

**THE REPORT OF THE  
JUSTICE COMMITTEE FOR THE  
MONTGOMERY COUNTY JAIL**

**FEBRUARY 26, 2019**



**Prepared for:**

**THE MONTGOMERY COUNTY  
BOARD OF COMMISSIONERS**

February 26, 2019

Judy Dodge, Montgomery County Commissioner  
Deborah Lieberman, Montgomery County Commissioner  
Carolyn Rice, Montgomery County Commissioner  
Montgomery County Administration Building  
451 West Third Street  
Dayton, OH 45422

Dear Commissioners,

On March 30, 2017 the Montgomery County Board of County Commissioners authorized the establishment of the Justice Committee for the Montgomery County Jail, empowering it to review whether the policies and procedures of the Montgomery County Jail ensure that best practices are followed, and whether there is need for any community investments to ensure a safe and humane environment there.

The members of the Justice Committee are mindful of the weighty responsibility entrusted to us, and of the faith our neighbors have placed in us to address these critical issues. We believe the report we submit to you today can serve as the blueprint for a jail that will not only keep its inmates safe, but also safeguard their civil rights and human dignity, while better preparing them for successful reentry into the community. It should likewise provide a safer and more satisfying workplace for its correctional staff.

As stated in the Executive Summary, there are three common threads running through the chapters of this report, namely the insufficiencies of the Jail's current physical plant, the severe overcrowding of the facility, and the critical understaffing of jail personnel. Addressing these problems will require the cooperation of the Board of County Commissioners for direction, allocation of funds, and construction; the Sheriff's Office to implement substantive policy and oversight changes; but also, the citizens of Montgomery County, who must ultimately underwrite these investments. A safe and healthy jail must be everyone's concern and responsibility.

Although the mandate of the Justice Committee has come to an end, each of us will be active and engaged observers of the implementation of our work. We are grateful for the opportunity given each of us to apply whatever particular expertise we brought to the project to alleviating a grievous situation in our community.

On behalf of the Justice Committee,

Rabbi Bernard Barsky, co-chair  
Dr. Gary LeRoy M.D., co-chair

## ACKNOWLEDGEMENTS

The Justice Committee would like to acknowledge with gratitude the following individuals and organizations whose invaluable assistance and cooperation have made our work possible.

**The Montgomery County Commissioners:** Dan Foley, Deborah Lieberman, Judy Dodge, who selected us for this responsibility

**The Montgomery County Sheriff's Office:** Sheriff Phil Plummer, Sheriff Rob Streck, Major Matt Haines, and the staff of the Montgomery County Jail

**CGL Companies:** Karl Becker, Brad Sassatelli, George Vose, Dr. Daphne Glindmeyer M.D., Dr. Ronald Shansky M.D.

**Mary E. Tyler,** Executive Director of Greater Dayton National Conference for Community and Justice

**Joe Spidler,** Criminal Justice Director, Montgomery County, Ohio

**Peggy Feyche,** Stenographer to the Justice Committee

**Peggy Yurczak,** Administrative Assistant to the Justice Committee

**Mary Zoeller,** Administrative Secretary to the Montgomery County Board of Commissioners

**The Citizens of Montgomery County** who participated directly or indirectly in assisting us with the completion of this document.

**RESOLUTION ESTABLISHING THE JUSTICE COMMITTEE FOR THE MONTGOMERY COUNTY JAIL AND APPOINTING DR. GARY LEROY AND RABBI BERNARD BARSKY AS CO-CHAIRS.**

**WHEREAS**, the Montgomery County Jail is entrusted with ensuring the safety of those incarcerated and staff assigned to the jail; and

**WHEREAS**, the community believes the need for an independent review of how jail policies and procedures are implemented to ensure that best practices are used; and

**WHEREAS**, the community believes a local, independent committee is needed to review any physical and/or community investments required to provide a safe and secure environment to promote positive prisoner behavior and to insure fair and humane treatment of all individuals incarcerated in the jail; and

**WHEREAS**, the number of people incarcerated at the County Jail with substance abuse and mental health issues continues to climb; and

**WHEREAS**, the members of the committee will be appointed to two-year terms; and

**WHEREAS**, the voting members being appointed for terms ending March 31, 2019, in addition to co-chairs Dr. Gary LeRoy and Rabbi Bernard Barsky, are Branford Brown, Michael Carter, Stephanie Cook, Reverend David Fox, Tony Rankin, Judge Greg Singer and Carol Smerz, and the Montgomery County Sheriff will be an ex-officio (non-voting) member of the committee.

**NOW THEREFORE BE IT RESOLVED** that the Montgomery County Board of County Commissioners authorizes the establishment of the Justice Committee for the Montgomery County Jail and appoints members with a term ending March 31, 2019.

**BE IT FURTHER RESOLVED** that the Clerk of Commission certify this Resolution and make an imaged copy of this Resolution available on the Montgomery County, Ohio, website at <http://www.mcohio.org/>.

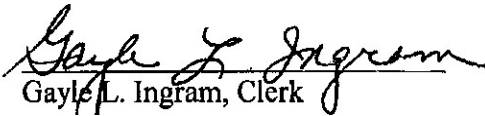
Mrs. Lieberman moved the adoption of the foregoing resolution. It was seconded by Ms. Dodge, and upon call of the roll the following vote resulted:

Mrs. Lieberman, aye; Ms. Dodge, aye; Mr. Foley, aye: Carried.

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I hereby certify that the foregoing is a true and correct copy of a resolution duly adopted by the Board of County Commissioners of Montgomery County, Ohio, the 30<sup>th</sup> day of March, 2017.

THE BOARD OF COUNTY COMMISSIONERS HEREBY FINDS AND DETERMINES THAT ALL FORMAL ACTIONS RELATIVE TO THE ADOPTION OF THIS RESOLUTION WERE TAKEN IN AN OPEN MEETING OF THIS BOARD OF COUNTY COMMISSIONERS, AND THAT ALL DELIBERATIONS OF THIS BOARD OF COUNTY COMMISSIONERS, AND OF ITS COMMITTEES, IF ANY WHICH RESULTED IN FORMAL ACTION, WERE TAKEN IN MEETINGS OPEN TO THE PUBLIC, IN FULL COMPLIANCE WITH APPLICABLE LEGAL REQUIREMENTS, INCLUDING SECTION

  
Gayle L. Ingram, Clerk  
Board of County Commissioners  
Montgomery County, Ohio

# **The Commissioners' Charge to the Justice Committee**

The mission of the Montgomery County jail is to provide a safe and secure environment to promote positive prisoner behavior and to ensure fair and humane treatment of all individuals incarcerated at the Jail. The Jail has capacity for approximately 900 persons daily.

Over the past year and a half, multiple civil complaints have been filed against the Montgomery County Commission and the Montgomery County Sheriff and Sheriffs staff by individuals who have been incarcerated at the facility, alleging civil rights and other violations. The Jail in recent years has also seen a significant increase in individuals who have mental health and substance abuse issues.

Due to these factors, the community believes a local, independent committee is needed to review and analyze the strengths, weaknesses and challenges of the Jail and provide recommendations for improvement to the Sheriff and Montgomery County Commissioners.

The Justice Committee was created by a Resolution of the Montgomery County Commission, as requested by the Montgomery County Sheriff, on March 30, 2017.

The Committee's charge: To review, analyze, and recommend improvements to the Montgomery County Commission and the Sheriff, regarding the following areas relating to the County Jail:

1. Training practices to promote the safest facility possible and to reduce number of future legal actions: Policies, procedures, practices, and training standards. Inclusive of current jail accreditations, from what additional training can Jail staff benefit to make the facility as safe as possible and minimize the number of future legal actions?
2. Mental/Behavioral Health programs: What specific programs-either currently in use or additional services - can help those with mental and behavioral health/drug addiction issues? What is the best practice—the best structure-- as to how these services get delivered in the jail?
3. Staffing: Are the current staffing levels on all shifts (watches) sufficient for the number of beds in the facility? Is the supervisory span of control within acceptable limits?
4. "Bricks and Mortar" improvements: Sheriff and Board of County Commissioner's staff are beginning to look at the physical improvements that need to happen at the jail. Architects and engineers will begin work on this as this Committee is being formed. Once the Committee understands the scope of options for capital improvements, what physical changes need to be made to the jail to address staff safety as well as the current needs of inmate

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# 1. Executive Summary

## THE JUSTICE COMMITTEE

The Justice Committee was established on March 30, 2017 by Resolution No. 17-0530 of the Montgomery County Commission. The resolution noted that “the community believes a local, independent committee is needed to review any physical and/or community investments required to provide a safe and secure environment to promote positive prisoner behavior and to ensure fair and humane treatment of all individuals incarcerated in the jail.”

The Commission established the Justice Committee in response to numerous federal lawsuits against the County and the Montgomery County Jail for excessive use of force and negligent medical care, in some cases leading to death. In the two years since the committee was formed the number of such lawsuits against the Jail and the County continued to rise. Although it was not within the purview of the Justice Committee to examine these cases, which are being adjudicated in court, we believe the recommendations contained in this report will significantly reduce occasions for future complaints.

The following persons were appointed as voting members of the Committee: Rabbi Bernard Barsky and Dr. Gary LeRoy (co-chairs), Branford Brown, Michael Carter, Stephanie Cook, Rev. David Fox, Tony Rankin, Judge Gregory Singer, and Carol Smerz. The Montgomery County Sheriff was designated as an ex-officio (non-voting) member of the Committee. Following the resignation of Mr. Rankin, Kurt Althouse, then Lieutenant and now Chief of the Vandalia Division of Police, was appointed to replace him. Sheriff Phil Plummer designated then Chief Deputy Rob Streck as his representative on the Committee. Chief Deputy Streck is now Montgomery County Sheriff.

The membership of the Committee brought expertise in medical and mental health, education, civil rights issues, and the local justice system – all crucial areas for evaluating the deficiencies and needs of the jail. However, aside from the Sheriff and members of his staff, only two Committee members had experience in jail administration, and most members had never seen the inside of a jail. Clearly, the first task of the Committee was to educate ourselves on the workings of the Montgomery County Jail, starting with a comprehensive tour of the facility and its resources, and familiarization with the two substantial volumes which establish policies and procedures for the Jail, the General Orders Manual and the Jail Handbook. In addition, the committee requested of the Sheriff an in-depth S.W.O.T. analysis of the Jail (Strengths, Weaknesses, Opportunities, Threats), which was prepared by Chief Deputy Streck. Three sub-committees were formed, one to consider jail operations and staffing, a second for medical and mental health issues, and a third for inmate grievances, use of force and civil rights issues.



After lengthy discussion, the Justice Committee agreed to engage a professional jail consultant to obtain an outside, independent assessment of jail conditions. The consultant was to act as the investigative arm of the Committee, and to issue its findings directly and only to the Committee. The company selected was CGL, which specializes in jail design, maintenance, operations, and facility planning. During the spring and summer of 2018, CGL - sometimes accompanied by members of the Justice Committee - conducted extensive interviews with jail staff, explored the physical facility, reviewed its organizational structure, operations, staffing, policies and procedures, data collection, handling of inmate complaints and grievances, instances of use of force, and the provision of medical and mental health services.

While the findings of CGL provide the core of the final report now presented to the Montgomery County Commission, they have been closely scrutinized, evaluated, edited and extensively supplemented by the Justice Committee in light of our own areas of expertise and our knowledge of local community conditions and expectations. The report here set forth is the report of the Justice Committee, and its recommendations.

The Justice Committee acknowledges the cooperation of the Montgomery County Sheriff's Office (MCSO) and the staff of the Montgomery County Jail, without whose cooperation this report could not have been made.

Regrettably, however, the Justice Committee did not have access to Jail inmates for interviews, which we regard as a deficiency in this report. In response, the Committee attempted to interview individuals who had recently been released from the jail. Two hundred seventy names were randomly culled from the county list of released persons and from referrals by the Montgomery County Reentry Office. Letters were sent inviting participation, with the inducement of a \$30 gift card. Only sixteen persons responded to make appointments, and only ten persons showed up to be interviewed. The interviews were conducted by Mary Tyler, Executive Director of Dayton NCCJ (National Conference for Community and Justice). This is too small a sample to provide other than anecdotal evidence. However, the testimony of these former inmates is consistent with the report of CGL consultants and the experience of Justice Committee members concerning the lack of cleanliness in the jail facility, the poor condition of plumbing and HVAC systems, overcrowding, non-responsiveness of the grievance system, and instances of excessive use of force, among other issues.

## **LIMITATIONS OF THE STUDY**

The resolution establishing the Justice Committee is explicit that the mandate of the Committee has to do with "ensuring the safety of those incarcerated and staff assigned to the Jail," providing "a safe and secure environment," and ensuring "fair and humane treatment of all individuals incarcerated in the Jail." The Committee has been mindful of these limits to its mandate. We are concerned about issues outside the jail which lead to overcrowding, and we have discussed in general terms the questions of bail reform, diversion programs, and alternative treatments for drug and mental health cases, including pre- and post-release opportunities. Dealing with these questions is crucial to the County's efforts at reducing the jail population and increasing jail

safety. But our investigation and report deal only with what happens to individuals from the moment they are brought into the Montgomery County Jail until the moment they leave.

The volatile issue of racism falls under the larger rubric of civil rights violations generally. The Committee is aware that specific allegations of racism have been made against the jail, and to our knowledge these have been addressed and rectified as they have arisen (for example, the assertion that African-American women were being designated to inferior housing, referenced in the report on Classification). But allegations and lawsuits concerning civil rights violations and excessive use of force have not arisen from only one racial/ethnic group. Our report has addressed these matters in our recommendations for vigilant oversight of the use of force; improvements in the system for filing and responding to inmate grievances; close monitoring of jail classification for racial bias, improved staff training in cultural competency, implicit bias, and use of force; and increased efforts at minority hiring of corrections officers.

## **THE SUMMARY**

We now summarize the major reports contained herein, while emphasizing that the individual chapters include many more extensive and detailed recommendations than can be included in this summary. Three common threads run through all the chapters of this report: (1) the insufficiencies of the Jail's current physical plant; (2) The severe overcrowding of the facility; and (3) the critical understaffing and the reliance on excessive overtime to compensate.

### **Jail Facility**

The current facility houses nearly twice the inmate population deemed appropriate for its capacity by the State of Ohio. This level of overcrowding makes the monitoring of inmates and the delivery of services extremely difficult. The design of the older, linear units makes effective inmate supervision virtually impossible, while the level of overcrowding in the newer and better designed pod units undermines whatever improvement in monitoring and inmate services they should have brought.

Program space has had to be converted to dormitory housing, so there is virtually no dedicated program space in the facility, and no space for private treatment of inmates. The medical unit lacks adequate examination rooms and no examination rooms are available on the housing units. The overcrowding also makes it impossible to maintain the legally required sight and sound separation for juveniles housed at the facility.

The booking area is not sized or designed to facilitate the processing of the current volume of offenders entering the facility, and does not allow for appropriate management of offenders with special needs. Further, the facility building systems are deteriorating and will require increasing levels of funding to assure ongoing operation of the facility.

The Montgomery County Jail facility does not provide a minimally adequate environment for staff or inmates. Renovation or remodeling to address the many problems with the facility is

neither practical nor cost-effective. The County should commence planning for the ultimate replacement of this building with a modern correctional facility that can house offenders in a humane manner, provide needed program services, and afford staff and inmates a safe environment.

## **Jail Operations and Staffing**

Jail operations are managed consistent with national standards. The Command hierarchy includes a Facility Administrator (Major), two Captains, and Sergeants who function as shift commanders. Unfortunately, the situation is marred by understaffing and lack of budgeted resources. The number of sergeants available to fill posts 24 hours per day, seven days per week is inadequate to meet the requirements of the facility. Insufficient staffing has ramifications that include excessive overtime, employee absenteeism, high employee turnover, lowered employee and inmate morale, and at times, operational problems. Our staffing recommendations indicate that the facility needs 59 additional staff. The addition of these positions should improve facility operations, increase the oversight and supervision of offenders, reduce staff overtime, and increase staff retention.

Furthermore, the elimination of the lieutenant position removed an intermediate level of supervision that is essential in managing correctional operations and allowing sergeants to focus on supervising line staff and addressing inmate issues. At present, the supervisory ranks are too thin at the Montgomery County Jail, inhibiting effective supervisory and management practices.

As noted in the Staffing report, we recommend the creation of essential intermediate levels of supervision within the Jail. This would include:

- reestablishing the lieutenant rank to act as shift commanders overseeing correctional operations of their assigned shift;
- staffing sergeant positions according to the relief factor requirements, to ensure that two sergeants are available on each shift, one to manage Booking and the other to manage Housing Operations;
- establishing a civilian corrections supervisor rank, which would report to a sergeant. This civilian position would also provide career and promotional opportunities within the corrections officer ranks that may help retain civilian corrections staff and improve employee morale.

Further, the efficiency of operations in the Booking Area of the Jail is impacted by the staffing shortfalls. A position of Receiving Officer was eliminated due to budget shortfalls, and the Classification Officer position is often combined with booking staff, which slows down the classification process. It is recommended that positions of dedicated Receiving Officer and of dedicated Classification Officer be created.

The number of officers posted in the housing units is insufficient for adequate supervision of the inmate population. It is recommended that staffing be increased in the linear units to ensure that two officers per floor are available during peak activity periods. Staffing should also be increased in the pod units so that during peak activity there is an officer available as a Rover between Pods A and B, and another between Pods C and D, to provide relief to the officer on pod duty.

## **Staff Training**

Work in a prison environment is complex and can be entirely different from any other occupation an employee previously held. Training is therefore critical to developing a skilled, motivated and committed jail workforce that understands the unique requirements of supervising offenders. A successful and ongoing staff training program is key to ensuring the safe operations of a correctional facility and at the same time safeguarding the rights of those incarcerated.

The Jail's training programs for all levels of staff appear consistent with national standards. The Field Training Officer training practices are thorough and complete. However, some form of enhanced incentive should be established for the important FTO positions.

Correctional staff should receive regular updated training on cultural competency, trauma-informed policing, implicit bias, and interpersonal communication skills as part of the annual 40 hours of in-service training. (Additional training recommendations are included in the Use of Force report.)

## **Classification**

The classification process assesses offender risk, security issues, and programmatic needs of offenders upon admission to the jail to ensure proper placement in the housing units. Placement should also be periodically reviewed to assess the ongoing appropriateness of the original placement. The classification process is heavily impacted by the overcrowding of the facility and the deficiencies in security especially in the linear housing units.

Understaffing in the Jail also has serious ramifications. In order for the classification process to operate effectively in a jail of this size, given the large number of commitments that take place on a daily basis, it is imperative that proper staffing of the classification process be maintained. The analysis found that, consistent with other staffing problems identified at the jail, the requirement that the classification process be staffed 24 hours per day, seven days per week is not being met.

As noted above, we recommend the creation of a dedicated Classification Officer for each watch, focused entirely on the classification of inmates and required to conduct an in-person interview with each new inmate. Additionally, we recommend adding a Classification Supervisor to oversee the classification process, to conduct ongoing review of the classification system,

including monitoring of compliance with policy and procedure, and of the effectiveness of the classification instrument.

## **Use of Force**

One of the critical areas of jail operations is management of the application of force by staff on inmates, who by their actions are required to be physically restrained and controlled. Proper practice requires written policy governing the use of force, as well as practices that include investigation and monitoring of force incidents, training and supervision of staff, and ongoing review of force issues. The Sheriff's Office has outlined a comprehensive policy on use of force, but we recommend developing a more detailed, jail-specific policy which fully identifies explicit requirements for the use of force in a correctional/jail setting, to replace Jail Manual Order # 3.5.1. This policy should detail the appropriate use of force and related procedures, including alternatives to use of force and specific prohibitions of use of force in certain situations.

This policy should identify use of the Emergency Restraint Chair as a use of force and require that established criteria be met before placing an individual in the chair when no other reasonable alternative is available. Precautions need to be taken to ensure that medical staff examine an individual and review medical records, prior to placement, or shortly after placement, due to the potential for serious medical conditions that can occur during the restraining process.

We also recommended the Sheriff's Office adopt additional practices to ensure adequate use of force analysis, accountability of staff's reported force incidents, and transparency with use of force incidents. To this end we recommend establishing an ombudsman process or civilian review panel to routinely reviews the Jail's use of force incidents, including all applicable reports, videos, photographs, and documentation, to build and maintain a degree of transparency and trust with the community. We would require that all evidence from a use of force incident, including electronic and physical evidence, be preserved, secured, and maintained appropriately so it cannot be deleted, destroyed, or tampered with.

## **Grievance System**

Grievance policies help ensure the rights of incarcerated individuals. Additionally, grievance policies impact the ability of offenders to access federal courts, as past rulings<sup>1</sup> have required offenders to exhaust all available administrative remedies before they access federal courts. An open and fair grievance practice is also an effective management tool because it provides a measure by which to determine whether facility policies are being appropriately followed by staff.

The policy differentiates between inmate "complaints" and "grievances." Specifically, a complaint is recognized as "an act that constitutes misconduct by an employee including a criminal act," or "any violation of the inmate's rights." Grievances, on the other hand, can be filed for any other matter related to facility operations, services, and programs. As a result of this

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<sup>1</sup> Woodford v. NGO (2006)

differentiation, there are separate processes for complaints and grievances. The policy also identifies distinct practices for processing health care grievances and non-health care grievances.

Jail staff indicated they had received only six complaints in the last 18 months, and that this was a total of both citizen and inmate complaints. The extremely low number limits the validity of any meaningful analysis. The Jail reported only nine written grievances in the past year. This number is also extremely low, as indicated by the chart in our report comparing the number of grievances filed in the Montgomery County Jail with other facilities across the country.

