this opinion is formed without any conversations with the inmates themselves.

The presence of a suicide policy, even if Brown's suicide was a factor in the riot, probably would not have altered the fact of Brown's death. Brown had not exhibited any suicidal ideation at the time he took his life. There is testimony and statements that Brown had previously attempted suicide when he was at MSP

previously. However, there was no evidence that he had contemplated suicide during his most recent admission to MSP. There is documentation that Brown was experiencing personal problems that were significant to him. Credible evidence at the inquest supports the conclusion that Brown was not breathing immediately prior to his discovery by the floor officer. Evidence also supports the conclusion that Brown received medical attention immediately following the opening of his cell. Finally, actions taken following the suicide, including a psychological autopsy and the numerous staff reports appear to be adequate.

H. There is no Emergency Procedures Plan:

Discussion: The Warden who preceded the current Warden did draft an "Emergency Procedure Plan" in July of 1981. As nearly as the Committee can determine, the draft was not finalized nor promulgated but did exist. Department policy 107, does require that each facility have an emergency procedural manual, and a "written plan" for disturbance control. It is apparent that the prison had not fully complied with the Department policy that was promulgated in February of 1984. That lack of compliance must be shared by the two Wardens who have administered the prison since 1984. That obviously includes the previous Warden and the present Warden. To his credit, the present Warden was working on such a policy at the time of the riot, but did not have it finalized. It is the Committee's opinion, that failure to have such policy in place must be shared by the Division Administrator of Corrections who is responsible for enforcement of Department policy. Given the fact that the current Administrator was only acting and newly appointed, he cannot be held accountable, however, the previous Administrator should have followed up on the requirement, and certainly the Warden should have made it more of a priority.

The Committee believes that if such a policy were properly written and promulgated, it would overcome such deficiencies as the nearly non- existent knowledge and understanding of the power over-ride system located in Command.

TRAINING: The NIC Team mentioned three specific areas of deficiency in training:

I. Staff training is inadequate, there is no long-term budget.

J. Cage officers in Max had no training in design features nor in emergency exit procedures;

K. There is no instruction (training) to new Max officers.

I. Staff training is inadequate, there is no long-term budget.

Discussion: There is and has been a recognized inadequacy in training at MSP. There is also ample documentation that the Warden and his staff have been diligent in their efforts to secure more funding for additional pre-service and in-service training. The inadequate situation in training is not related to any management deficiency at the prison. The causes for not having a "long-term budget" do not rest with prison management. The reason such a program does not exist clearly is with higher level authority to include the Legislature itself. The Committee interviewed a number of people who have obvious potential to significantly contribute into the management system of Montana State Prison. That potential should be tapped to its fullest. Many of the staff had pertinent suggestions on how training could be improved at the prison. There is a need to critique existing training based upon its product--that kind of input can be solicited from recipients and immediate supervisors to assist in the assessment of

need for change. More can and should be done to allow the opportunity for **all staff** to make suggestions designed to improve the prison operation.

J. Cage Officers in Max had no training in design features nor in emergency exit procedure.

Discussion: The Committee found, for the most part, that this allegation is true. Officers who were present during or immediately after the construction of the Max building were made aware of the design features of the Lexan and the fact that glass was placed as a cover to prevent the plastic (Lexan) shield from scratching. As time wore on, and turnover occurred, newer officers were not informed appropriately about the glass cover; the information disseminated was to the effect that the Lexan could not be penetrated easily, not even with a bullet fired from a gun. The fact that there was glass to shatter did come as a surprise to at least the officer in the East Cage.

Training in the operation of the control panels and in emergency exit procedures was primarily a function of pre-service and Sergeants. There were some newer officers trained by experienced officers. The extent and sufficiency of such training apparently varied with the diligence of the unit Sergeants to either do it himself or to see that it was done. The Committee found much inconsistency and although we would not characterize the "program" as one with "no training", it was certainly deficient with little or no method to assure completion nor to establish accountability to the trainers.

In fairness to the Sergeants, it must also be said that the Committee found little evidence that they were being trained in how to function in their positions.

Rather, there is more of an assumption, that if you make Sergeant, you have been prepared by your experience as a Correctional Officer. As a consequence, it was the opinion of the Committee that a major deficiency in training is the **lack of training** for those promoted to higher positions. This same situation is true for promotion to Lieutenant, Captain, and Security Managers.

K. There is no instruction (training) to new Max Officers.

Discussion: Most of what was stated in "H." above could be restated here as being applicable. The training to new Max Officers varied with the Sergeant. Often such training was minimal or non-existent. For others with a conscientious Sergeant, some training was completed, however, not always sufficient to the need.