Our report recommends establishing an independent Grievance Coordinator for the facility who is responsible for monitoring the grievance process, ensuring legitimate access to complaint and grievance forms, and serving as the first level of formal grievance review for all health care and non-health care grievances. The Grievance Coordinator should independently investigate the grievance and issue the first level ruling. The Grievance Coordinator should maintain a grievance log that ensures all paper grievances are documented in a standardized method and addressed in a timely manner.

Further, the facility should establish policy and practice that allows complaints of employee misconduct or grievances related to facility operations, services and programs to be sent directly to the Grievance Coordinator without intervention by housing unit staff. Complaint forms and grievance forms should be readily available and accessible to inmates in various Jail locations without the need to request these from the officer(s) or sergeant(s) supervising the housing units.

### **Medical Health Services**

The Jail's current health care policies are based on standards set by the National Commission on Correctional Health Care (NCCHC), and are in compliance with these standards. As reported by our jail consultant, nationally fewer than 10 percent of correctional facilities have achieved NCCHC accreditation, and the Montgomery County Jail is the only jail in the state of Ohio to have attained NCCHC accreditation. The jail's vendor, NaphCare, is well versed in these standards, and has put quality assurance systems in place to maintain compliance.

Nevertheless, there are significant deficiencies in health care provision, largely due to the inadequate facility and the current staffing plan.

One deficiency at the Jail is the lack of professionally equipped rooms on the housing units to perform sick call. Modern jail design typically includes private exam rooms in each housing unit, eliminating the need for staff transport of inmates to the clinic and expediting the sick call process. The number of exam rooms in the clinic is also not adequate to meet facility needs. Current exam rooms in the clinic are used for another purpose two half-days per week, severely limiting sick call exams, and resulting in assessments being conducted in a non-private setting.

Although the staffing level for the jail may be minimally adequate for the delivery of services, given the current intake volume and average daily population for the facility, the type of staff

utilized requires review. Currently the staffing pattern used in the Jail relies on the lowest acceptable level of professional credentialing for the specific job duties required.

Specifically, NCCHC standards require that a trained health care professional conduct the initial assessment and the follow up exam received by each inmate. The initial assessment, beyond determining obvious issues such as injury, intoxication, or physical impairment, must also identify and document an inmate's health care status so that issues such as communicable diseases, suicidal tendencies, and continuity of ongoing treatment receive timely and appropriate responses. The data from this assessment form the basis of the inmate's medical profile and record, which follows him/her throughout the incarceration. The screening allows a determination as to the presence of acute problems, chronic problems, required medications, suicidality, other mental health problems, dental problems, mobility and other ADA issues, and any other issue that might affect the management of the inmate. If problems are identified, the patient should be seen by an advanced level health care provider, or at a minimum, an advanced level provider is contacted for instructions regarding the next step.

In most large jails, a trained registered nurse performs this assessment of medical needs. The Montgomery County Jail uses paramedics. Although paramedics are highly skilled at responding to emergencies, performing an intake assessment is a different responsibility. The preferred option would be staffing the intake with an RN, 24 hours per day, seven days per week, who is responsible for the plan and disposition of the newest intakes. If LPNs or paramedics perform the intake screening, then the presence of an RN on each shift to determine the plan and disposition of each case might be sufficient. This approach avoids the use of RN resources to perform histories and physicals on healthy individuals. This is the most common approach to staffing for inmate health assessments at intake in urban jails.

## **Mental Health Services**

The provision of mental health care within the County Jail is critically affected by a crowded facility without designated space for inmate services. Mental health staff members are crowded into one office space, while psychiatric consultations and mental health evaluations are generally provided cell-front, without privacy or confidentiality. The facility must be able to provide competent intake, assessment, suicide evaluation, response to requests for services, mental health follow-up, monitoring of individuals in segregation or single cell tiers, and ongoing mental health care. This is currently not the case.

Plans for expansion or replacement of the facility should include a full capacity crisis stabilization/acute psychiatric care unit, designed for stays of one to five days for medical detoxification of illicit drugs as well as stabilization of those suffering acute psychiatric episodes.

Recruitment of quality mental health staff is difficult due to safety concerns and the reluctance of potential employees to work in a correctional environment. In order to improve recruitment, the Jail administration should engage local educational institutions by offering clinical rotations for medical interns/residents, and social work/counseling students. This, along with the development

of a safe and sufficient mental health treatment environment in a new facility, could help to dispel negative community perceptions and improve the recruitment of staff.

There need to be systems for full and open communication between medical health, mental health, and correctional staff in order to provide timely and integrated services. Bringing both medical and mental health care under the sole administration of a single provider starting January 1, 2019 should resolve this problem.

## **Inmate Programs**

Comprehensive and effective programming in a jail not only benefits individual inmates, but can benefit the entire criminal justice system and the community as well, by assisting returning citizens in their efforts to be successful upon release.

The Montgomery County Jail provides a significant number of programs led by outside volunteers, a large number of which are religiously based. There are also Alcoholics Anonymous and Narcotic Anonymous groups, and substance abuse peer support groups. GED tutoring is also provided.

However, given limited funding levels, there is no full-time staff assigned to provide support to the programming needs of the inmates other than the Program Coordinator/Chaplain. There is no funding for in-house substance abuse or other comprehensive educational programs. Jails of this size typically have a contingent of counseling and programming staff responsible for assessing inmate needs and assisting them in conducting group and individual counseling as well as case management. For example, the Berks County Jail in Pennsylvania houses nearly 1200 inmates, and has 16 counselors on staff. Without the funding for these staff, Montgomery County (with 900+ inmates) is unable to provide a significant amount of case management and treatment programming.

Funding should be provided to significantly increase counseling and program staff and to provide evidence-based programming for counseling and addiction recovery.

## **Compliance**

The Bureau of Adult Detention is responsible for auditing to ensure local jail compliance with Minimum Standards for Jails in Ohio. The Jail was determined to be in compliance with the majority of the Ohio Minimum Standards. Issues identified as noncompliant mostly relate to overcrowding and insufficient living and recreation space. Standards noted as Essential Standards were in total compliance. A total of eight important standards were found not in compliance.

Accreditation by the American Correctional Association is the gold standard when measuring correctional performance. The Montgomery County Jail is an accredited facility, meaning that it has passed all mandatory standards and at least 90% of the remaining non-mandatory standards.



The 2017 Audit Report indicated that the facility complied with 59 mandatory standards and 275 non-mandatory standards. Thirteen standards were in noncompliance at the time of the audit. Noncompliant standards mainly were due to overcrowding at the facility and the inability of the facility to meet space requirements for cell size and recreation areas. A standard related to daily recreation for inmates was also found in noncompliance, as well as certain standards related to the housing of juveniles.

The National Commission on Correctional Health Care (NCCHC) has developed the premier standards guiding healthcare provision in corrections. In 2017 NCCHC conducted an audit of healthcare at the Montgomery County Jail, and following corrective action on certain standards accreditation was granted on December 19, 2017.

The Federal Bureau of Justice Assistance (BJA) administers the Prison Rape Elimination Act (PREA) program, which is designed to improve safety of inmates and detainees. To pass the audit, a facility must comply with 38 standards, including: reporting and responding to incidents of sexual misconduct, investigating the misconduct, having in place a system for disciplining staff and inmates involved in misconduct, providing medical and mental health care to victims, and collecting and examining data related to PREA violations. The Montgomery County Jail was audited pursuant to the PREA standards in November 2014 and was found to be in compliance with all relevant standards.

## 2. Jail Facility

### **SCOPE OF INQUIRY:**

To evaluate the overall design and physical condition of the current Jail facility, and assess the degree to which the Jail can reasonably be expected to meet the County's long-term correctional needs in compliance with contemporary correctional standards.

This assessment is not intended to be an in-depth analysis of the building's physical conditions and systems (mechanical, electrical, and security), but to provide a general overview of the current facility's conditions with emphasis on inmate services, operational effectiveness, and the overall safety and security of the jail operation. The findings presented here are based on visual observation of the facility and did not involve technical assessment of the building by an engineer or an architect.

### **FACILITY DESIGN**

The original jail was built in 1965, with substantial additions to the facility in 1993 and 2004. The operation of the facility as currently utilized is 914 beds. Based on the Ohio Department of Corrections and Rehabilitation's Standards for Jails, the facility should actually house no more than 443 inmates. The additional capacity above the recommended is achieved through double-celling, triple-celling, and conversion of program areas and dayrooms to housing.

There are two major approaches to correctional housing unit design: indirect supervision and direct supervision. With indirect supervision, monitoring of offenders occurs remotely from outside the unit, whereas in direct supervision, an officer station is located directly within a housing unit. Contemporary direct supervision housing also typically includes attached secure outdoor recreation areas and small program rooms. Evidence-based research on correctional facilities has shown that direct supervision environments reduce the frequency and severity of anti-social behaviors in inmates, reduces violence, and facilitates rehabilitation.

The Montgomery County Jail is comprised of both styles of housing units. The oldest section of the jail contains indirect supervision housing, referred to as the "linear" units. Housing here is by small multi-person cells, each containing 6-13 inmates, depending upon the size of the unit. These units are located on the Second, Third and Fourth Floors of the original jail building. These units are particularly difficult to supervise because of their linear design and the lack of

direct visibility of the inmates. One corrections officer is assigned to each floor. The number of inmates supervised by a single officer ranges from 86 to 119 inmates. There are cameras placed throughout the linear units, but they are insufficient to observe the majority of offender activity. The physical design of these housing units does not allow for effective inmate supervision. Moreover, the units cannot be modified in a cost-effective manner to improve supervision. The Jail manages 273 beds in these units.

The newer housing units at the Jail, referred to as the “pods,” feature a contemporary, direct supervision design. The four housing units each contain 55 cells, have an officer station in the dayroom area, have an attached recreation area, and have an attached program services area. The physical layout is typical for a direct supervision housing unit and allows good visibility into housing and recreation areas. Unfortunately, crowding at the jail has forced double-bunking of each of the individual cells in these four housing units, and a recreation room converted to a dormitory housing eight inmates. These actions result in a present capacity of 114 inmates in two of the units that has an additional converted recreation room for housing. The other two units house 104 inmates. Because of the large number of inmates housed in these units, recreation is generally limited to one half of the unit at a time for safety purposes.

Administrative segregation is located in the linear units. The unit has 24 male beds and 8 female beds. The unit lacks adjacent recreation and program space to provide required out of cell time and does not meet professional standards for this type of housing.

The booking area’s design does not allow efficient processing of the approximately 25,000 offenders booked into the Jail each year. The area is quite congested during high-volume activity periods, with inadequate space to manage inmates with mental health issues and the potential for suicidal behavior. Specialized cells are not available for these cases, and mentally ill inmates are kept in regular holding cells in full view of inmates moving about in the reception area adjacent to the cells. This congestion is particularly noticeable in the female section, which is separate from the male section.

The facility also lacks an infirmary unit to house inmates with medical needs, although renovations are being planned to address this deficiency. The facility as a whole lacks any suitable space for the delivery of program services and private treatment space. There is also no dedicated unit to house juveniles who are required to be sight and sound separated from adults.

## **FACILITY CONDITION**

The physical building that houses the Jail has remained essentially unchanged over the years. While the physical structure is in adequate condition, many of the critical operating systems have been compromised or are in need of serious renovation. Staff indicates the building has ongoing roof, plumbing, and HVAC issues that have a serious, negative impact on working and living

conditions within the jail. For example, poor air circulation and air conditioning in the Linear Units can create stifling conditions. Given the age of the facility and the degree of crowding, such conditions are not a surprise.

Inmates and former inmates of the jail also note the uncleanliness of the facility. The Jail Administration has expressed concern that the lack of a full-time maintenance staff and adequate janitorial services has contributed to a decline in the environmental standards of the Jail. Currently, maintenance of the Jail is handled by the Montgomery County Facilities Management. That department has been responsive to maintenance emergencies, but can be hampered sometimes by the Jail's lack of correctional manpower to accompany maintenance workers through the facility; and it is not equipped to provide ongoing preventive maintenance or custodial staff for a 24-hour, 365-day operation, with an average of 900 inmates, employees, and visitors in it at any given time. To maintain acceptable environmental standards, the Jail Administrator asserts the need for a fulltime plumber and around-the-clock maintenance staff, as well as additional custodial staff to supplement inmate workers.

The County appears to make continuing efforts to address the most critical of these issues through its capital repair program. In 2018, the County committed to \$9.2 million in capital repairs for the following projects:

- Jail scanner cell
- First Floor Process Improvements Design
- First Floor Renovation
- Facility Assessment
- Fire Alarm Replacement Design Services
- Unit Ventilators and Fan Coil Replacements
- Boiler Replacement
- Kitchen Sanitary Drains and Piping Replacement
- Generator Replacement
- Wireless Duress & Cell Phone Amplification
- Access Control System, Detention Hardware and Opening Upgrades
- First Floor Process Improvements CONCEPT
- First Floor Renovation
- Chapel - Kitchen Floor Electric Locate & Bloodhound mapping
- Replace Liebert Battery Back Up in Copps Room
- Clean HVAC - AHU & Ducts
- Exercise/Replace Electric Switchgear
- Kitchen Floor Tile
- Replace 2 mixing valves
- Revisions to domestic hot water supply and return system

This level of investment to address ongoing maintenance issues will be required on a continual basis for the foreseeable future to prolong the useful life of the facility as it currently operates.

These projects however, will not address the fundamental design and use issues present in the facility.

#### **SUMMARY AND RECOMMENDATION:**

**The current facility has the following serious issues:**

***Inadequate capacity.*** The State of Ohio has determined that the current facility has a housing capacity of 444 beds, roughly half the average daily population managed at the facility. The current level of crowding makes monitoring inmates and the delivery of services extremely difficult.

***Poor design.*** The design of the linear units makes effective inmate supervision impossible. The pod units have a decent design, but the level of crowding there likewise makes supervision difficult. There is no ability to maintain adequate sight and sound separation for juveniles housed at the facility.

***Inefficient Operations.*** The booking area is not sized or designed to facilitate the processing of the current volume of offenders entering the facility, and does not allow for appropriate management of offenders with special needs.

***Lack of Program Space.*** Existing program space in the pod units has been converted to dormitory housing. There is virtually no other dedicated program space in the facility, and no space for private treatment of inmates. The medical unit lacks adequate examination rooms and no examination rooms are available on the housing units.

***Physical condition.*** Facility building systems are deteriorating and will require increasing levels of funding to assure ongoing operation of the facility.

**The Montgomery County Jail facility does not provide a minimally adequate environment for staff or inmates. Renovation or remodeling to address the many problems with the facility is neither practical nor cost-effective. The County should commence planning for the ultimate replacement of this building with a modern correctional facility that can house offenders in a humane manner, provide needed program services, and afford staff and inmates a safe environment.**

# 3. Jail Operations

**SCOPE OF INQUIRY:** To assess the adequacy of jail operations, including a review of organizational command structure, policy and procedure development, booking and receiving operations, housing operations, and indicator and data analysis.

## ORGANIZATIONAL COMMAND STRUCTURE

The Jail Division is one of four divisions within the Montgomery County Sheriff's Office. According to General Order Policy 2.1.1, Subject: Organizational Structure and Subdivisions, a policy issued by the Sheriff effective May 5, 2015, the Jail Division is responsible for prisoner housing, prisoner transportation, and court security. Jail subdivisions are Prisoner Work Detail Program, Prisoner Transportation, Court Security, and Contract Maintenance, including Food, Mental Health and Medical Services. The Jail receives support from the other three divisions of the Sheriff's Department for matters that require law enforcement involvement and/or investigations, as well as training, budget, personnel, and accreditation assistance.

The Jail is managed by a Major, who is an appointee of the Sheriff and a certified Peace Officer in the State of Ohio. This appointment and statement of responsibilities is codified in Jail Manual Policy 1.1.1, Subject: Jail Administration, a policy issued by the Sheriff effective April 6, 2013. The policy requires that the Major operate the Jail in accordance with Bureau of Adult Detention Standards of the Ohio Department of Rehabilitation and Corrections. The Major, as the Jail Administrator, reports directly to the Chief Deputy, who is second in command within the Sheriff's Office.

Two Captains report directly to the Major. The Administrative Captain oversees administrative matters, including booking operations, jail and lobby security, programming, and contract services. Contract services include food service, maintenance, medical services, and mental health services. The Captain of Operations manages inmate housing, details, transportation, inmate work programs, and court services.

Thirteen sergeants report to one or other of the captains. There are two sergeant positions listed on the security watches who are considered operations officers responsible for supervising officers and inmates in this large and diverse institution. The Booking Sergeant oversees the booking process, which includes responsibility for admissions and release, as well as ensuring that security and control is maintained in the booking area, which processes approximately 2,000 admissions per month, as well as all the release and court activity that takes place in that area throughout the day and evening. The Housing Sergeant is responsible for supervising the second, third and fourth floors, where the bulk of inmate housing is located.

Sergeants operate as shift commanders, responsible for all operations at the institution. Four sergeants are assigned to other functions: one for court security, one for details, one for inmate transportation, and one for administrative support to the Major and Captains. The remaining nine sergeants staff the Booking and Housing posts.

As the Staffing report indicates, there are staffing shortages in the sergeant's ranks which often leads to only one sergeant being on duty to supervise the entire jail operation. When this occurs, the lone sergeant is responsible for booking, housing, responding to emergencies, managing the watch roster and ensuring that reports and other obligations are completed in a timely fashion.

Lieutenant positions no longer exist in the Montgomery County Jail. The rank was apparently eliminated as a budget savings action. Lieutenants in a correctional command structure can be useful as the administrative leaders or shift commanders of an operational shift. They can manage administrative tasks, deploy personnel and supervise correctional operations. The presence of this position also allows sergeants to perform as first line supervisors, instructing and supervising correction officer performance. This is difficult to do when the sergeants are responsible for large-scale shift operations and administrative duties.

## **RECOMMENDATIONS**

**The organizational structure in place at the Montgomery County Jail has clear lines of authority and generally meets the requirements of correctional practice noted in national and state standards. Unfortunately, the situation is marred by understaffing and lack of budgeted resources. The number of sergeants available to fill posts 24 hours per day, seven days per week is inadequate to meet the requirements of the facility. The lack of a fully staffed unit according to the relief factor requirements means that at times there may be only one sergeant available to staff the institution. When that happens, the sergeant is responsible for the entire operation and, because of the workload, cannot effectively supervise the institution.**

**Furthermore, the elimination of the lieutenant position removed an intermediate level of supervision that is essential in managing correctional operations and allowing sergeants to focus on supervising line staff and addressing inmate issues. At present, the supervisory ranks are too thin at the Montgomery County Jail, inhibiting effective supervisory and management practices.**

**As noted in the Staffing report, we recommend the creation of essential intermediate levels of supervision within the Jail. This would include:**

- 1. reestablishing the lieutenant rank to act as shift commanders overseeing correctional operations of their assigned shift;**
- 2. staffing sergeant positions according to the relief factor requirements, to ensure that two sergeants are available on each shift, one to manage Booking and the other to manage Housing Operations;**

- 3. establishing a civilian corrections supervisor rank, which would report to a sergeant. This civilian position would also provide career and promotional opportunities within the corrections officer ranks that may help retain civilian corrections staff and improve employee morale.**

## **POLICY AND PROCEDURE**

In order to achieve accreditation, significant effort needs to be applied towards the development of policies and procedures that meet the national standards of the American Correctional Association, known as the Performance Based Standards for Adult Local Detention Facilities, Fourth Edition (4-ALDF). Furthermore, the Jail also has to be in compliance with the Ohio Minimum Standards for Full Service Jails, Chapter 5120: 1-8, that are monitored by the Bureau of Adult Detention of the Ohio Department of Rehabilitation and Corrections. The status of accreditation efforts is described in the Compliance report.

Two sets of policies and procedures have been developed. The General Orders are policies promulgated by the Sheriff that apply to specific divisions of the Department, or all divisions in the case of policies that have a broader scope. The General Orders include policies regarding the Use of Force, Organizational Structure, Unity of Command and Lines of Authority, General Management and Administration, Planning and Research, Fiscal Management, Budget Process, Purchasing, Accounting, Benefits and Leave, Collective-Bargaining, and a host of other administrative policies and procedures.

The Jail Manual is specific to jail operations. These broad ranging policies address employee issues, physical plant/maintenance, security issues, reporting, health and safety, booking and admissions, inmate rights and rules, classification, record-keeping, inmate management, programming, medical care, inmate services, and other management and administrative matters. The policies are drafted with reference to the appropriate section of the ACA standards that are satisfied by instituting a particular practice. For example, the jail policy on Inmate Counts is written to comply with ACA Standard 4-ALDF 2A-16 and 17, which calls for an inmate population management system that includes records on the admission, processing, and release of inmates. Furthermore, the standards require the facility to have a system for physically counting inmates. That system includes strict accountability for inmates. The language of the Jail Management Policy 5.17.1 Subject: Inmate Counts is consistent with the relevant standard as are facility practices.

## **FACILITY OPERATIONS: BOOKING AND RECEIVING**

Booking and receiving are among the busiest components of jail operations in large county facilities. The booking staff at Montgomery County Jail processes approximately 2,000 inmates per month, including sentenced inmates and those being held in pretrial detention. Booking activities are consistent with booking operations observed in other jurisdictions. Inmates arriving in the institution must be searched carefully for contraband, examined by medical personnel to



assess physical and mental health, entered into the jail database, fingerprinted and photographed for identification purposes, and have their property secured. Inmates entering the facility were observed being searched by officers, placed in a body-imaging scanner to detect potential contraband, processed in the manner described above, and then placed in holding pending their classification/placement in the institution. A number of jail staff are dedicated to these operations, including Booking Officers, Classification Officers, Jail Records Officers, Fingerprint/Photo Officers, Property Officers, and other Receiving Staff. In cases where an inmate is deemed unstable or a threat to self, he or she is placed in a holding cell and observed by staff frequently to prevent self-harm. The booking process as observed was handled professionally and in accordance with facility policy and procedure.