ADMINISTRATIVE: The administrative allegations are essentially the following:

L. The prison was not responsive to inmate needs. Conditions in Max were unnecessarily harsh.

M. The Max unit was run badly, living conditions for inmates unreasonable, a pattern of unnecessary use of force.

N. The criteria for placing and releasing inmates into and out of Max is poorly defined, overly subjective or unspecified. Resulted in Max being a large segregation unit rather than a classification level.

O. The tension level at the prison prior to the riot was very high.

P. Deficiencies in the fire alarm/power shut down system not addressed properly.

Q. Managers seldom visited Max and did not supervise or review when they did.

R. There were no incident reports filed by mid-managers or administrators on scene the day of the riot.

L. The prison was not responsive to inmate needs. Conditions in Max were unnecessarily harsh.

Discussion: The NIC Team may have ascertained information that this Committee did not. We did not interview inmates. The interviews this Committee conducted with staff gave no indication that they felt any non response to inmate needs. Max personnel interviewed denied that conditions in Max were "unnecessarily harsh". Quite obviously, there are at least two divergent perspectives of conditions in a prison--one from those incarcerated, and another from staff responsible for enforcing the conditions of incarceration.

It may be well at this juncture, however to discuss the matter of staffing on third shift. The Committee did find that third shift staffing in Max was inadequate and not responsive to potential inmate need. The Riot at Max document found that overall staffing was adequate. However, it noted that certain posts are overstaffed and certain posts are understaffed. Max is understaffed.

In the Committee's opinion, Max is understaffed on third shift. The Brown suicide incident reveals the problem with the staffing on third shift. If policy of Max is complied with, it is not possible for inmates on D - F block to be reached by staff until an additional officer arrives at the Unit. An inmate suicide could be

attempted in which the inmate is still capable of being revived if reached immediately upon discovery. Another example when a life could be saved if inmates were immediately accessible includes a heart attack.

We found management's response to this problem, including the warden's response, to be rather curt. The problem was dismissed as, "if they want to kill themselves they know when to do it, if they only want attention, they know when to make the attempt". This disregards the individual who makes a rash decision to end his life, but who may be helped through counseling to get through his problem. It also disregards other emergencies such as heart attacks.

The policy of the institution, which this Committee agrees with is that an officer will not enter a cell alone--the requirement for "2 on 1" must be met. This is a reasonable and necessary policy to assure the safety of staff. However, it was questionable in the minds of the Committee that management had thought of other implications of the policy such as medical emergency. One of the staffing results of the riot was to assign an additional officer to Max during first shift to supervise the yard. In the opinion of this Committee, it is vital that an additional floor officer be assigned to third shift to provide for **immediate** entry into the cell of a distressed inmate. There are times on third shift when the Command Officer is alone. There would be no possibility to send assistance without pulling an officer from another post. The delay created could result in serious injury or death of an inmate. This should be corrected.

M. The Max unit was run badly, living conditions for inmates unreasonable, a pattern of unnecessary use of force.

Discussion: The Max unit was obviously run poorly on September 22. We have noted other deficiencies in this report supra. Clearly, this Committee was critical of the chain of command and the apparent confusion of roles with Deputy Warden, High Side Security Manager and Command. Those situations require a priority review to correct the problems.

We interviewed a number of Max personnel. The Committee concluded that there was not a pattern of unnecessary force. Most staff thought that the policies and procedures for handling inmates in Max were reasonable, understood and followed. The Committee felt that if the use of unnecessary force was a "pattern", that such conduct would have generated a great number of inmate complaints to inmate advocates such as attorneys, counselors, relatives, administrative officials, and others with vested interest in such conditions. The Committee found no evidence of unnecessary use of force.

One of the living conditions complained of in the NIC report was that food temperature was not controlled well. Staff we interviewed, who ate the same food as the inmates, did not perceive this to be a problem. They indicated inmates had complaints of cold coffee, but which they felt was also unfounded. The prison has taken steps to insure temperature checks. Most of the staff felt that complaints of food were a commonplace inmate grievance, but generally without foundation.

N. The criteria for placing and releasing inmates into and out of Max is poorly defined, overly subjective or unspecified. Resulted in Max being a large segregation unit rather than a classification level.

Discussion: This Committee did not investigate into this allegation. We felt it was more properly a subject for internal review at the prison. We take note of the fact that this NIC allegation is at least partially confirmed in the "O'Brien Report".

O. The tension level at the prison prior to the riot was very high.

Discussion: Of the staff that this Committee interviewed, it was evident that there was concern that something was coming down on High Side. Staff was obviously alerted to that possibility and there was some tension concerning it. However, staff did not confirm to us that they felt inordinately tense due to this situation. Most staff expressed that disturbance rumors are commonplace in the prison and that although they had concern, their level of concern was not greater than routinely experienced.