Nevertheless, as frequently noted in this report, Montgomery County Jail staff are hindered by staff shortages, which often adversely affect the efficiency of the operation. A receiving position was eliminated due to budget shortfalls, and new technology, such as the body scanner, has been added without a commensurate increase in staffing. The Classification Officer position is often combined with booking staff, which can slow down the classification process.

Furthermore, the Booking Area's current design did not take into account the volume of activity caused by 26,000 admissions per year or the changing characteristics of the offender population. The Booking Area is quite congested during periods of high-volume activity, and there is inadequate space to manage inmates with mental health issues and potentially suicidal behavior. Specialized cells are not available for these cases and mentally ill inmates are kept in regular holding cells in full view of inmates moving about in the reception area adjacent to the cells. This congestion is particularly noticeable in the female section, which is separate from the male section. The facility also lacks an infirmary unit to house inmates with medical needs, although renovations are being planned to address this deficiency. There is also no dedicated unit to house juveniles, who are required to be sight and sound separated from adults.

## **RECOMMENDATIONS**

**As noted in the Staffing section of this report, there are staffing shortfalls impacting the efficiency of operations. It is recommended that a position of dedicated Receiving Officer be created, as well as a dedicated Classification Officer. Furthermore, staffing according to the established relief factor would ensure that critical posts are staffed at all times.**

**Renovation or replacement of the Booking Area should be considered in the future. An adequate facility should account for the volume of activity that currently exists and may exist in the future. Specialized cells should be included for suicidal and mentally ill inmates, juveniles, as well as a dedicated unit for inmates with medical needs and communicable diseases.**

## **FACILITY OPERATIONS: HOUSING**

The Bureau of Adult Detention has set the capacity of the Montgomery County Jail facility at 443 inmates based upon the design capacity of the institution. The facility has housed over 900 inmates in the past. Its current capacity, including temporary and emergency beds, is 899 plus 12 medical beds. There are two distinct types of housing units at the facility.

The Linear Units were built in the 1960s and are a traditional indirect supervision design, by which jail staff supervises inmates only intermittently, conducting hourly wellness/security checks. The officers are separated from the inmates by security grill work and security doors. The officers observe inmates from “catwalks” adjacent to the cell areas. These units are particularly difficult to supervise because of their linear design and the lack of direct visibility of the inmates.

Currently, one correction officer is assigned to each floor. This has been cited as a concern in the Staffing report. The number of inmates supervised by a single officer ranges from 86 to 119 inmates. Cameras are located throughout the linear units, but they are insufficient to observe the majority of inmate activity.

These units were not designed for close supervision, and are not considered acceptable practice by today’s standards. This issue has become a more prominent concern recently with the passage of the Prison Rape Elimination Act, which places more responsibility on correction officials to ensure that vulnerable inmates are not victimized. Intermittent observation increases the risk that misconduct may not be detected by correctional staff.

The design of these units also does not provide for easy access to recreation for the inmates, and as a result, the national standards for inmate recreation are not often met. Inmates held in the segregated unit, E-4N & S, should receive one hour out of cell each day. That is not possible given both the constraints of the physical plant and the issue of understaffing, which prohibits sufficient staff supervision of the recreation area. Eliminating linear housing units would also create a safer working environment for the corrections staff and provide more humane treatment of prisoners.

Additional concerns regarding the linear units include the condition of the physical plant itself. A walk-through of the units reveals numerous plumbing leaks, improper airflow and other maintenance issues.

The Pod Units are a more modern, direct supervision design where officers can view inmates from the floor and their desk area inside the housing unit. The assigned officer, of which there is one per unit, 24 hours a day, seven days a week, has direct visual on most of the housing unit and can interact with inmates on an ongoing basis. The intended capacity of these units is 55 inmates (one inmate per cell), according to the Bureau of Adult Detention. Due to overcrowding, however, additional beds were added to the unit as each cell was double bunked, and a recreation room was converted to a dormitory housing eight inmates. These actions resulted in a present capacity of 114 inmates in two of the units, including the additional recreation area converted for

housing. The other two units house 104 inmates. Because of the overcrowding of inmates housed in these units, recreation is generally limited to one-half of the unit at a time for safety purposes.

Additional housing units throughout the facility have been created by converting program space to inmate dormitories.

There is additional concern about the segregation unit E-4, which houses 22 inmates with disciplinary problems, protective custody, and in some cases mental illness. The unit is a poor design for the inmates being housed there. It lacks adjacent recreation and program space to provide for required out-of-cell time. This lack of adjacencies, along with understaffing, means that out-of-cell time often doesn't meet the requirements of national standards.

## RECOMMENDATION

**As noted, and addressed in the Staffing report, the number of officers posted in the housing units is insufficient to provide adequate supervision of the inmate population. It is recommended that staffing be increased in the Linear Units to ensure that two officers per floor are available during peak activity periods to supervise those units. It is furthermore recommended that staffing be increased in the Pod Units so that during peak activity there is an officer available as a Rover between Pods A and B, and another between Pods C and D. The age, physical condition and overcrowding of these facilities have placed great stress on the physical plant, particularly in the 1960s Linear Units. They should be scheduled for replacement as soon as practicable.**

## INDICATOR AND DATA ANALYSIS

Jail staff tracks certain data, which are important indicators of correctional performance. The incidents or issues that the data represents has a tendency to ebb and flow on a monthly basis. Indicators in 38 categories are collected monthly. The data can help determine problem areas that should be examined, analyzed and addressed. A rise in certain incidents can be an indicator of inmate and staff activity or misconduct that should be reviewed to determine whether there is need for remedial action. The following indicator data was drawn from monthly reports prepared by jail staff. Each of these indicators, as well as others, should be monitored on an ongoing basis and assessed because of their importance.

**Assault on Inmate:** Incidents of assault on an inmate by other inmates in the first five months of 2018 averaged nearly 16 per month. During 2017, the average was 20.58 per month. These numbers are relatively high and should be monitored monthly to determine if there is a pattern that could be addressed through administrative action.

**Contraband:** Contraband incidents average 48 per month. Contraband refers to any item that is not authorized, including drugs and weapons. The prevalence of contraband should be monitored to determine cause and potential weaknesses in perimeter security.

Use of Restraint Chair: Inmates are placed in the restraint chair to prevent them from committing self-harm, violent acts towards others, or property damage. Placement in the restraint chair is considered a use of force and should be a last resort. The average use of the restraint chair in 2017 was 6.4 per month. In the first five months of 2018 that number had risen to 11.4 per month. Management staff should examine decisions to place inmates in restraints to insure usage of the device is consistent with policy.

Refusing Medical Care: The number of inmates refusing medical care averages 20 per month. The reasons for these refusals should be examined to help determine if there are performance issues with the medical care provider or if there are issues with access to care.

Suicide Gestures: The number of inmates harming themselves, which are considered suicide gestures, has averaged 30 incidents per month for the last two years. Inmates may inflict harm upon themselves to gain attention or help for a mental illness. Incidence of actual suicide and suicide attempts are far fewer. There were two successful suicides in 2017, and two in the first five months 2018. There were fourteen incidents of attempted suicides in 2017, and one such occurrence in the first five months of 2018. An assessment of the motives and behaviors of these inmates might help inform jail staff on prevention measures.

Disturbances: Disturbances are averaging 21 per month for the past two years. Similar analysis should be conducted to determine their etiology and possible prevention measures.

Other indicators where data is collected are also important to monitor, including: placement in segregation, assaults on staff, forced moves, inmate deaths, facility lockdowns, property damage, use of Taser/OC spray, and the number of cell searches conducted.

## **SUMMARY AND RECOMMENDATIONS**

**Jail operations are managed consistent with national standards. The Command hierarchy includes a Facility Administrator, as well as captains and sergeants, who function as shift commanders. As noted in other sections of this report, the Command hierarchy would be improved by the addition of lieutenant positions operating as supervisors of the sergeants.**

**Policy and procedure development are conducted by an Accreditation Unit within the Sheriff's office that produces required policies and accepts input from staff to make revisions as deemed appropriate. Those reviews occur generally on an annual basis. The facility has achieved national accreditations indicating acceptable and compliant operational practices that meet national standards.**

**Booking and housing operations also function consistent with standards. However, they are adversely impacted by a deteriorating physical plant and staffing shortages caused by post reductions due to budget shortfalls.**

**Jail staff collect important indicator data that is useful in assessing facility performance. A formal system of data analysis can lead to taking remedial action to prevent future operational problems.**

**The main issue affecting jail operations are physical plant and staffing issues that have been described throughout this assessment. Solving these issues will continue to be a challenge, as the solution requires financial resources that, to date, have been unavailable because of broader economic problems.**

- 1. Jail management should consider an ongoing review process of the indicators and data collected as a management tool to assess individual and facility performance. A formal review process and analysis can be useful in making improvements to overall operations.**
- 2. It is further recommended that a post-incarceration survey and/or independent oversight/hearing board (ombudsman) be established to receive feedback from inmates incarcerated at the Jail to ensure adequate services are being provided or offered, treatment options are relevant for inmate needs, allegations of inhumane treatment or excessive force are thoroughly investigated, and risk management factors are identified that could be liabilities to the Jail and Montgomery County.**

## 4. Jail Staffing

**SCOPE OF INQUIRY:** Are facility staffing levels consistent with staffing requirements considering the function served, workload, coverage requirements and operational/program needs? Are staffing levels determined on the basis of the relief factor required to ensure that sufficient staff are present to fill critical posts? Is the supervisory span of control adequate in the current command structure? How does the staffing issue affect employee turnover, hiring and recruitment?

### **AUTHORIZED STAFFING LEVELS ARE INSUFFICIENT TO MEET STAFFING PLAN REQUIREMENTS**

The authorized staffing level for the Montgomery County Jail custody operations is 135 custody staff, comprised of 121 correction officers, 11 sergeants, two captains and one major. The funded staffing level for facility operations, however, is 128 custody staff. Thus, seven of the 121 correction officer positions are unfunded, which leaves 114 positions that can be filled at any given time. These staffing levels do not include deputy sheriffs that manage transportation and court details or civilian staff.

#### Authorized and Funded Custody Operations Staffing Levels

Position	Authorized Level	Funded Level
Major	1	1
Captain	2	2
Sergeant	11	11
Correction Officer	121	114
Total	135	128

Note: Does not include transport or court functions

A close examination of the daily security watch rosters indicates that a number of identified posts are left vacant during the course of watches. Examples of vacant posts include Admissions and Receiving posts, which are listed on the daily watch roster, but are rarely staffed. Other posts listed and not filled are Escort positions, Prisoner Property post, Ground Floor post, Medical Escort post, Dock Security post and, at times, Classification post. The reason for these posts being kept vacant is the lack of available staff to work them. A number of these posts are deemed critical but still go unstaffed.

The response of managerial personnel is to utilize overtime in an attempt to bring staffing levels up to what they consider a critical minimum level of staffing. This critical minimum staffing level is always less than the number of posts listed on the watch roster.

## CURRENT STAFFING DEFICIENCY/RELIEF FACTOR

A review of the Security Staffing Plan based on current staffing practices reveals that existing staffing levels do not provide an adequate number to fill needed posts. When staff take benefit leave time or are away from posts for training, there is not an adequate number of staff available to fill the vacant posts and provide relief. To determine the number of staff needed to adequately staff a jail requires the development of a relief factor. A relief factor identifies the number of Full-Time Equivalent staff (FTEs) needed to fill a single post. The relief factor understands that a single 8-hour post must be filled 2,920 hours a year (8 hrs. /day x 365 days per year). However, staff are only scheduled to work 2,080 hours per year (52 weeks x 40 hrs. /wk.). Additionally, staff can take benefit time off and are required to attend training, taking them away from posts. Therefore, staff actually are available to fill a post much less than 2,080 hours per year.

The facility had developed a relief factor of 1.83. When applying a relief factor calculation to seven day and/or five-day posts on the three operating watches, the staffing plan calls for 154 custody staff to be available to staff the rosters. This determination was made by using a relief factor of 1.83 for seven-day posts and a factor of 1.31 for five-day posts. The relief factor was developed by the Sheriff's staff in August 2018 based upon the analysis cited above.

The following table identifies the facility's current staffing plan when the relief factor is applied. The specific need for correction officers in this analysis is noteworthy. In order to properly staff the plan, 137 correction officers or 16 additional officer positions are required from the current authorized level of 121.

<b>Position</b>	<b>Current Custody Operations Authorized Staffing</b>	<b>Custody Operations Staffing with Relief Factor Applied</b>	<b>Additional Staff Needed</b>
Major	1	1	-
Captain	2	2	-
Sergeant	11	11	-
Correction Officer	121	137	+16
Total	135	151	+16

We note this assumes the current staffing plan and posts are sufficient to adequately staff the Jail's Custody Operations. Our review found this was not the case and that a significant number of additional posts were needed throughout the Jail. We will identify these additional posts and the resulting total staff needed later in this report.

## UNFUNDED POSITIONS

As discussed above, the authorized staffing level has proven to be insufficient to meet the demands of staffing the watch rosters. When applying the relief factor, the authorized level comes significantly short of the staffing needs. The overtime and staffing problem are

exacerbated by having unfunded positions as well as insufficient personnel to staff the security watches. Although the authorized staffing level is listed at 121 correction officer positions, the County has funded only 114 positions at this time. This funding discrepancy versus the authorized level results in seven positions being kept vacant.

## **RECOMMENDATIONS**

**The problem with current staffing levels is twofold. The funded level of corrections officer staffing is less than the authorized level and is significantly below staffing levels required to meet the daily needs of the institution. The vacant positions, combined with those that have been unfunded, create an issue that is near crisis proportion. Critical posts are kept vacant due to the unavailability of officers to staff them. The problem is further complicated by the fact that authorized staffing levels are in any case significantly below the number of staff needed to fill the posts listed on the watch roster.**

**The immediate need is to hire sufficient staff to bring staffing to the authorized level. This would require the County to fund all of the authorized positions as the first step in improving staffing and security. Additionally, the posts listed on the three watches, which constitute the Security Staffing Plan, need to be staffed on an ongoing basis. In order to accomplish this, the additional positions need to be funded and operational strength raised to 151 positions, consisting of 137 correction officers, 11 sergeants (exclusive of the Transportation and Courts sergeants), two captains and one major. This is the operational strength needed to adequately staff the three watches as they are designed.**

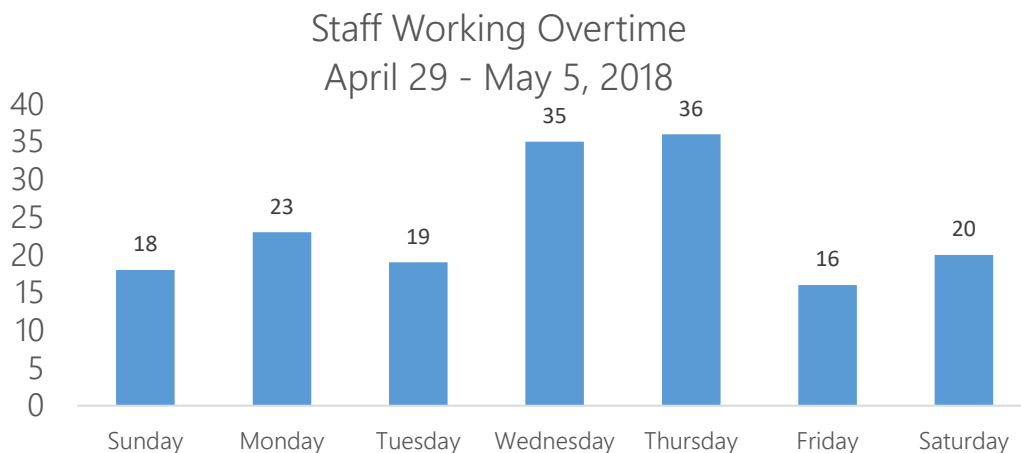
## **RELIANCE ON OVERTIME**

The use of overtime to address daily staffing needs has become so pervasive that on a regular basis there is a lack of volunteers to work the overtime and, as a result, using reverse seniority per the Collective Bargaining Agreement, officers are required to work overtime shifts. During a randomly selected week in April/May 2018, 167 instances of overtime were needed to maintain minimum staffing levels. Much of this overtime was forced upon officers because of the unavailability of volunteers to work the shifts. The impact of such high overtime use, especially forced overtime, has a harmful effect on employee morale and job satisfaction. Employees who are most at risk for resigning from the job are those that are less invested and have limited experience. Placing this additional burden of being forced to work extra shifts contributes to the employee turnover problem. Unfortunately, the Collective Bargaining Agreement's overtime distribution rules protect senior employees from forced overtime, which leaves only the less experienced staff to work it. This has a likely effect on the turnover rate discussed below.

The Collective Bargaining Agreement between Montgomery County and the Ohio Patrolmen's Benevolent Association, Civilian Unit January 1, 2017 – December 31, 2019, Section 27.3 (F) (2) reads:



“The Employer reserves the right to require overtime of employees. If it becomes necessary to require overtime, assignments will begin with the least senior employee, by bargaining unit seniority, in the job classification in that section, unless a more senior employee voluntarily accepts the overtime. Notwithstanding the language below, current, qualified bargaining unit members may also be permitted to work voluntary overtime in another classification in accordance with the overtime selection rules.”



## RECOMMENDATIONS

- 1. Excessive use of overtime to staff facility rosters can be curtailed if there are sufficient personnel available to work their standard work weeks and ensure that proper staffing levels are maintained. County officials should consider funding additional correction officer positions, to the levels that the current staffing plan and relief factor calculation call for.**
- 2. Additionally, consideration should be given to meeting with collective bargaining agents to develop a fair system of overtime distribution when forced overtime is required. This would include having senior officers participate in working forced overtime shifts, as well as the less senior employees.**

## CORRECTION OFFICER TURNOVER/ RECRUITMENT AND RETENTION

The Montgomery County Jail is experiencing difficulties in attracting and retaining candidates for correction officer positions. At the time of this writing, there were 10 vacant correction officer positions unfilled because of difficulty in recruiting new personnel and retaining existing personnel. There was only a small pool of correction officer candidates available for hiring consideration.

One reason for the retention problem is that a number of good performing correction officers strive for promotions within the organization to become deputies, who are compensated at a higher level and typically assigned to court security and patrol functions. Officers also are good candidates for law enforcement positions in the community and a number of correction officers resign to become police officers.

Additionally, the rigors of the job, which include working forced overtime and operating in an overcrowded environment with less staff than desirable, appears to contribute to dissatisfaction with the job, often resulting in resignation and employee turnover. High turnover rates are an issue nationwide in corrections and needs to be examined further and addressed in Montgomery County.

The turnover rate for correction officers in Montgomery County in 2017 was 28% (N=33). The majority were resignations, and four correction officers were promoted to deputies. In 2017, twenty-five correction officers resigned, one was terminated, two retired, two were probationary released, one accepted a medical retirement, one was granted an involuntary Disability Separation, and one accepted a voluntary Disability Separation. A review at 2018 numbers through May reflect a similar turnover rate in the 25%+ range is likely.

It is also notable that whereas African Americans over the last five year represented approximately 38% of the Montgomery County jail population, the staffing of the jail is 80% white and only (18%) non-white. The difficulty of recruiting minority populations into law enforcement is a nation-wide problem. The Montgomery County Sheriff's Office reports ongoing efforts to recruit in minority communities, minority schools, and at recruitment fairs that focus on minorities; to use focused advertisement in various media; and to build better relationships with the community.

## **RECOMMENDATIONS**

- 1. The issue of addressing employee turnover in corrections does not lend itself to an easy solution because of the difficult nature of the work and promotional opportunities for experienced officers. Steps should be taken to improve employee job satisfaction and morale. We recommend conducting an exit interview for all correction officers who resign, to identify those factors that lead to employee turnover.**
- 2. Addressing staffing, forced overtime, and workload issues described above are likely to have a positive impact. Additionally, training and good supervisory practices can also assist. Consideration should be given to establishing a working group of management and labor to address these issues and identify steps that can be taken to improve retention and attract more candidates for correction officer positions.**
- 3. We recommend that the Sheriff's Office consider more focused recruitment efforts for corrections staff, including continued focus on minority recruitment.**

- 4. We also recommend establishing a civilian corrections supervisory rank that could benefit the agency with span of control and provide incentive and promotional opportunity for correction officers.**

## **COMMAND STAFF - SPAN OF CONTROL**

The facility is managed by a major who is the facility administrator. Reporting to the major are two captains, one whose primary duty is administrative and another whose primary duty is operations manager. These staff have broad responsibilities, including emergency planning, use of force reviews, inspections/walk-throughs, employee evaluation and discipline, inmate discipline, training, employee hiring, and security and control of the institution. They should not be operating as shift commanders, except on an occasional basis. They are presently working alternative shifts in order to have some management presence during off hours.

The next level of command in the institution are the sergeants. There are two sergeant positions listed on the security watches, one to oversee the booking process and the other to oversee inmate housing. The Booking Sergeant is responsible for admissions and release and ensuring that security and control is maintained in the booking area. The booking area is dynamic with activity, processing approximately 2,000 admissions per month, as well as all the release and court activity that takes place in the booking area throughout the day and evening. The Housing Sergeant is responsible for supervising the second, third and fourth floors of linear housing as well as the Jail pods, where the bulk of inmate housing is located.

Both the Booking and Housing Sergeant positions are considered operations managers responsible for supervising officers and inmates in this large and diverse institution. Because of staffing shortages, there are times when only one sergeant is on duty to supervise the entire operation. That sergeant must oversee booking and housing, as well as respond to emergencies, manage the watch roster and ensure all obligations are met. Operating an institution of this size and complexity with one supervisor is not standard or appropriate correctional practice.

## **RECOMMENDATIONS**

- 1. Reestablish the Lieutenant rank, which was previously eliminated. Two lieutenant posts should be created, one to serve as the Second Watch Commander (Day Watch), and the second as the Third Watch Commander (Evening Watch). This will add a level of command to take control of and manage the two most active operating watches and oversee the sergeants functioning as the floor supervisors.**
- 2. Assign a sufficient number of sergeants to ensure that both the Booking Sergeant and Housing Sergeant posts are staffed 24 hours per day, seven days per week. This requires that a minimum number of two sergeants be assigned and staffed on each shift.**

## **BOOKING AND RECEIVING OPERATIONS**

Booking and receiving operations are a critical aspect of jail management. Approximately 26,000 offenders per year are booked into the institution to await processing on a criminal charge or to serve a county jail sentence. Those arriving at the institution must be received, medically cleared, searched, identified, have their criminal charges entered into the system, their property secured and classified for placement within the institution. The process is overseen by a Booking Sergeant, who is responsible for ensuring the functions noted above are completed. Currently, the Booking Sergeant has other duties if he/she is the only sergeant on duty on a particular watch. When that is the case, a burden is placed on the remaining staff to ensure that the functions that need to be carried out are completed. Additional booking functions are carried out by the Booking Officer, Jail Records Officer, Prints/Photo Officer, Prisoner Property Officer and the First Floor Receiving staff. Recently, a new search tool, the Body Scanner, is operated by the booking staff on each newly admitted offender to ensure that no hidden or concealed contraband enters the facility.

A position listed on the roster as the Receiving Officer had primary duties that included searching and processing new offenders. Those functions are now carried out by the remaining staff in the booking area. It should also be noted that the Classification Officer, whose main responsibility is to evaluate each new inmate to determine the level of risk the offender poses and where they can be housed safely so as not to be a threat or potential victim, is often burdened with ancillary duties. The Classification Officer position on some of the operating shifts is combined with booking staff due to staffing shortages, and share responsibilities with them in addition to their classification duties.

## **RECOMMENDATIONS**

- 1. The consultant determined in this analysis that the elimination of the Receiving Officer post and the combining of the Classification Officer post at times with the Booking Officer post is inconsistent with the design of the Security Staffing Plan and poses a risk to institutional security and safety. A dedicated Receiving Officer can ensure that search and processing of inmates is carried out efficiently and consistent with good security practices. Staffing this post also takes the pressure off booking and first floor staff from having to multitask, and reduces the risk of a security breach in the booking area and holding cells. It is recommended that the Receiving Officer post be reestablished and staffed on a regular basis.**
- 2. Furthermore, the Classification Officer position is critical to institutional safety and security. The placement of offenders in housing can be a complicated process, as certain categories of inmates need to be separated from one another and housed in cell areas that are consistent with their offender characteristics. Because of the volume of intakes occurring throughout the day, the presence of a dedicated Classification Officer reduces risk of disruption and violence in the institution. This position should be filled on each of the three watches and not routinely combined with other booking or jail duties.**

## SECURITY AND PERIMETER COVERAGE

Security Control: There are two workstations in Security Control. These officers control door ingress/egress access throughout the facility, receive calls from inmates who need attention, activate emergency procedures and monitor activity, observe inmate movements in the living units via the 300-camera video surveillance system, as well as communicate to law enforcement authorities and vehicles transporting inmates. This is an extremely busy and complicated post, requiring two officers on second and third watches. Staffing levels do not permit this post to be staffed as frequently as necessary, particularly on the Third Watch, which is one of the busiest shifts at the institution.

Ground Floor: The lower level, or ground floor of the facility, is a busy area that houses the Kitchen, Commissary, Laundry, and Loading Dock. The Loading Dock serves as an ingress/egress point of the perimeter for product delivery to the Kitchen, Commissary and storerooms. It is intermittently staffed with a laundry officer and occasionally a dock officer. Civilian staff often enter the facility through this dock area, as well as vendors delivering products. The manner in which this area of the facility is staffed and supervised is inconsistent with proper correctional practice and lends to a weakness in facility security that should be addressed.

## RECOMMENDATIONS

- 1. The workload in the Security Control requires adequate staffing on both second and third watches. It is recommended that the Security Control post be staffed with two officers on second and third watches.**
- 2. The ground floor is a critical area of the institution as it provides an avenue for contraband flow and a potential escape route if not properly supervised. The Ground Floor post has been unoccupied for some time and presents a security risk. It is recommended that the Ground Floor post be staffed on a regular basis on all three watches. It can be combined with laundry supervision when that post is staffed.**

## HOUSING AND INMATE SUPERVISION

Linear Units. These housing units were built in the 1960s and are a traditional indirect supervision design where staff supervise inmates intermittently and conduct hourly wellness/security checks. The officer views the inmates from a narrow linear corridor, or “cat walk”, that runs behind the cells and is separated from them by steel grill work. The units were not designed for close supervision, which by today’s standards is not considered acceptable practice. This issue has become a more prominent concern since passage of the Prison Rape Elimination Act (PREA), which places more responsibility on correction officials to ensure that vulnerable inmates are not victimized. Intermittent observation increases the risk of misconduct occurring which cannot be detected by correctional staff.

Current practice is to deploy a single officer on each floor in the linear units. The assigned officer supervises between 10 and 15 housing units that contain between 86 to 119 inmates. Wellness checks in the general population units are conducted hourly. The assigned officer is also responsible for responding to inmate requests and complaints, supervising meal delivery, providing toiletries, and other security related duties. These are multiple occupancy units; therefore, inmates are often unsupervised directly until the officer is available to make his/her tour of the units. Video surveillance of these housing units is limited and there are numerous blind spots, where an inmate cannot be observed or monitored. Procedures also dictate that the officer cannot enter the housing unit without the availability of backup. There is no officer assigned for this purpose.

Pod Units. The Pod Units are more modern direct supervision correctional design, built in the 1990's. There is a single officer assigned 24 hours per day, seven days per week to supervise the direct supervision pods. The officer is responsible for supervising up to 114 inmates in a 48-cell unit. Because of the overcrowded facility census, each of the cells is double bunked and a recreation room was converted to an eight-bed dormitory in each pod. Two of the pods have an additional 10-bed converted dormitory. Officers and inmates interact directly with one another within the common areas inside the pods. Two pods house 114 inmates and two pods house 104 inmates. The actual capacity of these units is 55 inmates, according to the Ohio Department of Corrections and Rehabilitation, Bureau of Adult Detention.

This is a very busy post on second and third watches and the assigned officer has little time to leave his workstation and provide close supervision within the unit. This impacts the ability to conduct searches, make regular wellness checks, and closely supervise activities in areas where there are blind spots. Because of the large number of inmates residing in these units, recreation is limited to one-half of the pod or less at any given time. This reduces the out-of-cell time that would normally be available for inmates in a less overcrowded environment. Officers also cannot leave the pod without either locking down the inmates in the pod or locating an officer to relieve them. The level of supervision is inadequate and should be addressed as soon as possible.

Medical Supervision and Escort. There are no officers assigned on the watch rosters to provide supervision in the medical clinic, or specifically supervise inmates being held in medical cells. These duties are performed by floor officers in the area, but the lack of dedicated staffing for this area is a significant concern. The absence of dedicated staff to supervise inmates while being treated in the medical clinic poses a potential physical risk to the clinician who is treating the inmate. Additionally, without the presence of an officer to supervise activities and monitor equipment, the likelihood of medical instruments being misused or stolen is significantly greater. A medical escort officer is sometimes available to supervise the area, but that officer is frequently transporting inmates back and forth between the housing units and the medical clinic.

A second concern is with the medical cells adjacent to the clinic. These cells are intermittently supervised by first floor staff, who also have responsibilities for supervising the male and female holding areas and inmates being monitored for suicide prevention. Medical cells are another area of vulnerability related to the medical clinic and a significant security risk.

Another concern is the lack of escort officers on third watch to escort inmates between the housing units and the medical clinic for services. Inmates may wait for an extended period of time to be moved from their housing area to the medical clinic or returned to their housing unit. This results in inmates not being seen/treated as scheduled and limits the productivity of the medical staff.

## **RECOMMENDATIONS**

- 1. Linear Units should have additional staffing assigned as long as linear housing units are being utilized. At a minimum, a second officer on each of the second, third and fourth floors should be available on second and third watch to address the need and ensure that there is an officer available to back up the primary officer and to conduct additional security and safety checks. As we understand it, staffing of these floors did include a second correction officer in the past but was eliminated due to budget shortfalls.**
- 2. Due to the large number of inmates housed in the pod units, which is well above the rated capacity, additional correction officer supervision is necessary. In order to provide a safe and secure environment, it is recommended that a pod rover officer position be established on second and third watches. One of the rover officer positions can be assigned to Pods A and B and the second rover officer to Pods C and D. This would result in the addition of two posts on each second and third watch.**
- 3. It is recommended that a post be created on the active second and third watches to oversee the medical clinic area as well as the medical cells. This will add security and safety for the medical staff and patients in this area. Similarly, a medical escort post should be added on third watch to address the escort issue noted above. This escort post will also allow more efficiency in inmates being evaluated and treated by medical and mental health staff.**

## **SUMMARY**

**Jail staff currently operate with constraints caused by insufficient staffing levels and a reduction in security posts that have an adverse impact on safety and security in the institution. The staffing issues have reduced correction officer supervision of inmates and lessened the ability of supervisors to oversee institutional operations and support and supervise staff. Insufficient staffing has ramifications that include excessive overtime, employee absenteeism, high employee turnover, lowered employee and inmate morale, and, at times, operational problems. Addressing the staffing and supervision issues should be a high priority of policymakers and corrections officials in the interest of staff and inmate safety.**

These additional posts are necessary to ensure the safety and security of the facility as well as staff's ability to adequately address the workload requirements that result from managing a facility of this size. Our consultants independently developed a relief factor for the jail and determined a seven-day post requires a 1.84 relief factor. This relief factor is slightly higher than that developed by the facility (1.83). Given these additional posts, the total number of staff needed to manage custody operations is 194. The following table provides a breakdown of these staffing needs by position compared to currently funded levels.

<b>Position</b>	<b>Current Custody Operations Authorized Staffing</b>	<b>Recommended Custody Operations Staffing</b>	<b>Additional Staff Needed</b>
<b>Major</b>	<b>1</b>	<b>1</b>	<b>-</b>
<b>Captain</b>	<b>2</b>	<b>2</b>	<b>-</b>
<b>Lieutenant</b>	<b>0</b>	<b>2</b>	<b>+2</b>
<b>Sergeant</b>	<b>11</b>	<b>11</b>	<b>-</b>
<b>Correction Officer</b>	<b>121</b>	<b>176</b>	<b>+55</b>
<b>Total</b>	<b>135</b>	<b>192</b>	<b>+57</b>

The facility is severely understaffed. Our staffing recommendations indicate that the facility needs 59 additional staff. The addition of these positions should improve facility operations, increase the oversight and supervision of offenders, reduce staff overtime, and increase staff retention.

Based on the 1.84 relief factor, the following table provides the number of Jail staff needed to be assigned to each watch:

**Recommended FTEs per Watch**

<b>Position</b>	<b>2<sup>nd</sup> Watch 7:30 am – 3:30 pm</b>	<b>3<sup>rd</sup> Watch 3:30 pm – 11:30 pm</b>	<b>1<sup>st</sup> Watch 11:30 pm – 7:30 am</b>	<b>Total Recommended Staffing – All Shifts</b>
<b>Major</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>1</b>
<b>Captain</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>2</b>
<b>Lieutenant</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>2</b>
<b>Sergeant</b>	<b>4</b>	<b>4</b>	<b>3</b>	<b>11</b>
<b>Correction Officer</b>	<b>70</b>	<b>64</b>	<b>42</b>	<b>176</b>
<b>Total</b>	<b>79</b>	<b>70</b>	<b>45</b>	<b>192</b>



We note that the numbers in the table above represent the total number of staff assigned to the shift, not the total number that will be on duty on a given day. The number assigned to the shift takes into account the relief factor, i.e. the fact that assigned staff also have regularly scheduled days off, can use benefit time and, therefore, can be assigned to a post, but not scheduled to work on a specific day. For example, on the 2<sup>nd</sup> Watch, 79 FTEs will need to be assigned to staff the 47 posts that must be filled each weekday. The number of posts that need to be filled during weekdays per watch are as follows:

**Recommended Posts per Watch**

<b>Position</b>	<b>2<sup>nd</sup> Watch 7:30 am – 3:30 pm</b>	<b>3<sup>rd</sup> Watch 3:30 pm – 11:30 pm</b>	<b>1<sup>st</sup> Watch 11:30 pm 7:30 am</b>	<b>Total Recommended Staffing – All Shifts</b>
<b>Major</b>	<b>1</b>	<b>0</b>	<b>0</b>	<b>1</b>
<b>Captain</b>	<b>2</b>	<b>0</b>	<b>0</b>	<b>2</b>
<b>Lieutenant</b>	<b>1</b>	<b>1</b>	<b>0</b>	<b>2</b>
<b>Sergeant</b>	<b>3</b>	<b>3</b>	<b>2</b>	<b>8</b>
<b>Correction Officer</b>	<b>40</b>	<b>35</b>	<b>23</b>	<b>98</b>
<b>Total</b>	<b>47</b>	<b>39</b>	<b>25</b>	<b>111</b>

On any given weekday, 47 staff should be working on the 2<sup>nd</sup> Watch, 39 on the 3<sup>rd</sup> Watch and 25 on the 1<sup>st</sup> Watch. In total, 111 staff will need to report to work over a period of 24 weekday hours. Some of the posts only operate 5 days a week, so weekends generally require fewer staff.

# 5. Staff Training

**SCOPE OF INQUIRY:** Do existing staff training practices provide employees with the skills, knowledge and attitude necessary to perform their duties consistent with policy and procedures and to respect the rights and dignities of detainees?

Work in a prison environment is complex and can be entirely different from any other occupation an employee previously held. Training is therefore critical to developing a skilled, motivated and committed jail workforce that understands the unique requirements of supervising offenders. A successful and ongoing staff training program is key to ensuring the safe operations of a correctional facility and at the same time safeguarding the rights of those incarcerated.

## **NATIONAL STANDARDS BEST PRACTICES**

The American Correctional Association (ACA) standards provide strong guidance for staff training. ACA requirements include the following:

- New employee orientation.
- Correctional officer academy training.
- Training for new correctional officers.
- Specific annual training for clerical/support employees, contractors, correctional officers, health care staff, supervisory staff, staff assigned to specialized emergency units, and part-time staff.

## **MONTGOMERY COUNTY JAIL TRAINING POLICY**

The Montgomery County Jail's training policy (according to Jail Manual 2.3.1, Staff Training) is consistent with ACA standards. The policy requires that all new employees receive 40 hours of orientation prior to assignment in the jail. This training includes:

- Working conditions
- Code of Ethics
- Employee rights and responsibilities
- Staff rules and regulations
- Personnel policies

In their first week correctional officers receive training in the use of force, defensive tactics, first aid/CPR, as well as use of automated external defibrillators.

All new correctional officers are initially paired with a Field Training Officer (FTO) who monitors, instructs and assists them for a 45-day period after hire. The employee and the FTO work side by side during this time and the FTO evaluates his/her performance at multiple points during this time. The employee must successfully complete the FTO program before being allowed to work in the jail independently.

In the first year of service, new correctional staff must attend a corrections academy approved by the Ohio Peace Officers Training Commission. The policy determines that staff must receive at least 140 hours of comprehensive training, including:

- Security Practices
- Supervision of offenders
- Signs of suicide risks
- Suicide precautions
- Use of force regulations and tactics
- Report writing
- Inmate rules and regulations
- Rights and responsibilities
- Fire and Emergency procedures
- Key Control
- Interpersonal relations
- Social/cultural lifestyles of the inmate population
- Communication skills
- First Aid/CPR
- Counseling techniques
- Cultural Diversity
- Sexual Abuse/Assault

Moreover, staff are required to receive an additional 40 hours of training every subsequent year. Supervisors also receive 40 hours of annual training consistent with national standards.

## **FIELD TRAINING OFFICERS**

Correctional officers are not required to attend the academy prior to assuming a post in the facility. While it would be preferable to have staff complete their 140 hours of academy training prior to working in the facility, this can be cost prohibitive due to the fact that the academy training is not always available (which would delay hires), and that it is not uncommon for staff to voluntarily terminate after a short time working in a correctional facility.

Because correctional officers do not receive academy training prior to assuming a post, their work with the Field Training Officer (FTO) gains critical importance. FTOs serve as a new correctional officer's first mentor and can set the tone for his/her future performance and behavior.

Our review of the FTO practices at the Montgomery County Jail found them to be thorough. A detailed training manual is issued to each correctional officer that identifies:

- FTO mission.
- Staff responsibilities.
- Principle and guidelines for working in a direct supervision environment.
- Comprehensive checklist of procedures and duties that the FTO must explain and/or demonstrate to a new employee.

Additionally, while in FTO status new correctional officers must be evaluated at the 15-day, 30-day and 45-day mark of their training. They are not allowed to work alone on a post until they successfully complete FTO training. Our review of completed evaluations found them to be detailed. The evaluations include a checklist of categories upon which the new employee is rated, including attendance, knowledge, written and oral communications, work quality, etc. A narrative of the employee's work is also developed by the FTO and provides specifics of the correctional officer's overall performance.

New correctional officers remain on probation for one year after their hire date. During that time, they also receive quarterly evaluations in addition to the three FTO evaluations. As a result, new correctional officers are evaluated seven times during their first year of employment.

Newly promoted sergeants also go through an FTO training period that lasts between two and four weeks.

One issue uncovered was the lack of field training officers. At the time of our review, there were only 11 FTOs in the facility. The following table breaks down the FTOs by shift:

<b>Shift/Position</b>	<b>Number of FTOs</b>
1 <sup>st</sup> Watch	3
2 <sup>nd</sup> Watch	2
3 <sup>rd</sup> Watch	5
FTOs for Sergeants	1
<b>TOTAL</b>	<b>11</b>

Participating as an FTO is voluntary and there is little incentive to take on these extra duties. FTOs previously received 40 hours of compensatory time off for participation, but this is no longer the practice. The current bargaining unit contract allows for an additional \$0.35 per hour for FTO's. This results in an extra \$14.00 per week for assuming these important duties.

If there are not enough FTOs on the shift to which a new correctional officer is assigned, that correctional officer is reassigned to a different shift where there may be an available FTO.

We were informed that the number of FTOs has been decreasing and it is clearly insufficient to adequately support the training requirements of new correctional officers. During 2017, 30 correctional officers had to be replaced due to resignation or termination.

#### **SUMMARY AND RECOMMENDATION:**

- 1. The Jail's training programs for all levels of staff appear consistent with national standards. The Field Training Officer training practices are thorough and complete. However, some form of enhanced incentive should be established for the important FTO positions.**
- 2. Correctional staff should receive regular updated training on cultural competency, trauma-informed policing, implicit bias, and interpersonal communication skills as part of the annual 40 hours of in-service training. (Additional training recommendations are included in the Use of Force report.)**

# 6. Classification

**SCOPE OF INQUIRY:** Does the formal offender classification process effectively assess offender risk, identify security issues and assess programmatic needs upon admission to the Jail, resulting in proper placement of offenders. Subsequently, are offender classifications reviewed after a period of time to assess the appropriateness of their ongoing placement? Additionally, is the facility housing plan sufficient in providing options for the placement of offenders based upon their risk and need?

## NATIONAL STANDARDS BEST PRACTICES

The best practices regarding the offender classification in jails is outlined in the Adult Local Detention Facilities (ALDF) fourth edition standards for the operation of jails. Standard 4-ALDF-2A-30 reads as follows:

*“There is a formal classification process that starts at admission, for managing and separating inmates, and administering the facility based upon the agency mission, classification goals, and inmate custody and program needs. The process uses verifiable and documented data about inmates. The classification system is used to separate inmates into groups that reduce the probability of assault and disruptive behavior. At a minimum, the classification system evaluates the following:*

- *mental and emotional stability;*
- *escape history;*
- *history of assaultive behavior;*
- *medical status;*
- *age;*
- *need to keep separate.”*

Furthermore, classification best practice and national standards call for ongoing review or reclassification of inmates in response to changes in their behavior and circumstances.

Additionally, it is imperative that the jail has available resources to place inmates based upon their individual offender characteristics and the security needs of the facility. Inmates are typically separated by age, gender, medical needs, behavioral issues, legal status and special housing issues, where appropriate. The facility housing plan should specifically separate males from females, juveniles from adults, and predators from potential victims. The housing plan typically provides multiple occupancy areas of the facility, as well as individual cells for disruptive inmates or those who need separation from others for various reasons, including protective custody and medical/mental health issues.

## **MONTGOMERY COUNTY CLASSIFICATION POLICY**

The classification process at the jail is governed by Jail Manual Policy 5.8.1, Subject: Classification, a policy issued by Sheriff Phil Plummer on October 7, 2016. The policy describes procedures to be followed consistent with the ACA standards referenced above, as well as Department of Corrections Bureau of Adult Detention standards.

Procedures are outlined that require staff to house inmates in order to maintain racial diversity in the housing units, ensure that male and female inmates are kept separate from one another and don't have site and/or sound contact. Juveniles, pursuant to Ohio Revised Code are also kept separate to maintain a sight and sound barrier from adult inmates. Procedures dictate the manner in which classification data is compiled and assessed as part of the classification process. Furthermore, inmates are to be screened to ensure medical issues are addressed prior to placement in housing.

The policy/procedure includes an objective point-based classification scoring instrument to assess offender risk based on various categories related to their individual characteristics. This includes a review of charging/sentencing data and past criminal history, an assessment of answers to standardized questions asked during screening, medical issues, and past behavioral history. The numerical score helps determine risk level to assist with the placement decision. Ultimately, the Classification Officer makes a determination of the classification level based on the scoring instrument and other relevant factors. The scoring instrument can be overridden by the Classification Officer based upon professional judgment. The classification process is typically completed shortly after the inmate's admission to the facility and it must be completed prior to placement in the various housing units. It should be noted that the entire classification process relies heavily on documentation and criminal records. Although the Classification Officer does review a questionnaire prepared by booking personnel, in which the inmate answers standardized questions, the Classification Officer does not personally conduct an interview with the inmate.