P. Deficiencies in the fire alarm/power shut down system not addressed properly.

Discussion: The earliest date of record noting a problem with the system was in February of 1991. In the Committee's interview with the Maintenance Supervisor of the Prison, we learned that the system was understood by him to incorporate the fire alarm and power shut down system located in Command. He stated that the system was functional prior to February and had been tested. In February Supreme Electronics took out a control board with the intent to repair it. In March, Supreme took out a second control board. The removal of the control boards rendered the system silent. Supreme did not return and the system was silent until October of 1991, when Supreme returned with the Boards and reinstalled them after the riot. The Maintenance Supervisor kept a detailed

record of his contacts with Supreme Electronics and the parent company Auto-Call. His record indicates that he made 26 separate contacts, between February and September 22 about the system and the need for repair (see attachment 1).

The Maintenance Supervisor contacted the Warden in May for assistance and the Warden wrote a letter to Supreme Electronics on May 15. Supreme responded about 2 weeks later but could not repair the system supposedly for lack of parts. There is a well documented trail of contact thereafter until right up to the date of the riot.

The Committee concluded that the Warden was unaware that the power shut down was an integral part of the alarm system. The system was installed during the term of the previous Warden. Given the present Warden's style of management delegation, he delegated the problem to Maintenance to get it repaired. There is no indication that maintenance contacted the Warden after the May letter. The Committee believes that the Warden delegated to maintenance the expectancy to carry the problem to its conclusion. It appears that maintenance was aggressive in attempting to resolve the problem. The Warden could have followed up on the matter with maintenance, but evidently did not. The Committee was concerned that the Warden had no knowledge of such an important security feature as the power shut down capability in Command. The Committee believed that the Warden should have been more aggressively involved in seeing that the system was repaired.

Additional concerns of the Committee were that no one in Command was aware that the system was down; what the system was designed to do; and how

the system is operated. Apparently no one in Command, or for that matter in all of Security had been trained in the use of the system. The system is key operated. On the day of the riot, there was only one key in Command. The system requires two keys to be fully operational. The system was inappropriately labeled, and still was when the Committee looked at it. The labeling did not make it clear what each key controlled. The system had not been tested using Security personnel; therefore they had no first hand experience with its function. At the time the Committee made its visits, there still had been no training in the system, nor to our knowledge had it been tested beyond the test that occurred after installation of the control boards in October.

Q. Managers seldom visited Max and did not supervise or review when they did. Discussion: The Committee felt that this allegation is substantially true. Visits to Max by managers were infrequent. Visits from Command to Max were essentially non-existent. Part of the problem has to do with the previously noted confusion in the chain of command issues. The general consensus of Command was that Max was under the direct supervision of the Deputy and that the High Side Security Manager had been delegated some responsibility to Max, but that they had little to do with Max except perhaps routine contact evidenced in the assignment of staff.

Most Command personnel interviewed stated they would have visited Max more often had they not been bogged down in paper processing. When they did get out their primary visitation effort was to other areas of the compound.

Some staff said that on the occasions when they were visited that there seemed to some visual check of what they were doing, however, the majority stated that the visits were for other purpose such as visiting with an inmate. The Committee concluded that there was little, if any, "review" of staff performance during the visits of management officials.

R. There were no incident reports filed by mid-managers or administrators on scene the day of the riot.

Discussion: Policy does require that all personnel present during a disturbance file an incident report. The DCT Team generally complied with the policy. It is true that mid-managers and administrators did not. The basic reason provided for not filing incident reports was that they were too engrossed with more important matters, and could not find the time to sit down and complete a report. The Committee believes that in the aftermath of the riot, that it was very difficult to allocate time to a desk function of report writing. It is difficult to be overly critical of this failure to follow policy and write a report. The Committee became aware that management and administrative staff were putting in long and difficult days, frequently being denied appropriate rest. It is suggested that individuals with extreme demands on their available time could use a hand recorder when walking between assignments and later have it transcribed, so as to produce a concurrent record which may prove valuable in future events.

STAFF PROFESSIONALISM: The NIC allegations were the following:

S. Staff regularly swear at with or about inmates, and staff taunt and demean inmates.

T. Staff don't have a professional appearance.

U. Staff are careless about maintaining confidentiality regarding inmate informants.

S. Staff regularly swear at, with or about inmates, and staff taunt and demean inmates.

Discussion: Although there was denial about swearing at, with or about inmates, the Committee strongly felt that such activity occurs with great frequency. Many we interviewed either admitted to the activity or had first hand knowledge of it. Most perceived it as a problem that needed correcting. From our interviews, the Committee found no evidence of staff taunting or demeaning inmates. This could, however, be attributable to the fact that most staff were aware of this allegation and were defensive. The Committee strongly recommends more training, both formal and OJT type, be devoted to inter-personal communication development of officers.