Reclassification is the process that takes place after an inmate has been at the facility for 30 days of continuous incarceration. This aspect of policy further conforms to ALDF Standard 4-2A-31 governing the reclassification process. That standard calls for periodic review of the inmate's status and provides for a revision in the status and placement based upon changes in behavior and circumstances. The reclassification process includes the use of a classification form that is completed by the Classification Officer and approved by a supervisor. Finally, with regard to reclassification, the policy requires the Booking/Release Sergeant to conduct a review of 15 reclassification cases each month to assess for compliance with the policy and procedures. Additionally, the reclassification process should allow for the inmate to appeal his/her placement decision. All of these processes described in the Classification Policy are consistent with national standards and correctional best practices.

## CLASSIFICATION STAFFING

In order for the classification process to operate effectively in a jail of this size, given the large number of commitments that take place on a daily basis, it is imperative that proper staffing of the classification process be maintained. The analysis found that, consistent with other staffing problems identified at the jail, the requirement that classification process be staffed 24 hours per day, seven days per week is not being met. There are classification officers assigned to classification duties on First Watch (11:30 PM to 7: 30 AM), and Third Watch (3:30 PM to 11:30 PM). However, on Second Watch (Day Shift), the Classification Officer position is combined with the Booking Officer responsibilities to ensure that there are sufficient staff assigned to handle incidences of high-volume in the booking process. Therefore, on this very active shift the Classification Officer cannot commit full-time to classification duties because of other needs that must be met. The Classification Officer also assists with the booking process on First Watch, depending on workload.

The concern here is that the classification process requires more than simply classifying each new admission to the facility and ongoing reclassifications as necessary. Classification policy and practice should be audited on an ongoing basis, which cannot be accomplished when the work load is high and only allows for classifying inmates and maintaining booking processes on a timely basis. For example, the objective point-based instrument utilized in classification should be regularly evaluated to ensure that it is measuring the important aspects of offender risk. The instrument should be valid and reliable, measuring what is intended to be measured and resulting in appropriate outcomes and decisions. The instrument should also be evaluated to determine if outcomes are consistent with expectations. Currently the Jail does not track the number of overrides or the reasons for deviating from the instrument's suggested classification, making it difficult to evaluate the reliability of the instrument or the need for changes.

The National Institute of Corrections, in its important monograph regarding jail classification, speaks to the importance of having a valid and reliable classification process that relies on good information and consistent decision-making, contributing to the overall security and safety of the facility.<sup>2</sup> We have addressed in the staffing portion of this report the need for consistent staffing of the Classification Officer position.

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<sup>2</sup> National Institute of Corrections, by James Austin PhD, Objective Jail Classification Systems: A Guide for Jail Administrators, February, 1998. This document provides guidelines for the development and management of objective jail classification systems. These classification systems have six essential components, which are the use of classification instruments that use reliable and valid criteria, appropriate use of overrides, sufficient staff trained and dedicated to classification functions, a housing plan consistent with the classification system, automation of the OJC system and periodic formal evaluations of the OJC system. Validity as used here ensures that the system is determining risk level based upon valid criteria, which is consistent with the inmate's behavior. Reliability speaks to the system providing for similar classification decisions for comparable inmates. Although, somewhat dated, this OJC manual maintains its relevancy to today's operations.



## THE CLASSIFICATION HOUSING PLAN

A critical aspect of the classification process is the availability of appropriate housing to place offenders based upon their risk and need. Classification officers described the process used to place offenders once the classification risk level is determined. The facility provides three options for placing offenders: the linear units, the direct supervision pods, and a few small dormitory units.

The linear units are primarily for housing inmates of a higher risk level, with aggravating circumstances requiring a higher level of security placement. The linear units are typically smaller than the direct supervision pods, but are operated under the principle of indirect supervision, where officers periodically or intermittently supervise and check on offender well-being. Inmates held in these units are often considered behavioral problems, escape risks, members of gangs, and/or have committed serious crimes. These inmates are often viewed as predators requiring close supervision. But these inmates considered most in need of close supervision actually receive less supervision in the linear housing units. This can result in a harmful effect on facility operations and overall safety. However, this isn't a problem caused by improper classifications, but by the lack of appropriate secure housing at the facility.

Inmates who are considered more extreme security problems are placed in the Administrative Segregation area, which consists of 22 individual cells that are also not directly supervised. Inmates in this area are kept in their cells 23 hours per day, and in some cases 24 hours when recreation options are not available. Placement in these cells is mainly reserved for inmates who are escape risks or have severe behavioral problems. Because of limited placement options, inmates requiring protection from others may also be housed in these cells, as well as inmates with mental health issues that can't be managed in general population cells. Placement in Administrative Segregation must be approved by a Sergeant and placement recommendations often are made by the Classification Officer. Administrative segregation status reviews are conducted by a Sergeant every 30 days, or more frequently if circumstances dictate. A formal weekly review process does not take place.

Placement for females is somewhat limited at the facility. As a response to allegations made in 2017 that African-American females were racially segregated and more frequently assigned to the older, more crowded linear units than white females, Pod A was converted to female housing and all females (with the exception of those in administrative segregation) were removed from the linear units and housed together in Pod A. However, this has created new problems, with inmates of various classifications housed together. The pod has a capacity of 104 inmates, 96 of whom are double bunked in cells originally designed for one inmate, and 8 of whom are in an eight-bed dormitory, a converted recreation room now used for housing. Staff have compartmentalized the unit to the point where there are three separate recreation periods for inmates with like classifications. This is necessitated by the requirement to keep certain inmates separated from one another, and the need to manage mental health inmates in the unit. The three separate recreation areas reduce daily recreation to between two and three hours per day. Unfortunately, the facility lacks much-needed mental health housing for inmates with active mental health problems, so accommodations are made in Pod A to house them. Female

placements also take place in the Booking holding cells and unit W-1-1, which is a small dormitory.

The remainder of the Pod Units and small dorms are reserved for male inmates with a medium to minimum-security designation. This includes inmates who provide labor throughout the facility. All of these units are quite crowded as each cell is double bunked, and adjacent dormitories, which are former recreation rooms, are also utilized for housing.

There is a lack of specialized housing in the facility to house inmates in need of close supervision for mental health issues, suicidal tendencies and potential threats of victimization. Staff reported that in certain cases where an inmate needs to be closely supervised, his or her housing placement is in a cell close to the officer's desk area in one of the pods. This is a less than ideal solution for housing these types of inmates, but there are few other options in the current facility.

The housing problem becomes even more significant when there are juveniles in the health facility. As noted previously, according to standards and regulations, juveniles should be held in sight and sound separation from adults. The lack of housing options for this generally small cohort of inmates results in them being placed in what are called medical cells adjacent to the facility medical examination area. This doesn't comply with sight and sound separation requirements, but housing for specialized categories of offenders doesn't exist.

## **RECOMMENDATIONS**

- 1. The Classification Officer position should be staffed on each watch as a dedicated position focusing entirely on the classification of inmates. This will require proper staffing of booking and release responsibilities in order to free the Classification Officer from those duties. A supervisor should be designated as the Classification Supervisor to oversee the classification process, ensuring that all jail inmates reside in a safe environment without real or implied evidence of inappropriate segregation. The Classification Supervisor would be responsible for ongoing review of the classification system, which includes monitoring policy and procedure compliance, as well as an ongoing review of the objective point-based classification instrument. In light of the recent allegation of segregated housing for African-American females, the supervisor should also monitor that race or ethnicity are not factors in the classification process.**
- 2. The supervisor and classification officers should conduct a periodic audit of the classification system. This will require data collection on classification outcomes and a review of the objective point-based instrument to determine if it is effective, valid and reliable. The number of overrides should also be tracked and evaluated as part of this process. Additionally, the audit should examine overall compliance with the policy/procedure regarding classification to ensure that initial classification and reclassification requirements are being complied with.**

3. We recommend that the Classification Officer conduct an in-person interview with each inmate as an additional factor to consider while making the classification decision. Interviews can be helpful in identifying risk factors that may affect the inmate's incarceration such as enemy issues, gang affiliations, and medical/mental health issues. The interview can also be useful in assessing programmatic needs and making referrals to treatment programs.
4. A staff member should be designated to conduct weekly reviews of inmates being held in Administrative Segregation to assess their ongoing need for segregated housing, and to ensure that they are receiving treatment and services as appropriate. Inmates maintained in segregated housing should also be classified on a periodic basis. A review process can also serve as a productive tool to set goals and provide incentives to inmates to improve their behavior leading to their transition to general population.

The Housing Plan discussed above is challenging and doesn't adequately provide for the proper housing of certain categories of inmates. The linear units are not designed for housing male inmates considered security risks, nor are there adequate accommodations for different categories of female inmates and juveniles in the facility. Specialized housing for mentally ill offenders is lacking, and the holding cells in the Booking Area have by default become housing for suicidal inmates and seriously mentally ill inmates. The Administrative Segregation cells have also become a last resort option for inmates with mental illness.

5. We recommend that planning for the renovation and/or replacement of the facility should take into account the need for housing options for the various categories of inmates, with special attention being given to close custody housing and housing of special populations.

## 7. Use of Force

**SCOPE OF INQUIRY:** One of the critical areas of jail operations is management of the application of force by staff on inmates, who by their actions are required to be physically restrained and controlled. Are use of force policies and practices in the Montgomery County Jail consistent with national standards and requirements of the law? Proper practice requires written policy governing the use of force, as well as practices that include investigation and monitoring of force incidents, training and supervision of staff, and ongoing review of force issues.

The following analysis was conducted on the Montgomery County Sheriff's Office Use of Force Policy, as well as the practices, training, and procedures required of personnel when use of force occurs. A review of use of force statistics and randomly selected use of force case files were also examined in this analysis. The review also examined use of the Restraint Chair and related policy.

According to the Montgomery County Sheriff's statutory authority and the policies promulgated under his administration, staff are authorized to use force under specific circumstances. The American Correctional Association (ACA) addresses Use of Force in its Mandatory Standard 4-ALDF-2B-01, which is applicable to Adult Local Detention Facilities accredited by ACA, including Montgomery County. This standard describes the proper use of force as follows:

*“The use of physical force is restricted to instances of justifiable self-defense, protection of others, protection of property, and prevention of escapes, and then only as a last resort and in accordance with appropriate statutory authority. In no event is physical force used as punishment”.*

Use of force incidents occur on a fairly routine basis at the Montgomery County Jail. As the table below outlines, incidents requiring staff intervention using force occurs on average 54 times per quarter or approximately 18 times per month using 2017 and First Quarter 2018 data. Staff reported that a substantial amount of this activity takes place in the Booking Area, and to a lesser degree throughout the remainder of the facility. This is typical and attributable to newly admitted detainees entering the facility either intoxicated or unwilling to comply with staff direction and orders.

Use of Force Incidents by Quarter: January 1, 2017 through March 31, 2018

<u>Category</u>	<u>Qtr. 1, 17</u>	<u>Qtr. 2, 17</u>	<u>Qtr. 3, 17</u>	<u>Qtr. 4, 17</u>	<u>Qtr. 1, 18</u>
Montgomery County Jail	51	54	58	45	61

(Data provided by Montgomery County Sheriff's Office)

A closer look at incidents in Quarter One of 2018 revealed that of the 61 incidents where force was applied at the jail, 19 were cases in which a chemical agent was deployed to gain compliance from the detainee. In seven of the 61 cases, the TASER device was deployed, and in three of the cases, both the TASER and chemical agent were deployed.

The Sheriff's Office Inspectional Services Unit maintains a number of records on use of force and analyzes each incident in an effort to ensure that the use of force is being applied lawfully and according to policy. For example, on a quarterly basis the database is queried to determine how many force incidents correctional staff are involved in. Any staff member involved in more than three incidents in the quarter is evaluated by command and training staff to ensure policy is being complied with and staff's actions were proper. This is a good practice designed to identify staff who may need counseling and/or training on the proper use of force.

## **USE OF FORCE POLICY**

General Order # 1.1.3, Subject: Use of Force

Sheriff's Office staff reported that the main policy providing guidance regarding use of force is General Order # 1.1.3, Subject: Use of Force issued by Sheriff Phil Plummer. This policy's effective date is November 25, 2016. The policy provides guidance on the use of force, and is applicable to all members of the Sheriff Department, including the law enforcement division, as well as jail personnel. The policy statement (1.1.3) reads as follows:

*"The Montgomery County Sheriff's Office recognizes and respects the value and special integrity of human life. In vesting law enforcement officers with the lawful authority to use force to protect the public welfare, a careful balancing of all human interests is necessary. Furthermore, the Sheriff's Office is desirous of maintaining the confidence and respect of the community it serves, through agency accountability and a use of force review process. The Sheriff's Office policy is that its personnel will use only the force that is reasonably necessary to effectively bring an incident under control, while protecting the lives of personnel and the public. This directive defines the limits of individual discretion and provides guidelines for the exercise of this discretion".*

Section A of the policy describes "Force to Effect Lawful Objectives" as the primary guidance to staff regarding the application of force. Relevant sections read:

*A.1. Personnel must use only reasonable force to accomplish lawful objectives. The Sheriff's Office prohibits indiscriminate use of force. Personnel may use force only to protect themselves and others, or to effect an arrest and detain an individual.*

*A.2. The definition of force is the use of power to affect, influence, or persuade an individual's behavior. All personnel should view force as continuous succession or a continuum, with the escalation of force in direct proportion to an appropriate objective.*

*A.3. A deputy making an arrest may only use such force, as he believes is reasonable, to:*

*Detain an offender, make the arrest, and sustain the detention.*

*Overcome resistance.*

*Prevent escape or recapture after escape.*

*Protect himself or others.*

The policy includes specific guidance with respect to the use of deadly force, discharge of firearms, less than lethal munitions, as well as reporting requirements. There is discussion on the use of the "Action – Response Use of Force Continuum", which the Sheriff requires personnel to use as guidance in the application of force. The Continuum is a tool that provides guidance on what actions may be taken in response to a detainee's physical resistance or aggressive actions.

Sheriff's Office staff, including jail personnel, are trained annually in the proper use of force in order to comply with these policy requirements. A lesson plan was developed for the training, which is consistent with the various provisions noted above. The lesson plan includes PowerPoint presentations on Use of Force and use of the Emergency Restraint Chair.

Jail Manual # 3.5.1, Subject: Use of Force.

A second policy regarding use of force was issued by Sheriff Phil Plummer, effective January 20, 2016, which is also entitled Use of Force. The policy statement reads as follows:

*The Montgomery County Sheriff's Office uses the Action – Response Continuum as a guideline when dealing with instances requiring force. The use of physical force is used in instances of justifiable self-defense, prevention of self-inflicted harm, protection of others, protection of property, prevention of riot and escape or other crimes and in controlling or subduing a prisoner who refuses to obey a staff command or order and then only as a last resort and in accordance with appropriate statutory authority.*

Additional sections of the policy provide guidance concerning "Confrontational Situations", employee use of OC spray and/or the TASER device, medical evaluations, writing an incident report and use of force report after the force incident. Other issues covered include staff backup, response to officer in trouble, court disturbance calls, emergency assistance/staff backup in various locations of the facility, and other emergency assistance procedures.

This particular policy provides limited guidance to staff regarding the principles and procedures for use of force within the jail environment, other than making a general policy statement and making reference to the Action – Response Continuum. It mainly addresses associated procedural matters related to staff response to emergencies in the facility.

## **USE OF FORCE POLICY ANALYSIS**

The primary use of force policy, General Order # 1.1.3 is an overarching policy regarding use of force applicable to all Sheriff's Office staff. Its primary focus is to provide guidance to law enforcement personnel working in the community. Emphasis is placed on use of firearms, deadly force, weaponry, and ammunition, all of which have limited applicability to jail operations. Certainly, the procedures relating to less than lethal weapons, reporting, administrative review of incidents, and the provision of medical aid are applicable to jail operations. However, the primary focus of this policy document is to guide those involved in law enforcement activity and there is little specificity related to jail operations.

Jail Manual Policy #3.5.1 is a supplemental, but not necessarily a complimentary policy. It lists as its subject use of force and the policy language appears to mirror the American Corrections Association, Adult Local Detention Facility standard relating to the Use of Force (ACA, ALDF, 2B-01). Otherwise, the policy provides limited direction to staff regarding the use of force and the document's emphasis appears to be on procedures to follow during incidents, which is different than the guidance normally provided in a jail-oriented use of force policy.

To summarize, the General Order # 1.1.3 Use of Force is a comprehensive policy document that is applicable to all employees of the Sheriff's Office, with an emphasis on law enforcement activity as opposed to corrections activity. The policy is clear that force should only be used in a lawful manner and the force applied should only be the amount reasonably necessary to gain control. As a point of emphasis, that force should never be used as a means of discipline, retaliation, or punishment.

Jail Manual Policy #3.5.1, other than offering a statement relating to the proper use of force, provides little guidance to jail staff that is specific to their situations and environment. Neither of these policies address the use of the Emergency Restraint Chair as a use of force. Many correctional/jail organizations consider the use of these restraint devices as a category within general use of force policies, therefore clearly including it in the use of force policy. The policies typically address the criteria for placing an individual in the restraint device, the procedures to obtain authorization, as well as reporting requirements, medical evaluation, exercising limbs to insure proper circulation, and release procedures. It is noted that there is a separate policy on use of the restraint chair in the Jail Manual, but there is no direct connection to either use of force policy.

## RECOMMENDATIONS

We recommend establishing a detailed jail specific policy which fully identifies specific requirements for the use of force in a correctional/jail setting be developed to replace Jail Manual Order # 3.5.1. This policy could serve as a single guide for correctional staff, detailing the appropriate use of force and related procedures. This policy should identify use of the Emergency Restraint Chair as a use of force and require that established criteria be met before placing an individual in the chair.

Topics that jail leadership should consider for inclusion in the policy include:

1. A statement at the beginning of a Use of Force Directive that sets forth general principles:
  - the force used shall always be the minimum amount necessary, and must be proportional to the resistance or threat encountered;
  - the agency has a zero-tolerance policy for excessive and unnecessary force;
  - the best and safest way to manage potential use of force situations is to prevent or resolve them without the need for physical force, including the practice of de-escalation methods and Interpersonal Communication (IPC) skills;
  - force shall not be used as punishment or to intimidate or threaten a detainee.
  - the use of excessive force is expressly prohibited and shall result in discipline of the involved staff.
  - an explicit requirement that staff may use force only when reasonably necessary to:
    - prevent physical harm to staff, visitors, detainees, or other persons, as a last resort and where there is no practical alternative available;
    - prevent or stop the commission of crimes, including riot, assault, escape, or hostage taking;
    - enforce facility rules, policies, regulations, and court orders where lesser means have proven ineffective and there is an immediate threat to the safety of persons or the security of the facility, or an immediate need for compliance, or prevent serious destruction of property.



2. **An explicit prohibition on the following:**
  - **the use of force to punish, discipline, assault, or retaliate against a detainee;**
  - **the use of force in response to a detainee’s verbal insults, threats, or swearing;**
  - **the use of force after control of a detainee has been established;**
  - **provoking detainees to commit an assault in order to justify use of force;**
  - **the use of unnecessarily painful escort or restraint techniques;**
  - **causing or facilitating detainee-on-detainee violence, or otherwise exposing detainees to an unreasonable risk of being assaulted by other detainees;**
  - **pressuring or coercing detainees, staff, or non-Department staff to not report use of force.**
3. **A discussion concerning using the minimum amount of force that appears reasonable, and escalating the force only if necessary, to stop or control the detainee. (This discussion can include the force continuum that the Sheriff’s Office has adopted in its current policy.)**
4. **The use of verbal techniques, de-escalation methods, and Interpersonal Communication skills (IPC) designed to diffuse the situation if time and circumstances permit. Use of force avoidance procedures should be outlined in policy.**
5. **A requirement to limit the use of force, if time permits, until a warning or command has been given and the detainee has had time to comply with it before applying force.**
6. **A requirement that medical attention be provided to staff and detainees injured during the use of force incident as soon as practical after an incident.**
7. **A requirement that no staff involved in a use of force incident participate in escorting the detainee away from the scene, including to the medical clinic or holding area except in extraordinary circumstances when there is no reasonable alternative.**
8. **Include provisions and procedures for planned use of force, such as cell extractions.**
9. **Include requirements and specific criteria for when less than lethal weapons such as oleo capsicum and the Taser may be used, and include that these weapons should only be used as a last resort after all options of lesser force have been considered and determined to be not practicable.**

- 10. A policy that recommends limiting or avoiding the use of force on special needs population and juveniles, if feasible.**
- 11. A requirement that correctional staff summons medical staff to examine detainees as soon as possible after a use of force incident.**
- 12. A requirement that correctional staff document detainees' injuries or alleged injuries through photographs and/or video.**

## **USE OF FORCE REVIEW PROCESS**

The process for administrative review following a use of force is outlined in policy General Order 1.1.3, Subject: Use of Force, Sections J and K. This policy was issued by the Sheriff, effective November 25, 2016.

Section J requires that written reports be prepared by personnel involved in any type of force incident. This requirement applies to all situations where force is used, irrespective of whether an injury has occurred. It is incumbent on the staff member using force to document the incident and submit a report.

Section K of the policy describes a supervisor's responsibilities with respect to reviewing use of force incidents. The supervisor is required to determine whether the use of force:

- Was in compliance with policy;
- Indicates a requirement for additional training;
- Warrants a policy revision;
- Necessitates the re-evaluation of Sheriff's Office training or equipment.

Supervisors are required to document in a memorandum any concerns regarding the force incident, and disseminate the Use of Force Report through the chain of command to the Chief Deputy.

Section K 2 of the policy requires the Chief Deputy to review all use of force reports to determine if any further investigation is warranted by the Sheriff's Office Inspectional Services Unit (ISU). According to the policy, this determination is made after consideration of the following:

- Were the agency's directives followed?
- What type and degree of force was used and was it appropriate for the detainee's behavior?
- Were there any complaints about excessive force made regarding the incident?

- Did correctional staff utilize or attempt to diffuse the situation through the use of de-escalation methods?

The Inspectional Services Unit is comprised of one sergeant and one detective, and is responsible for conducting the formal reviews of use of force cases, particularly those that pose a concern that excessive force may have been used. The ISU is required to generate a report on its findings through the chain of command to the Chief Deputy and ultimately to the Sheriff. Furthermore, ISU investigators are required to describe relevant facts and circumstances. After consideration of these factors, a conclusion is drawn regarding the appropriateness of the use of force and whether any employee violated an agency directive or policy. Ultimately, the Chief Deputy reviews and forwards the report to the Sheriff for review.

The procedures described are consistent with General Order 1.1.3, beginning with a requirement that an employee using force must document that use of force in a Jail Incident Report, per Policy 3.10.1, Subject: Jail Incident Reports, Section A1. The report is required to be completed before the end of the watch and submitted to the supervisor for review. The supervisor, normally a sergeant, is responsible for collecting reports, reviewing them, downloading any video of the events, and forwarding the report package to the appropriate jail captain for subsequent review. The review process, as it was described, takes approximately five days to complete with the following parties being involved in the chain of command: the immediate supervisor, normally a sergeant; a captain; the Major or Facility Administrator; and the Chief Deputy.

The Chief Deputy may elect to refer the matter to the Inspectional Services Unit if there are concerns of excessive force. The matter may also be reviewed by the Facility Administrator/Major or his designee that could include a sergeant or captain.

The system, inclusive of the policies and procedures cited here, heavily relies on the decisions made by the officer(s) involved in the use of force and/or the sergeant supervising operations. The sergeant is made aware of an incident by a correctional officer or other party, and is responsible for gathering Jail Incident Reports and designating the matter as a Use of Force. Once that determination is made, it is incumbent on the sergeant to order that use of force reports be prepared, video recordings be gathered and downloaded, medical reports be secured, and any relevant evidence be protected.

During this review, it was reported that there have been occasions when an incident involving use of force generated a jail incident report, but did not get designated or escalated as a use of force. Situations like this have occurred in the past and therefore have a likelihood/propensity to occur in the future if there are differing evaluations of the facts of a given case. In order to prevent future occurrences, jail incident reports are now evaluated and audited daily by the Administrative Sergeant, who reports directly to a captain. This administrative review by the management's designee is partly designed to identify any cases of force application that may have not been so designated by the sergeant on duty at the time. This process is useful to ensure that legitimate use of force cases is properly identified and reported, as well as to safeguard against these cases being miscoded as a less serious event. The Sheriff and his staff should be commended for adding this feature to the review process to ensure force cases are identified and processed in accordance with policy.

## **RECOMMENDATION**

**The Use of Force procedures that are outlined in the Sheriff's Office General Orders Manual and Jail Manual lack specificity for correctional staff and do not address several areas which have been identified as potential sources or allegations of inappropriate and/or excessive use of force. We recommend the Sheriff's Office employ the following procedures to provide additional safeguards against allegations of misconduct.**

- 1. Provide clear guidance and training to all Jail supervisors on what is and is not considered a use of force incident.**
- 2. Require all evidence from a use of force incident, including electronic and physical evidence, be preserved, secured, and maintained appropriately so it cannot be deleted, destroyed, or tampered with.**
- 3. Create a cultural competency among all correctional staff that involves utilizing proven de-escalation methods and communication skills to limit or avoid the use of force.**
- 4. Clearly communicate to all jail staff that inappropriate or excessive force incidents will not be tolerated and will be thoroughly investigated for any wrongdoing.**
- 5. Protect any correctional officer, staff member, or inmate who reports or alleges inappropriate or excessive use of force by another correctional staff member.**
- 6. Establish an Ombudsman process or civilian review panel that routinely reviews the Jail's use of force incidents, including all applicable reports, videos, photographs, and documentation, to build and maintain a degree of transparency and trust with the community.**

## **USE OF FORCE PROCEDURES ANALYSIS**

The Sheriff's Office policies on use of force procedures are thorough and consistent with best law enforcement practices. Force incidents are required to be documented. Evidence is collected and subsequent analysis of the incident takes place to ensure that proper procedures were followed and the policy was complied with. There are, at a minimum, four levels of review beginning with the sergeant on the scene and ending with a review by the Sheriff's Chief Deputy. In cases where there are inconsistencies or concerns that policy violations occurred, a procedure is in place to refer the matter to the Inspectional Services Unit for further investigation. As an example of this policy in practice, Jail management recently corrected a potential flaw in the process by ensuring that the Administrative Sergeant reviews daily incident reports from the previous watches to ensure that jail incident reports are properly coded, so that an incident involving force is designated as a use of force.

## RECOMMENDATIONS

**Recent use of force incidents in the Jail suggest that current use of force procedures analysis may be inadequate or lacking. We recommended the Sheriff's Office adopt additional practices to ensure adequate use of force analysis, accountability of staff's reported force incidents, and transparency with use of force incidents. These recommendations include:**

- 1. Establishing minimum monthly random supervisory review of Jail surveillance video cameras of common locations where use of force incidents occur and document the review;**
- 2. Requiring mandatory review of all video footage involving use of force incidents by at least one supervisor and one command staff member and document the review;**
- 3. Collecting data on the detainees involved in use of force incidents to determine whether substance abuse, mental health issues, special needs, or other similar extenuating circumstances were factors in the detainee's behavior;**
- 4. Determining if services were identified that could benefit this detainee's behavior to prevent future force responses.**

## USE OF FORCE TRAINING

A CGL consultant conducted a review of the Sheriff's Office training curriculum and lesson plans with respect to use of force. Newly hired correctional staff received a 2 ½ hour training session on use of force in their first week on the job before having contact with detainees. This training is conducted prior to their assignment of working alongside a Field Training Officer, referred to as an FTO. During their first year of employment, corrections officers are required to attend a Corrections Academy, which consists of 145 hours of state-mandated training. The academy curriculum includes training on the use of force. Additional training is provided on an annual basis and the training includes classroom training. The 2017 Lesson Plan for corrections in-service training indicates that on day one of the training students are trained in the Sheriff's Office use of force policy, including any updates to policy that have been made. According to the lesson plan, training is followed by a written test. Furthermore, a PowerPoint presentation was developed as a training aid. The PowerPoint outline includes training on the Action-Response Continuum and other aspects of the use of force policy.

The amount of time committed to training on the use of force, both pre-service and in-service, is adequate and consistent with the practices of an ACA accredited jail. Training content reviewed consisted of documents and lesson plans, but the consultant did not observe the actual training.

## **RECOMMENDATIONS:**

**The Sheriff's Office provides correctional staff initial training, academy training, and in-service training on use of force procedures and policies. In addition to this training, we recommend the Jail also:**

- 1. subscribe to and provide all correctional staff with monthly legal updates on search and seizure, arrest law bulletins, and/or use of force cases or incidents;**
- 2. provide a minimum of four hours training on proper use of force techniques, Jail policy on force incidents, de-escalation methods, Interpersonal Communication skills, or similar training as part of correctional staff annual in-service training.**

## **CASE REVIEWS**

Consultant team members met with managerial staff at the Jail to review use of force procedures and analyze actual case materials for several selected use of force incidents that occurred in 2017 and 2018. Five case packets from 2017 and six case packets from 2018 were selected at random for review. Cases included the following types of incidents:

- placement in the restraint chair;
- incident controlling a detainee outside of his cell;
- incident where the detainee refused to attend court;
- a case where a detainee was forcibly taken down to the ground;
- an inmate's refusal to lock down in a cell in the Booking Area;
- a fight between two detainee participants;
- an incident where the detainee refused to get dressed and was in possession of drugs;
- a case where a detainee was harming himself and had to be restrained.

In a number of these cases the chemical agent oleo capsicum (O.C., or pepper spray) was applied and in two cases a sergeant administered the TASER device to gain control.

The use of force report packages included the use of force reports that addressed the detainee's actions, the officer's response, the nature and presence of injuries, and supporting documentation, including photographs, log entries, witness reports and detailed descriptions of the incidents.

Furthermore, the case materials included the review completed by the supervisor on the scene and subsequent review by the facility managers and the assigned investigating employee. The reports the consultant representative reviewed were comprehensive.

The review process was conducted to gain an understanding of how use of force cases were being documented and subsequently reviewed by supervisory personnel. It was also conducted to determine if the case materials and reviews were consistent with policy General Order 1.1.3, Subject: Use of Force. The consultant representative did not review video recordings as part of this review process. In all of the cases reviewed, the policy requirements of General Order 1.1.3 were in substantial compliance with policy and the case packets were professionally prepared. Additionally, the consultant representative reviewed three cases where excessive force was suspected. Each of these case packets contained a thorough review of the facts and actions taken to correct staff performance.

## **THE EMERGENCY RESTRAINT CHAIR**

The Emergency Restraint Chair is a device that allows for the restraining of an individual at four or five points. The chair is used under normal circumstances to restrain out of control individuals to prevent them from causing harm to themselves, others, or from damaging property. The consultant representative observed three restraint chairs at the Montgomery County Jail stored in the Booking Area of the facility. These devices are portable in order to bring them to the scene of a disturbance where a detainee requires restraint. Once a detainee is placed in the chair, each arm is restrained by leather strap to the chair's armrests, as well as each leg to the leg rests. The detainee is further restrained at a fifth point, which includes securing the body to the chair using the shoulder straps.

The Restraint Chair receives considerable use at the jail. Citing statistics provided by jail personnel, there were 77 instances of restraint chair use or an average of 6.4 per month in 2017. In 2018 through May, there were 57 instances of chair use, or an average of 11 per month, a significant increase over the 2017 average.

The applicable policy providing guidance on this subject is Policy # 3.6.1, Subject: Use of Restraints, effective July 25, 2016 issued by Sheriff Phil Plummer. Section C of the policy relates specifically to the placement of individuals in a restraint chair. The policy requires that placement in the restraint chair be approved by a supervisor and that health care staff be notified in order to conduct a physical and mental assessment of the detainee. Additional procedures are outlined in this section to guide staff on use of the restraint chair.

Supervisors are required to instruct staff to prepare a Jail Incident Report regarding placement of a detainee in the chair, and the supervisor furthermore is required to download any video recordings onto a CD-ROM and submit it to their superiors along with the incident reports. Reference is made in the policy to the requirement for jail incident reports; however, section B.2 and B.3 specify that a use of force report is to be submitted, *if necessary*. The policy is unclear as to the criteria that must be used to make a determination of the necessity of the use of force report; however, it seems to indicate that not all applications of restraint chair use are considered a use of force.

Jail Incident Reports Policy # 3.10.1 (A.1.) does indicate that an incident report is required if force is used to control a prisoner, and further states that an incident report is required if “an inmate remains in the restraint chair at the end of the shift.”

This language somewhat conflicts with the requirement stated in the Use of Restraints Policy (# 3.6.1), that an incident report is required when restraining detainees; and language calling for an additional incident report at the end of the shift is unclear and should be clarified.

The applicable ACA standard regarding use of restraints is 4-ALDF-2B-03, which is a mandatory standard for accredited facilities. It reads:

*“Four/five-point restraints are used only in extreme instances and only when other types of restraints have proven ineffective. Advanced approval is secured from the facility administrator/designee before a detainee is placed in a four/five-point restraint. Subsequently, the health authority or designee must be notified to assess the detainee’s medical and mental health condition, and to advise whether, on the basis of serious danger to self or others, the detainee should be in a medical/mental health unit for emergency and involuntary treatment with sedation and/or other medical management, as appropriate. If the detainee is not transferred to a medical/mental health unit and is restrained in a four/five-point position, the following minimum procedures are followed:*

- *direct visual observation by staff is continuous prior to obtaining approval from the health authority or designee;*
- *subsequent visual observation is made at least every 15 minutes;*
- *restraint procedures are in accordance with guidelines approved by the designated health authority;*
- *all decisions and actions are documented.”*

This standard points out that four/five-point restraints, which include the restraint chair, are only to be used in extreme circumstances (emphasis added) with the approval of supervisory authority.

The Montgomery County Jail’s Use of Restraints policy does state in Section A.1. that restraints are not to be used as punishment or for convenience of personnel. They are not to be applied for more time than necessary and should be considered in the following situations:

- when inmates are or have the potential to become self-destructive;
- when inmates pose an assault risk to staff, other inmates, and/or visitors;
- when necessary to prevent escape or prevent damage from occurring to the facility;
- when transporting an inmate outside the security area of the facility.



The policy does not directly address situations whereby placement in the restraint chair is considered a use of force. In fact, the policy suggests that restraint chair placement may or may not be considered a use of force. This decision is made by the on-site supervisor.

## **RECOMMENDATIONS**

- 1. To comply with the spirit of the ACA standard and the Sheriff's Office Jail policy, placement in the restraint chair should explicitly be considered a use of force situation and should only be applied in those cases where no other reasonable alternative is available, such as placement in a segregated cell or attempting to diffuse the situation through communication with the detainee by the supervisor or mental health clinician. The use of the device is a last resort after considering other options.**
- 2. As noted in the Training Outline used for annual in-service training, serious medical conditions can occur during the restraint process. Precautions need to be taken to ensure that medical staff examine an individual and review medical records prior to placement, or shortly after placement when time does not otherwise permit, to determine whether the individual has any medical and/or mental health issues that could be further complicated by placement in the restraint chair.**
- 3. Inmates should not be held in the chair for more than two hours, consistent with most correctional policies regarding the use of this device. In any situation when an individual is held in the chair beyond two hours, medical staff need to be involved and the individual's arms and legs must be exercised to ensure proper circulation.**
- 4. The use of non-lethal weapons (e.g. Taser, pepper spray) on any detainee secured in a restraint chair should be explicitly prohibited.**
- 5. Each case where the restraint chair is used to control a detainee should be examined to determine if proper procedures were followed and the criteria of dangerousness to self or others, or the destruction of property were met, and other techniques were proven to be ineffective to gain compliance. In order to achieve this, it is recommended that each case of restraint chair use be deemed a use of force, and use of force reporting procedures, including subsequent review by superiors, be conducted. Limiting the use of the chair to those cases where there are no other viable options to gain control will ensure compliance with ACA standards and reduce risk of liability.**
- 6. An annual review of the Use of Force policy should be conducted, including the restraint chair policy, to ensure it complies with common correctional facility procedures and protocols.**

# 8. Inmate Grievances

**SCOPE OF INQUIRY:** Do existing grievance practices allow inmates unrestricted access to the grievance process and ensure grievances are adjudicated in a fair and expeditious manner?

Grievance policies help ensure the rights of incarcerated individuals. Additionally, grievance policies impact the ability of offenders to access federal courts, as past rulings<sup>3</sup> have required offenders to exhaust all available administrative remedies before they access federal courts. An open and fair grievance practice is also an effective management tool because it provides a measure by which to determine whether facility policies are being appropriately followed by staff.

## NATIONAL STANDARDS BEST PRACTICES

The American Correctional Association (ACA) standard regarding inmate grievance practices is very broad, and provides little specificity. ACA standard 4-ALDF-6B-01 states: “An inmate grievance procedure is made available to all inmates and includes at least one level of appeal.”

## EXISTING POLICY

The Montgomery County Jail has an established grievance policy (Inmate Complaint and Grievances, 5.28.1). The following represent the major components of this policy:

- Defines and distinguishes between inmate “Complaints” and “Grievances;”
- Identifies separate grievance processes for health care related and non-health care related grievances;
- Requires inmates to make an informal (verbal) attempt to resolve a concern before filing a written grievance;
- Describes the grievance appeal process;
- Defines the use of the “Grievance Line”.

The policy differentiates between inmate “complaints” and “grievances.” Specifically, a complaint is recognized as “an act that constitutes misconduct by an employee including a

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<sup>3</sup> Woodford v. NGO (2006)

criminal act,” or “any violation of the inmate’s rights.” Grievances, on the other hand, can be filed for any other matter related to facility operations, services, and programs.

As a result of this differentiation, there are separate processes for complaints and grievances. The policy also identifies distinct practices for processing health care grievances and non-health care grievances (grievances concerning conditions of confinement, discipline, program participation, use of telephone & mail, food, clothing and bedding, etc.).

No matter whether the concern is a “complaint” or a “grievance”, the first step in the process is an attempt at informal resolution. The policy defines this informal resolution process as beginning with the inmate contacting the housing unit officer and explaining the complaint to him. The housing unit officer then contacts either the housing sergeant (for complaints or grievances of a general nature) or the Health Care Services Administrator (for health care related grievances), who then reports to the housing unit to meet with the inmate, attempts to resolve the concern, and determines if the inmate has a complaint or a grievance. If the concern cannot be resolved informally, the inmate is provided the appropriate form (an Employee Complaint Form, an Inmate Grievance Form, or a Health Care Grievance Form).

## **EMPLOYEE COMPLAINTS**

If the concern is determined to be a complaint and the inmate files an Employee Complaint Form, the policy requires processing to follow the “Professional Conduct Investigation” chapter of the General Orders Manual. This general order specifies the Sheriff’s Office policy for conducting investigations of alleged employee misconduct. An employee complaint is forwarded through the chain of command and assigned to either a supervisor or the Inspectional Services Unit for an internal investigation based on the seriousness and type of the allegation.

Jail staff indicated they had received only six complaints in the last 18 months, and that this was a total of both citizen and inmate complaints. The extremely low number limits the validity of any meaningful analysis. The Jail consultant focused instead on inmate grievances, which while still a low number, occur with greater frequency than complaints. The real issue with both systems is the Jail’s preference for informal resolution of inmate issues. This can be a good policy, but holds the potential for abuse if inmates feel there are obstacles to their access to the grievance system.

## **GRIEVANCES**

There are different procedures for the handling of written non-health care related grievances and written health care grievances.

For non-health care related grievances, if an informal resolution with the housing unit officer cannot be achieved, the Housing Sergeant is called to the unit to attempt to resolve the matter. If it cannot be resolved, the inmate is provided an Inmate Grievance Form. Once the inmate files a

written grievance, the first level of review is by the facility Operations Captain, who is responsible for investigating the grievance and issuing a ruling.

For health care grievances, an inmate must first explain the issue to the housing unit officer. If the housing unit officer cannot resolve the issue, the Health Care Services Administrator (HSCA) is called to the unit to try to informally resolve the issue. If the HSCA cannot resolve the issue, the inmate is provided a Health Care Grievance form. The HSCA is also the first level of review after a formal Health Care Grievance is filed. They are responsible for investigating the grievance and issuing a ruling.

In all cases, inmates are allowed to appeal any ruling by the Operations Captain or HSCA. However, the appeal requires the inmate submit a different form (Jail Request Form) to the Jail Administrator within 24 hours of receiving the decision.

The facility also has a grievance telephone line that inmates can access (typically in the housing areas) to address a concern. Policy outlines that this should be used when an inmate does not feel their grievance/complaint was handled appropriately. A correctional officer assigned to the Jail Administrator is required to review the line every weekday and forward the information to the Jail Administrator for review. CGL reviewed the automated form that is completed for each Grievance Line call and it includes the following: date, grievant name and booking number, housing location, supervising staff, compliance synopsis, response, general area of complaint (programs, justice, care, etc.), and category of complaint (medical, laundry, legal, etc.).

Further communication with the facility administrator found the policy language regarding the Grievance Line is not reflective of actual practices. In actuality, the Grievance Line typically serves as an informal means of submitting a concern and is not used as a follow up to a previously submitted grievance. The Jail provided CGL with a log of calls to the grievance line between January 2018 and June 2018. These grievance line calls totaled 41 during the period.

## **GRIEVANCES FILED**

The Montgomery County Jail verbally reported only nine written grievances in the past year. The number of grievances reported is extremely low and can be interpreted in two distinct ways; either the facility makes an extraordinary effort to resolve all grievances at the informal level, or there are potential barriers that prevent or dissuade inmates from filing grievances.

This low number of grievances was noted in the 2016 ACA reaccreditation audit which stated that “a review of the Significant Incident Summary also is exceptional for the fact that there have been absolutely no grievances substantiated or not substantiated in the facility for food, medical, commissary, mail, etc. for the past three years of the audit cycle. We found this highly unusual for a facility of this size.”

CGL’s national experience regarding the low number of grievances in the Montgomery County Jail mirrors the concerns noted in the 2016 ACA accreditation report. Table 1 provides a

breakdown of the number of grievances filed in local detention facilities of various sizes across the country.

<b>Facility</b>	<b>Column A Annual Grievances Filed</b>	<b>Column B Rate of Annual Grievances filed per Inmate</b>	<b>Column C Rate of Grievances Filed Compared to Montgomery County</b>
<b>Montgomery County, OH</b>	<b>9</b>	<b>0.01</b>	
Bergen County NJ	361	0.4	40 x greater
El Paso County, CO	1,771	1.2	120 x greater
Wake County, NC	1,568	3.2	320 x greater
Davidson County, TN	4,653	1.6	160 x greater
Berks County, PA	1,493	1.4	140 x greater
Baltimore, MD	5,217	1.7	170 x greater
NY City Jail System	9,300	1.1	110 x greater
Louisville Metro Detention Center	1,693	0.8	80 x greater

To control for the varying population sizes of the facilities CGL developed a rate identified in Column B which reflects the number of grievances filed in the year per inmate. Column C then compares this rate to Montgomery County’s rate (0.01). For example, the facility with the lowest rate of grievances was Bergen County NJ, which had a population of nearly 1,000 inmates and had 361 grievances filed. This results in rate of 0.4 grievances filed for every inmate which is 40 times greater than the rate of grievances filed in Montgomery County.