T. Staff don't have a professional appearance.

Discussion: Since what constitutes a "professional appearance" is a matter of reference and opinion, it was difficult for the Committee to draw any valid conclusion on this matter. The uniformed staff appear to maintain their uniforms adequately and others in the facility appear to be groomed appropriately.

U. Staff are careless about maintaining confidentiality about inmate informants.

Discussion: The Committee interviewed extensively about this matter, but found no one who had participated in or knew about breaches in confidentiality regarding inmate informants. A number of staff expressed that they knew of the

importance of maintaining such information confidential and that it would be "foolish" or "stupid" to breach it.

The Committee did feel that there was need of a clearly written and defined policy on the matter of how to handle such information. Such a policy should be broadly distributed, and clearly understood by staff. It should contain information on all the necessary safeguards to enable the security of the information and the informant.

CLOSING COMMENTS

The Committee looked hard for information regarding inmate abuse subsequent to the riot. We interviewed for abuse in the double line leading out of Max and into "No Mans Land". Committee member Gooch called the NIC chairman in an attempt to obtain names of officers they reported interviewing who had reported abuse. The NIC Team felt that they could not break the confidentiality they had promised and would not release the names. Chairman Schwartz was, however, very cooperative in personally calling the officers to ask them to come forward if they elected to break their own anonymity.

We did receive one call from an officer who would not identify himself, but did discuss what he had witnessed. This officer stated he was at some distance away, looking through binoculars, which would indicate a Tower officer. He stated that he "saw inmates fall", he saw officers, one on each side of an inmate grab them under the shoulders "and just drag them". He stated that he thought he saw officers "grab the cuffs" of the inmates and hyper-extend the shoulders.

He did not see any abuse in "No Mans Land". He did not see any other abuse. He further described what went on in the line from Max to No Mans Land as "morally correct". He said that no one was hit with clubs. He described the treatment as "rough". He could not identify anyone in the line either officer or inmate. He worked in Reception during post riot, and stated that nothing happened that was abusive or cruel. He said what was done in Reception "was justifiable use of force".

In all of the interviews conducted with other staff, we found no one who indicated that he witnessed any abuse either in Max with the DCT Team nor outside in the line to no mans land.

The Committee did become aware of what has been termed the "dragging" of inmates into no mans' land. This was observed by staff and evidently did happen. However, staff we interviewed stated that it was not abusive. It was conducted in the effort to prevent injury to inmates who had fallen. They were picked up by two members of the line and "carried" or "dragged" backwards over into non man's land. Staff felt the action was necessary to get the inmates out of harms way from other inmates who were being rapidly exited out of the Max building. While understandable that such action can be interpreted as rough treatment, the Committee felt that given the circumstances, it was not only not abusive, but necessary.

The Committee is aware of the great concern the NIC Team had over reported treatment of inmates in Reception during the post riot period. Those

concerns are being addressed in the FBI investigation, and were intentionally not a part of this Committee's inquiry.

OTHER RECOMMENDATIONS

1. We recommend that the prison develop and print a pocket size book of pertinent policy for general distribution to all staff upon employment.

2. We recommend that staffing in Command be augmented with an "Administrative Sergeant" on first and second shifts to relieve the Command Officers of paper work and enable them to provide the duty mandated in their position descriptions, with particular reference to visits to units, the explanation of policy and procedure expectation to personnel, and the training of personnel where necessary.

3. We recommend that a formal program of training be developed for staff who are promoted to Sergeant, Lieutenant, Captain and Security Manager.

4. We recommend a review of all positions descriptions from Correctional Officer up through Deputy Warden and that they be rewritten to better explain expectancy.

5. We recommend that evaluation documents be rewritten subsequent to the PD rewrite, and that the standards more accurately reflect measurable duties and responsibilities.

6. We recommend the clarification of existing policy and post orders (we understand this is now in process) and the development of certain new policies.

7. We recommend that more emergency training be implemented of all staff apart from DCT training.

8. We recommend that all Command personnel be trained in all aspects of the systems and the resultant expectancy for all such equipment found in Command.

9. We recommend that the prison training program be expanded in both pre-service and in-service.

10. We recommend that the Max chain of command be clarified and that duties and responsibilities for the administration of Max be written, and fixed to establish certain accountability.

11. We recommend the development and promulgation of an institution-wide Use of Force Policy.

12. We are aware that the Warden is in process of developing an Emergency Procedures Plan. Such is an obvious need. Certainly part of such a plan should be the development of emergency procedures for all posts and importantly for Command.

13. We recommend that a written policy and procedure be developed for the maintenance of confidentiality standards for inmate informants.

14. It is imperative that the role of Command be clarified. Presently the security of the prison is maintained or broken on the position of Sergeant. Sergeants are being delegated a large part of the responsibility for security and training. Much of the delegation of authority to the Sergeant level may be inappropriate. Command should be strengthened where necessary to provide for staff resource sufficient to its mission.