We noted that the Montgomery County Jail indicated the reasons the grievances are low is because they make efforts to resolve grievances at the informal level. Our observations of supervisory staff in the housing areas found there was positive communication between captains, sergeants, and the inmates. Additionally, the Grievance Line was used as an informal means allowing inmates to grieve a concern.

Current Jail policy requires inmates to first attempt to resolve a “complaint” through the housing officer. Complaints are defined as grievances of potential staff misconduct. In fact, the US Department of Justice has developed basic standards for inmate grievance procedures in state and local jails<sup>4</sup>. One relevant portion of these standards include:

*40.7.b: “No inmate or employee who appears to be involved in matter shall participate in any capacity in the resolution of the grievance.”*

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<sup>4</sup> 28 CRF 40 Inmate Grievance Procedures

Requiring inmates to first address an issue of staff misconduct in a face-to-face with a housing officer could deter inmates from ever bringing a valid complaint forward. Additionally, it may put inmates in the position of addressing a complaint to the officer who is a subject of the grievance.

## **RECOMMENDATIONS**

- 1. Establish an independent Grievance Coordinator for the facility who is responsible for monitoring the grievance process, ensuring legitimate access to complaint and grievance forms, and serving as the first level of formal grievance review for all health care and non-health care grievances. The Grievance Coordinator should independently investigate the grievance and issue the first level ruling.**
- 2. While requirements that inmates attempt to informally resolve a grievance are appropriate, the facility should establish policy and practice that allows for complaints of employee misconduct, civil rights or racial grievances, grievances related to facility operations, services and programs circumvent the normal process and be sent directly to the Grievance Coordinator without intervention by housing unit staff.**
- 3. Employee Complaint Forms and grievance forms should be readily available and accessible to inmates in various Jail locations without the need to request these from the officer(s) or sergeant(s) supervising the housing units.**
- 4. Establish grievance boxes in each housing unit where inmates can confidentially submit their completed grievance.**
- 5. Establish a grievance log, maintained by the Grievance Coordinator, that ensures all paper grievances are documented in a standardized method and addressed in a timely manner.**
- 6. Establish a practice for health care related grievances where the HCSA is not both the informal arbitrator of the concern and the first level of formal grievance review.**
- 7. Ensure that policy identifies that any employee complaint regarding alleged staff misconduct is immediately reported to the Jail Administrator.**
- 8. Change Jail policy to allow inmates a more reasonable time to file an appeal. Specifically, inmates should be provided at least five days after a grievance decision to consider and file a grievance appeal. We note that the actual grievance form (Prisoner Grievance Form, Form 0042) indicates an inmate can appeal within five days (excluding weekends and holidays) but is contrary to current Jail practices.**

- 9. Revise Jail policy to reflect that the Grievance Line actually serves as another option for informally addressing an inmate concern. Establish a practice where the Grievance Line is tested by the Grievance Coordinator on a weekly basis to ensure functionality.**
- 10. Make employee complaint forms and grievance forms available to inmates in both English and Spanish.**
- 11. Train staff annually on appropriate inmate grievance procedures.**
- 12. Educate/inform inmates on the grievance procedures and employee complaint process during Jail orientation and/or in the Jail handbook.**
- 13. Differentiate between the Employee Complaint Form, Non-Health Care Grievance Form, and Health Care Grievance Form.**
- 14. Consider revising grievance forms to solicit more specific information from an inmate on their grievance.**

# 9. Medical Health Care

**SCOPE OF INQUIRY:** A review of the Montgomery County Jail medical health program conducted in December 2018<sup>5</sup> examined the effectiveness of health care delivery throughout the Jail, focusing on the adequacy of resources allocated to the health care program, program management, policies, medical clinic services, and intake assessment.

It should be noted that this review took place prior to the new contract with the Jail's healthcare provider, NaphCare, on January 1, 2019. Under the new contract NaphCare is also responsible for provision of mental health care. With these changes, and the addition of new staff, the Jail is in position to make changes according to the recommendations in this report, as well ensure a better integration of medical and mental health care services.

Health care services at the Jail are provided by both licensed staff and health care trained professionals. Medical services are provided by a physician as well as a nurse practitioner (NP) under the supervision of a physician. Registered nurses (RN's) are available daily to evaluate inmates referred to them by correctional staff or other departments and to see inmates who specifically request to see the nurse.

## POLICIES

The primary components of an effective correctional health care program include intake assessment, primary care access (sick call), chronic disease management, unscheduled onsite and offsite services (emergencies), scheduled onsite and offsite services (consultations and procedures), medication management, dental services, mental health services, and women's health services. Effective delivery of these services requires a vision of what the service should look like and what they should be able to accomplish after the promulgation of policies and procedures, and staff is trained. The objective should be to establish a level of care that is consistent with recognized national standards, such as the National Commission on Correctional Health Care (NCCHC) Standards for adult jails.

Policies and standards established by the NCCHC provide national benchmarks for the effective operation of correctional healthcare throughout the United States. These standards address clinical issues, treatment protocols, administrative controls, staff training and development, disease prevention, quality assurance, safety and emergency procedures, data management, sanitation, and other key issues, reflecting the professional consensus on best practices in all of

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<sup>5</sup> The review was conducted by Ronald Shansky, M.D. on December 19, 2018, on behalf of the Justice Committee.



these areas. The NCCHC maintains an accreditation system that verifies correctional facilities' compliance with these national standards. The accreditation process consists of a rigorous series of reviews, evaluations, audits, and hearings.

In the course of resolving litigation and investigation of jail conditions, the US Department of Justice, and the federal courts have recognized NCCHC accreditation as evidence that health care delivery in a correctional facility meets community standards. Nationally, fewer than 10 percent of correctional facilities have achieved NCCHC accreditation. The Montgomery County Jail is the only jail in the state of Ohio that has attained NCCHC accreditation. Nevertheless, there remain significant deficiencies to be corrected.

A review of the Jail's current health care policies indicates they are substantially based on NCCHC standards and in compliance with these policies. The jail's vendor, NaphCare, is well versed in these standards, and has put quality assurance systems in place to maintain compliance.

Our review did note one significant area of non-compliance. In April 2018, the NCCHC published new standards that included a significant change regarding "Non-emergent Health Care Requests and Services". The former standards require conducting a medical assessment in response to an inmate request within 48 to 72 hours after receipt of the written request from the inmate. The newly published standards state that, "After receipt of the health service request, the program is required to perform a face-to-face assessment within 24 hours, seven days a week." This requirement has caused many correctional facilities to increase the number of staff committed to the health service request and review process. It is recommended that a follow-up investigation should ascertain whether this new standard is being met.

Compliance with this new standard at the Montgomery County Jail will require an additional 1.5 LPN FTEs. This staffing will provide for seven-day coverage of one position to review sick call request and assure scheduling of an assessment within 24 hours. This additional staffing will be required for the Jail to continue to assure accreditation of its health care program. (See Recommendation 1)

## **PHYSICAL PLANT**

One of the deficiencies of the health care program at the Jail is the lack of professionally equipped rooms on the housing units to perform sick call. Modern jail design typically provides the creation of private exam rooms in each housing unit. This eliminates the need for staff transport of inmates to the clinic and expedites the sick call process. It would be helpful if such rooms were created within the existing housing units. However, current levels of crowding in the facility make such an initiative impractical. The number of exam rooms in the clinic also is not adequate to meet facility needs. Current exam rooms in the clinic are used for another purpose two half-days per week. This in effect severely limits sick call exams or requires conducting assessments in a non-private setting.

The key issues noted throughout the facilities are the amount of space allocated for delivery of services and the degree of privacy allowed by existing space. While optimal facilities are not currently available, workable improvements can be achieved through healthcare staff communicating and working with custody staff to address their issues. This is a short-term solution until a new jail facility can be built. (See Recommendation 2)

## **SICK CALL**

The most critical component in any correctional health care system with regard to ensuring unimpeded access to care is an efficient and effective sick call process. National standards call for establishment of systems that assure that each inmate, on a daily basis, may transmit a request for care directly to health care staff. The essential characteristics of an effective sick call system are:

- All inmates have the opportunity to make a daily request for service;
- Requests are picked up and/or reviewed only by health care staff;
- Health care staff triage requests for service on a daily basis;
- Inmates are notified of responses to their request for treatment.

(See Recommendations 1 and 3)

Based on the findings made in the appointment, the patient may then be referred where indicated to an advanced level clinician or a mental health specialist. The system should also have designated timeliness targets for the advanced level assessment, when medications are ordered, as well as timeliness benchmarks from the time of order to receipt of the medication. The sick call process should be monitored on a regular basis for quality assurance to minimize potential liability and assure the cost-effective use of the resources allocated to the program.

The Jail's current sick call management system generally conforms to this process. However, the sick call review process could better address emergent issues. Currently a nurse reviews sick call requests during the third shift and summarizes the presenting complaints in the medical record. Because the review takes place on third shift, the system does not formally triage requests to prioritize and address urgent complaints. It would be inappropriate to pull patients from their cell on the third shift. As an alternative, an evening shift nurse could conduct a quick review of daily sick call requests and if indicated, could order an immediate assessment of an inmate with an emergent issue.

## **REFUSAL OF MEDICATION SERVICES**

Inmate refusal to take prescribed medication is a common problem in correctional facilities. The appropriate response to this issue is counseling with the prescribing clinician. Most large jails provide specific instructions to nurses as to when they must refer an inmate for such counseling.

For example, if an inmate refuses his or her medications on three consecutive occasions, the nurse administering medications must arrange for a counseling session with the ordering clinician. The Montgomery County Jail policies address the issue of non-adherence of critical medications, such as insulin, but lacks specificity as to when the nurses are specifically required to refer to the prescribing provider. Establishing specific criteria for referral to counseling could improve compliance with medication orders. (See Recommendation 4)

## **STAFFING**

Jail health care system staffing level needs are a function of the scale of service delivery, as determined by the size of the inmate population, its demographic profile, the volume of intake, and the rate of turnover in the population. Examples of factors that drive staffing requirements include the following:

- Sick call frequency
- Intake procedures
- Medication distribution schedule and procedure
- Chronic disease clinics (diabetes, hypertension, asthma, etc.)
- Specialty care programs (OB/GYN, physical therapy, geriatric care, etc.)
- Infirmary service level required
- Required procedures in support of lab, toxicology, radiology, pharmacy, and other services (x-rays, blood draws, blood pressures, IV's, etc.)
- Health education responsibilities
- Quality assurance
- Information management/medical record responsibilities
- General administrative duties

In order to determine required staffing levels, policy in each of these areas must be defined and translated into actual task, process, and work responsibilities. This entails determining the amount of time required to perform essential tasks, the process for managing performance of these tasks, and the overall amount of necessary time and staff, given the number of inmates to be provided service in the time available. The following table shows the current staffing complement at the jail, per the amended NaphCare contract.

Montgomery County Jail Health Care Staffing

Position	1 <sup>st</sup> Shift	2 <sup>nd</sup> Shift	3 <sup>rd</sup> Shift	Total FTE
Health Service Administrator (RN)	1.00			1.00
Director of Nursing	1.00			1.00
Mental Health Nurse (RN)	0.40			0.40
Medical Director	0.35			0.35
NP/PA	1.00			1.00
Dentist	0.15			0.15
Dental Assistant	0.15			0.15
Psychiatrist	0.45			0.45
Psych NP/PA	1.00			1.00
Mental Health Director	1.00			1.00
Mental Health Professional (MHP)	2.60			2.60
Discharge Planner (MHP)	3.00			3.00
Administrative Assistant	1.00			1.00
Registered Nurse (RN)	2.00	1.40	1.40	4.80
Licensed Practical Nurse (LPN)	4.20	4.20	1.40	9.80
Booking Nurse (LPN)	1.40	1.40	1.40	4.20
Booking EMT	1.40	1.40	1.40	4.20
Mental Health Professional (Psych RN)		1.00	2.10	3.10
<b>TOTAL</b>	<b>22.10</b>	<b>9.40</b>	<b>7.70</b>	<b>39.20</b>

The level of staffing established for the jail is adequate for the delivery of services, given the current intake volume and average daily population for the facility, and is consistent with the resources required to maintain operational compliance with NCCHC standards. To attain this level of performance, health care staffing levels in the Jail are somewhat higher than in jails that do not meet NCCHC requirements. The following table compares health care staffing ratios in Montgomery County with other mid-size county jail systems. None of these other systems has attained NCCHC accreditation.

County	Jail ADP	Health Care FTEs	# of Inmates per Health Care Staff
Montgomery, OH	822	39	21.1
DuPage, IL	789	30	26.3
Marion, OR	672	17	39.5
Pierce OR	1,150	36	31.9
Wake, NC	1,300	35	37.1
Waukesha, WI	559	11	50.8

While the level of staffing in the Jail is generally adequate, with the few exceptions noted in this report, the type of staff utilized may require review. The staffing pattern used in the Jail relies on the lowest acceptable level of professional credentialing for the specific job duties required. For example, the Jail's current practice utilizing LPNs to perform sick call assessments could conflict with the Ohio State Nurse Practice Act, as it may require licensed practical nurses to act beyond the scope of their license. In most jails, LPNs assist in and participate in assessments but do not perform an independent assessment, which is only within the scope of duties of registered nurses. This issue should be assessed in the context of the requirements of the Nurse Practice Act. (See Recommendation 5)

## **INTAKE PROCESSING**

Access to healthcare services begins with the arrival of the inmate into the correctional system and the accompanying screening process. In addition to assessing obvious issues, such as injury, intoxication, or physical impairment, jail staff has affirmative responsibility to identify and document an inmate's health care status so that issues such as communicable diseases, suicidal tendencies, and continuity of ongoing treatment receive timely and appropriate responses. The objective here is to collect enough information to establish significant health concerns that may require immediate attention in order to avoid medical emergencies. These data form the basis of the inmate's medical profile and record, which will follow him/her throughout his/her incarceration. Following the initial intake screening, the inmate should receive a more detailed health assessment and examination within 14 days of admission to establish a complete medical history.

The key to an effective intake process is to ensure receipt of accurate, complete medical information from each inmate entering the system. NCCHC standards require that a trained health care professional conduct the initial assessment and the follow up exam received by each inmate. In most large jails, a trained registered nurse performs this assessment of medical needs. The screening consists of a series of questions that allow a determination as to the presence of acute problems, chronic problems, required medications, suicidality, other mental health problems, dental problems, mobility and other ADA issues, and any other issue that might affect the management of the inmate. If problems are identified, the patient should be seen by an advanced level health care provider, or at a minimum, an advanced level provider is contacted for instructions regarding the next step.

Montgomery County uses paramedics to perform this function. Although paramedics are highly skilled at responding to emergencies, performing an intake assessment is a slightly different responsibility. The preferred option would be staffing the intake with an RN, 24 hours per day, seven days per week, who is responsible for the plan and disposition of the newest intakes. (See Recommendation 6) There should also be criteria according to which patients, based on their clinical data, are determined to require a history and physical by an advanced level provider within either 24 hours, 72 hours, or seven days, depending upon the level of acuity they display. For example, complex medical problems such as type 1 diabetics or poorly controlled diabetics, hypertensives, and asthmatics should be designated acuity level 1 that requires the history and

physical within 24 hours. Acuity level 2, applicable to all other patients with chronic problems, should have a history and physical performed within 72 hours of intake. Acuity level 3, which requires a history and physical within seven days, would apply to those patients where there is a diagnostic question that needs more data points to resolve, such as daily blood pressure monitoring or finger stick monitoring. (See Recommendation 7)

The intake process also includes a recently implemented pre-booking screen, performed by an LPN. This process diverts people to an emergency room for medical clearance if they are in a state that is determined to be not acceptable in the jail. This is a common methodology used to deflect people who are potentially beyond the capabilities of jail health care services.

## **QUALITY ASSURANCE**

Peer review is a critical component of an effective quality assurance system. Current Jail procedures requires that the HSA, Director of Nursing, or other qualified designee conduct a biweekly review of 10% of the sick call health records of physicians, advanced clinician providers, nurses, mental health staff, and dental staff. This system is not consistent with accepted professional practices for the conduct of peer review. As a general principle, only a clinician should review the records of other primary care clinicians, dentists should review the documentation and performance of dentists, and mental health staff should be reviewing the provision of mental health. (See Recommendation 8)

## **MENTAL HEALTH CARE**

Coordination between the mental health and medical programs has reportedly not been effective for some time. The splitting of this responsibility between two contractors, with no means to establish an effective working relationship does not serve the best interests of providing effective health care. No one provider is looking at the overall condition of an individual patient, encompassing both medical and mental health conditions. The nursing staff caring for mentally ill individuals typically does not have access to the mental health record, thereby limiting their knowledge of the mental illness of the person under their care. A system of communication between medical and mental health providers needs to be developed to ensure a holistic approach to the patient and continuity of care. Communication is difficult and recordkeeping inefficient due to the need for multiple medical records. Further, overall care and treatment planning is handicapped by the lack of a common vision or plan that coordinates both mental and medical health services into a balanced, comprehensive health program. The plan for NaphCare to assume responsibility for both the medical and mental health programs as of January 1, 2019 will be a positive step in addressing these issues.

## **RECOMMENDATIONS**

- 1. Add 1.5 LPN FTEs to comply with new NCCHC sick call standards for the timely review of sick call requests.**
- 2. Plans for expansion or replacement of the current jail facility should include a professionally equipped examination room in each of the housing units as well as in the clinic area.**
- 3. Create a process for triage review of sick call cases on second shift to enable identification and treatment of emergent cases.**
- 4. Establish criteria for referrals to counseling for inmates who refuse their medication.**
- 5. Assess current LPN job responsibilities for compliance with the Ohio Nurse Practice Act.**
- 6. Add 4.2 RN FTEs to current intake staffing to manage health care screening dispositions currently conducted by paramedics.**
- 7. Establish criteria for the urgency of the history and physical based on the data collected during intake.**
- 8. Utilize peer evaluators to provide quality assurance reviews, consistent with each profession.**
- 9. The Jail and its contracted provider for medical/mental health services should provide orientation for all their employees, to include jail facility orientation. This orientation would be a coordinated effort to train employees.**
- 10. It is recommended that an annual institutional review of the use, secure tracking, documentation and distribution of controlled medications should occur within the correctional facility.**

# 10. Mental Health Care

**SCOPE OF INQUIRY:** Are the inmates in the Montgomery County Jail receiving the mental health, addiction and health services needed and in a timely manner? Handling persons with mental illness and addiction issues has become a distinct point of attention in the Jail. Due to lack of adequate or effective treatment for mental illness and addiction, events even including completed suicides have occurred. One of the most critical and important issues in the jail is the number of completed suicides in the past few years. The policies and procedures are to help employees deal with persons who are mentally ill and pose a risk of harm to themselves or others. This report is divided into three main areas: facility, continuity of care, and mental health and addiction treatment.

It should be noted that this review took place prior to the new contract with the Jail's healthcare provider, Naphcare, on January 1, 2019. Under the new contract Naphcare replaces Samaritan Behavioral Health (SBH) for provision of mental health care. With these changes, and the addition of new staff, the Jail is in a position to make changes according to the recommendations in this report, as well ensure a better integration of medical and mental health care services.

## **FACILITY DESIGN**

The facility is poorly designed with no space for mental health services or consultation. Mental health staff members are crowded into one office space. Psychiatric consultation and mental health evaluations are generally performed cell front, leading to a lack of confidentiality and impediments to full engagement with the individual participating in the consultation. There are no camera systems to allow for monitoring of individuals housed in suicide watch cells, segregation, or on single cell tiers. In addition, the cells in segregation have bars, which is a significant safety risk due to the increased risk of self-injury for individuals housed in segregation.

There are four cells in the intake and booking area designated for individuals requiring suicide precautions, two for males and two for females. The area where these cells are located is busy, stimulating, and without privacy. Individuals garbed in suicide safety smocks are in full view of other individuals.



## **CONTINUITY OF CARE**

### **1. Systems Issues**

Reportedly there are 11 different courts referring individuals to the Montgomery County Jail. Many of the court systems are not aware of what services the jail system can or cannot provide to individuals. Apparently, the courts can be demanding and make requests that are either impossible to fulfill or are a significant resource drain.

The system external to the jail tends to overuse the jail system in lieu of accessing community resources. For example, on the first day of the visit, there were 173 individuals in the facility due to probation violations. An intermediate step that could be utilized prior to admission to the jail, such as a day reporting center, could reduce this number, thus reducing overcrowding at the facility. In another example reported, the courts have sent individuals to the jail facility in order to access substance detoxification. This is a service that can and should be accessed in the community.

In an effort to address the inappropriate referrals and communication with the court systems and to improve inter-facility communication between corrections, mental health providers, and medical providers, the facility hired a treatment coordinator. The current individual in this position is well versed in the available community resources and an excellent source of information to the jail system providers.

### **2. Intake/Screening**

Observations of the intake/screening of individuals entering the facility revealed that individuals were queried multiple times regarding suicidal ideation or mental health histories. Unfortunately, these queries were not performed privately, reducing the likelihood that individuals queried were forthcoming or honest regarding their ideations. When individuals reported a history of mental health treatment in the community, intake staff members were noted to request medical records or call the dispensing pharmacy to obtain information regarding prescribed medications so that a gap in medication administration could be avoided.

The facility admits and processes a large volume of individuals who are engaging in substance use. Currently, toxicology screens are only performed on individuals who report substance use in the previous five days or for women who report possible pregnancy. This allows for individuals to slip through the cracks and avoid identification of substance use disorders.

Interviews with facility medical, mental health, and correctional staff revealed marked communication issues between the entities, with a lack of collaboration and integration. There were monthly mental health team meetings including members from SBH, NaphCare, and corrections, where “high risk” individuals were reviewed, these meetings were of limited utility given the overall issues between the agencies and the lack of services. While some of the communication issues were the result of “turf” battles between NaphCare and SBH, other issues were related to the charting/documentation programs. For example, corrections staff utilize

Tiburon and NaphCare staff utilize an electronic medical records program, TechCare. SBH staff members enter information into both records. Much of the information regarding suicidal behavior and suicide watch status is documented in Tiburon, a program that NaphCare reportedly has limited ability to access.

Furthermore, the lack of integration between medical and mental health staff reportedly resulted in issues with access to care. For example, there was an individual who was assessed by SBH mental health staff as reporting auditory hallucinations. There was no follow-up recommended and this individual was not referred to psychiatry.

There have been increased episodes of violence. Given the lack of psychiatric clinical resources and the perceived need to reduce the use of regularly prescribed medications, there is cause for concern that the facility was relying on or overusing crisis psychiatric medications and/or physical restraints.

For the year 2017, data revealed a total of 247 incidents of inmate/inmate assault with the first eight months of 2018 showing a lower incidence at 78. It was not clear if mental health issues were contributing to these incidents of assault, as the data were not reported in a manner to determine this. What was interesting, and perhaps predictive of the issues was the use of the restraint chair. For the year 2017, the restraint chair was utilized 77 times, for an average of 6.4 times per month. For the first eight months of 2018, the restraint chair was utilized 57 times, for an average of 7.1 times per month (cf. Justice Committee report on Use of Force.) In addition, in just the month of August 2018, four individuals received emergency/crisis psychotropic medication via an intramuscular injection. These data are concerning. Improvements in psychiatric care and the mental health system could reduce the reliance on these restrictive and inappropriate methods of dealing with mental health crises.

### **3. Staff Recruitment**

Both SBH and NaphCare had vacancies in mental health staff positions. Both entities reported difficulties in staff recruitment due to safety concerns and the reluctance of potential employees to work in a correctional environment. These are issues that are common to correctional health care providers.

### **4. Quality Assurance**

The facility has limited quality assurance measurements performed, and those that are, are limited to the requirements of their National Commission on Correctional Health Care (NCCHC) accreditation. In June 2017, the facility was found not in compliance with requirements for suicide prevention, intoxication and withdrawal, storage of controlled medications, and care for segregated inmates. Reportedly, these deficiencies were addressed, although facility staff members were not able to access information regarding the resolution.

Per the documentation provided, NaphCare did perform one follow-up quality assurance study regarding suicide prevention. Staff interviews indicated that NaphCare has performed quality

assurance monitoring regarding SBH documentation that is entered into the NaphCare electronic medical record since October 2017. Per SBH staff, they were not informed of the results of these quality assurance audits, making them useless for performance improvement. Reportedly, SBH performs peer review of mental health documentation, but results of these audits were not provided

## **MENTAL HEALTH/SUBSTANCE USE TREATMENT**

There are limited options for individuals requiring acute psychiatric treatment. Individuals with acute psychiatric needs are inappropriate for the jail facility and require resources such as psychiatric treatment and mental health services that are not available at the jail facility.

The Jail can refer such individuals to an inpatient psychiatric hospital in Cincinnati. However, there is a long wait for admission, as there are limited beds and the facility serves a total of 11 counties. At the time of the visit, there were 82 individuals from the Montgomery County Jail who were receiving inpatient services. Another issue is ongoing psychiatric and mental health care once the hospitalized individuals are stabilized and returned to the jail facility.

### **5. Mental Health Services**

There were no mental health services occurring at the facility beyond crisis assessment. Conversations with SBH providers indicated that per their contractual agreement, they were only to provide “crisis” services and response inclusive of assessing individuals for the need for suicide precautions and for the need for emergent psychiatric hospitalization (e.g. “pink slip”). Although the SBH staff members performed the required mental health evaluations of identified individuals within 14 days of admission and every 90 days thereafter, these evaluations were scant, devoid of detail, did not consistently include a review of symptoms. None of the examples reviewed included diagnoses and overall, the evaluations were not clinically useful.

It was concerning that the SBH staff indicated they were not aware of the NCCHC requirements for a full mental health assessment for individuals requiring mental health services within 14 days after identification. SBH staff leadership was concerned that if a full evaluation was performed, and treatment needs were identified, this would trigger the need for treatment that was not currently available.

There were currently no daily mental health rounds performed in administrative segregation. Interviews with individuals housed in administrative segregation indicated they had not seen a mental health provider on their unit in over a week. Discussions with correctional staff indicated that SBH staff members were seen on the administrative segregation unit two to three times per week, but that they did not regularly sign the visitor’s log. Interviews with SBH staff indicated that administrative segregation rounds were scheduled and occurred weekly, with the interactions occurring at the cell front.

SBH staff members were responsible for responding to “kites” or requests for mental health intervention from individuals. There was a list of “kites” pending response, with some waiting over seven days. Even so, as no ongoing mental health services were available, the response would not generate ongoing treatment or follow-up.

## **6. Psychiatric Services**

Psychiatric services are provided via NaphCare. There is currently one psychiatrist, providing nine hours of clinical services per week. These services occur on the weekends. A psychiatric nurse practitioner provides 40 hours of clinical services per week.

Staff interviews revealed a lack of coordination between psychiatry services and mental health services provided by SBH. The assessment evaluations performed by SBH staff were brief, devoid of detail, did not include diagnostic information, and were reportedly useless to the psychiatric providers.

Given the paucity of psychiatry clinical resources, the psychiatrist reported relying on very brief evaluations, less than ten minutes, performed cell front. It was estimated that during a nine-hour scheduled clinic, the psychiatrist saw approximately 35 individuals. As such, these psychiatric clinics were triage based. Medical records reviewed and the interviews performed revealed that medication initiation and dosage adjustments often occur in the absence of clinical evaluation of an individual. This was justified as “because if we don’t, we can’t keep up.”

There was concern that budgetary issues, specifically the clinician’s perceived need to reduce costs of psychotropic medications, were negatively influencing prescribing practices and impeding care. Clinicians reported that with reductions in the use of regularly prescribed medication there have been increased episodes of violence. Given the lack of psychiatric clinical resources, and the perceived need to reduce the use of regularly prescribed medications, there is cause for concern that the facility was relying on or overusing crisis psychiatric medications and/or physical restraints.

NaphCare staff members are responsible for determining the need for suicide precautions and for the discontinuation of suicide watch. It was documented that individuals requiring suicide precautions were in need of “stabilization,” but there was no mental health treatment provided other than medication. Following the discontinuation of suicide watch, there was no mechanism for follow-up care or ongoing mental health services. In fact, three separate staff interviews discussed concerns that the lack of post-suicide watch follow-up may have contributed to a recent death via suicide.

Per the facility staff, there were a total of four completed suicides between August 2017 and August 2018. Data provided by the facility via the Significant Injury Summary Report for January through May 2018 indicated there had been two completed suicides, one incident of a suicide attempt, and 150 suicide gestures. This is likely an under reporting of the suicide attempts in the facility. Conversations with facility staff indicated that they classify a suicide

attempt as occurring when an individual requires “medical treatment.” Suicide gestures are classified as when an individual makes a “statement” regarding suicidal ideations.

The National Commission on Correctional Health Care survey in June 2017 indicated that the facility was not in compliance with their requirements for the Suicide Prevention Program. Further quality assurance documents provided for review indicated that issues remain. For example, per the quality assurance monitoring performed for the month of May 2018, the facility noted an overall compliance of 71%. The results revealed two areas with compliance levels less than 90%, specifically that all inmates on suicide watch have a completed risk assessment form resulted at 22%, and that a mental health evaluation is completed by a trained mental health professional resulted at 45%. There was no documentation of corrective action performed as a result of this quality assurance study, although the study recommended corrective action stating, “Health Services Administrator and Assistant Health Services Administrator to meet with SBH supervisor to discuss training of SBH mental health staff and correct procedure for filling out forms.” There was no documentation provided indicating that this occurred.

Overall, the data reviewed indicated significant issues with regard to suicide prevention and highlighted the need for corrective action regarding the suicide prevention program at this facility.

In response to this deficiency the Sheriff’s Office commissioned a report by Lindsay M. Hayes of the National Center on Institutions and Alternatives on suicide prevention practices. This report was issued on December 28, 2018. The summary of its recommendations is attached as an appendix to this report, and the implementations of these recommendations should be monitored.

## **7. Substance Abuse Treatment Services**

The facility has a medical detoxification program, with anywhere from 35 to 75 individuals receiving detoxification services at a given time. The facility engaged the services of two peer support staff (one male, one female). These staff members made positive strides with regard to promoting participation in substance abuse treatment. There were limited Narcotics Anonymous (NA) and Alcoholics Anonymous (AA) groups operating in the facility along with other recovery groups provided via faith-based organizations, as well as one anger management/conflict resolution group. Given the volume of individuals requiring detoxification services, there was a need for expansion with regard to the availability of substance abuse treatment opportunities in order to expose individuals to 12-step models and engage them in treatment.

The facility has secured a contract for samples of Vivitrol medication for use by opioid addicted offenders. If an inmate is interested, NaphCare provides programming to educate them on medical assisted treatment. NaphCare will also provide the first Vivitrol injection prior to release.

## **8. Discharge Planning**

The facility recognized the need for discharge planning, and made some attempts to provide assistance to individuals pending discharge, but given the sheer volume of approximately 2500 individuals leaving the facility in a given month, their efforts were nominal. Under a grant from the Bureau of Justice which expired in September 2018, discharge planning was provided in collaboration with SBH and Wright State University to obtain information from and provide resources to individuals with short facility stays. At the time of this review, discharge planning was provided both via Samaritan Behavioral Health and NaphCare, each with two discharge planners. Taken together, the facility performed discharge plans for approximately 300 individuals, indicating that approximately 2200 individuals do not receive any community referrals for resources.

The amended contract with NaphCare effective January 1, 2019 includes three discharge planners to handle the volume of individuals leaving the Jail.

## **9. Medication Administration**

Reportedly, there are significant issues with medication diversion in the facility. Currently, the nurses rely on individuals to identify themselves and show their armband prior to medication administration. The armband did not have a photograph of the individual or a bar code to correspond to the medication administration record, allowing for error. In addition, there were reportedly no regular mouth checks performed other than for those individuals receiving medications via a detoxification protocol.

## **RECOMMENDATIONS**

**The following recommendations are listed in the order of importance as viewed by the Committee. First on the list is the facility and our recommendation to enhance the ability to offer effective and efficient mental health and substance abuse services. The second recommendation is identified as Continuity of Care, with a special emphasis on suicide prevention in the jail facility. These recommendations are suggested to enhance compliance with accreditation standards and oversight of services offered to inmates. The third recommendation is treatment of mental health and substance abuse issues. This is imperative in offering programming and services relating to ongoing continuity of care. Also, the risk of suicides in the jail and the completed suicides by recent history make this on of the most serious issues.**

## **FACILITY**

- 1. The facility should consider renovations to their current physical plant to decrease the reliance on barred cells. Instead, the facility should offer Plans for expansion or replacement of the jail facility should include a confined crisis stabilization/acute psychiatric care unit. This unit would include a full capacity triage, appropriate**

screening for mental health issues beyond self-reporting and per National Commission on Correctional Health Care (NCCHC) standards. The design should include stays of 1 to 5 days for medical detoxification of illicit drugs, as well as stabilization of those suffering acute psychiatric episodes. The area may be dedicated inside the current facility or in a separate facility, reporting that those in active detox still total, on balance more than 50 inmates on any given day and that the administration of psychotropic medications, due to increased funding from the Stepping Up initiative has doubled in the last year. A facility such as this would, space permitting, also enable local competency restoration for defendants who currently wait in the jail for a bed in a state hospital from 2 to 5 weeks. Finally, this facility would provide a healthful solution to the suicide issues in the jail.

2. Designated space for intake, screening, mental health services and psychiatric services is necessary. This space should be private, allowing for confidentiality.
3. The use of monitored camera systems and adequate staffing are recommended for continued surveillance.

#### **CONTINUITY OF CARE**

1. There is a need for a comprehensive quality assurance program inclusive of regular and corrective actions. The quality assurance would encompass requirements for NCCHC auditing and reviews of medical and mental health services to ensure the provision of appropriate services.
2. Ensure that all medical and mental health providers have access to the same documentation systems. As of 1/1/19 all of the providers of care will be sharing the same system. Further, improved record keeping and sharing of the same, enable the implementation of improved discharge planning for immediate assimilation with treatment providers and physicians, medication administration, housing assistance, education and vocational training.
3. In order to improve recruitment of quality mental health staff, the facility could consider engaging local educational institutions by offering clinical rotations for medical interns/residents, and social work/counseling students. This, along with the development of a mental health treatment environment, could help to dispel negative community perceptions and improve the recruitment of staff.
4. Staffing issues have been identified by the consultants and are crucial to mental wellness addiction issues and primary medical issues in the jail. While crisis stabilization adequately staffed might solve some of these issues, ongoing medical issues as well as detection of decompensation or mental health medication and monitoring of any developing suicidal ideations, require an enhanced clinical staff. Telemedicine provides a useful, more affordable means to enhance physician

staffing. Further, attention should be given to the consultant's criticism that staffing is comprised of the "lowest acceptable level of professional credentialing for the specific job duties required, particularly regarding assessments".

5. Provide education to the 11 referring courts regarding psychiatric and mental health services available at the Montgomery County Jail. Continue the fulltime position of treatment coordinator in the jail. Encourage more transparency regarding mental health or substance abuse beds available in the community.
6. For individuals returning to the Montgomery County Jail from inpatient psychiatric treatment, there is a need for ongoing mental health treatment. Given the volume of individuals requiring inpatient treatment, the facility should consider establishing a mental health unit, a program that could address the overall fragmented care within the facility with counselors to offer individual and group counseling for follow-up.

#### **TREATMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS**

1. The facility needs to provide intake, assessment, suicide evaluation, response to requests for services, mental health follow-up, monitoring of individuals in segregation or single cell tiers, and ongoing mental health care. The staff hired at the jail need to liaison with the medical and correctional staff to provide timely and integrated services.
2. The facility should consider a program where the individuals are provided an armband with their photograph and a corresponding bar code that can be scanned in order to confirm their medication prescriptions. In addition, in an effort to further prevent the diversion of medication and to ensure adherence to regimens, mouth checks must be performed for all medication administration events.
3. The facility should consider toxicology screening on all facility admissions. The cost is influential in that decision but could improve quality of care and getting inmates the treatment that they need timelier. This could decrease the number of preventable medical emergencies.
4. The facility has limited psychiatric resources. In order to increase the availability of mental health providers, they could consider the use of telemedicine. It also offers a useful, more affordable means to enhance the physician staffing.
5. The Montgomery County Jail could consider a contract with an inpatient psychiatric facility for acute treatment needs and stabilization.
6. The Jail should significantly increase discharge planning to accommodate more inmates in need of mental health and other re-entry services after release.



## CONSULTANT NOTE ON REVIEW PROCESS

This review of jail mental health service was based on interviews with facility correctional, medical, and mental health care staff, including the facility treatment coordinator, Health Services Administrator, facility psychiatrist, Samaritan Behavioral Health staff, discharge planning staff, intake/assessment staff, and peer support staff. Observations of the intake process and psychiatry rounds were also performed. In addition, individual inmates were observed and interviewed. Staff members interviewed were welcoming and appeared candid regarding the limitations and issues associated with the provision of mental health services in the current system.

Documents requested, received, and reviewed include the following:

1. The facility census and average length of stay.
2. The names of individuals requiring suicide watch status for the two weeks prior to the visit.
3. The names of individuals administered emergency psychotropic medications in the 30 days prior to the visit.
4. Intake screening and intake assessments for a sample of five individuals.
5. Mental health evaluations for a sample of five individuals.
6. Data regarding the quantity of mental health screening, mental health evaluation, and psychiatric evaluations for the month 7.27.18 through 8.27.18.
7. Supervision schedules for unlicensed mental health staff.
8. National Commission on Correctional Health Care Accreditation Report of the Health Care Services at Montgomery County Jail dated June 30, 2017.
9. NaphCare Suicide Watch Prevention Quality Improvement Study dated May 2018.
10. Samaritan Behavioral Health and NaphCare list of curriculum of mental health staff training and attendance logs.
11. Interdisciplinary Mental Health meeting minutes dated July 5, 2018 and August 1, 2018.
12. Jail Commander daily report for 8.21.18.
13. Significant Incident Summary Reports for 2017 and for 1.1.18 through 5.23.18.

14. Psychiatric and mental health staffing plan entitled Jail Based Behavioral Health Services Inventory.
15. Written description of psychiatric and mental health services available in the Montgomery County Jail entitled Jail Operations Study-Mental Health.
16. Policy and Procedure entitled “Suicide Prevention” effective 10.22.12.
17. NaphCare Health Care Policy and Procedure entitled “Intoxication, Withdrawal, and Detoxification” effective 9.19.14. This included information and protocols regarding treatment with Buprenorphine and Vivitrol.

During the visit, the facility census was 843 individuals. The Montgomery County Jail is a busy, crowded inner city jail facility. The average length of stay in the facility in 2017 was 19.59 days for individuals charged with a felony and 6.14 days for individuals charged with a misdemeanor. The facility performs a large number of intake assessments. For example, the total number of intake screenings performed from 7.27.18 through 8.27.18 was 1904. There were 402 mental health evaluations and 37 psychiatric evaluations performed during this same period of time.

At the time of the visit, medical services inclusive of psychiatry (e.g. psychiatrist and psychiatric nurse practitioner) were contracted through NaphCare. In addition, NaphCare employed one discharge planning staff. NaphCare had an open position for a mental health treatment provider. Samaritan Behavioral Health (SBH) was contracted to provide “crisis” mental health services, consisting of screening individuals and providing crisis response. SBH staff determined if individuals required enhanced levels of supervision (e.g. suicide watch status) or if individuals could be downgraded from suicide watch status, but this did not include follow-up.

Under a new contract, since January 1, 2019 NaphCare has assumed responsibility for all mental health services in the Jail.

# 11. Inmate Programming

**SCOPE OF INQUIRY:** Are inmates afforded access to effective education and programs that afford them the opportunity to improve their abilities and skills necessary to change their behavior and become successful upon release?

Comprehensive and effective programming in a jail not only benefits individual inmates but can benefit the entire criminal justice system and the community by assisting inmates in their effort to be successful upon release.

## NATIONAL STANDARDS BEST PRACTICES

The American Correctional Association (ACA) has detailed standards regarding inmate programming in jails. A highlight of key ACA inmate program standards includes:

4-ALDF-5A-01: Inmate programs and services are available and include, but are not limited to, social services, religious services, recreation, and leisure time activities.

4-ALDF-5A-02: The plan for inmate programs and services provides for identification and use of available community resources.

4-ALDF-5A-03: Staff are available to counsel inmates on request; provision is made for counseling and crisis intervention.

4-ALDF- 5A-04: Inmates with drug and alcohol addiction problems are provided with substance abuse programs including monitoring and drug testing.

4-ALDF-5A-05: There is a treatment philosophy within the context of the total correctional system as well as goals and measurable objectives. These documents are reviewed at least annually and updated as needed.

4-ALDF-5A-06: There is an appropriate range of primary treatment services for alcohol and other substance abuse inmates that include, at minimum, the following:

- Inmate diagnosis
- Identified problem area
- Individual treatment objectives
- Treatment goals

- Counseling needs
- Drug education plan
- Relapse prevention and management
- Culturally sensitive treatment objectives, as appropriate
- The provision of self-help groups as an adjunct to treatment
- Prerelease and transitional services
- Coordination efforts with community supervision and treatment staff during the prerelease phase to ensure a continuum of supervision and treatment.

4-ALDF-5A-09: Inmates have access to educational programs and, when available to vocational counseling and vocational training. Educational and vocational programs address the needs of the inmate population.

4-ALDF-5B-01: Sufficient space is provided for inmate visiting.

In addition to these standards ACA also identifies expected practices for access to mail, telephone, recreation, library services, religious services and a commissary/canteen.

We note the 2016 American Correctional Association Audit found the facility non-compliant in the following program related standards:

4-ALDF-2A-64: Jail did not provide an hour of exercise per day outside of cells for special management inmates. At that time the jail had only one recreation officer and were exploring adding an additional recreation officer. The additional recreation officer has since been hired.

4-ALDF-5C-01: Similarly, the jail did not provide one hour of exercise per day outside of cells for general population inmates. The facility has since hired an additional recreation officer to correct this issue.

The following standards were found non-applicable during the ACA audit:

4-ALDF-4C-37: The jail did not offer a chemical dependency treatment program.

04-ALDF-5A-07 and 08: The jail does not offer a therapeutic community or coordinated approach to deliver treatment programs.

## **MONTGOMERY COUNTY JAIL POLICY**

There are three jail policies that specifically address inmate access to programs and services:

- Inmate Programs (5.22.1): Addresses access to religious, educational, library and recreation.
- Visitation (5.27.1): Addresses access to visitation

- Telephone Use: Addresses access to use of telephones

Additionally, the Prisoner Counseling policy (6.8.1) provides general direction for inmates seeking medical, mental health or pastoral counseling.

## **FACILITY PRACTICES**

In the Montgomery County Jail, programs are coordinated by a Program Coordinator/Chaplain position. Our interview with the Program Coordinator/Chaplain found that the facility offers a significant number of programs provided by outside volunteers, the majority of which are spiritual based. The following is a list of programs provided:

- 12-step program for alcoholics: Provided separately for males and females.
- 12-step program for narcotics: Provided separately for males and females.
- Men's Issues: Men's issues from a biblical standpoint.
- Men's Reflections: Program for men to voice what they are facing.
- Spiritual Solutions: Provided separately for males and females substance recovery related program.
- Domestic Violence/Anger Management: provided for male inmates.
- Celebrate Recovery from the Inside: Provided separately for males and females. Merges 12 step program into 8 biblical-related steps.
- Job Readiness: Provided separately for males and females. Designed to prepare inmates for employment.
- Y.E.S. Program: Program for females with history in the sex industry provided by Oasis House.
- Circles of Recovery: Restorative justice program for females.
- Sacred Stories: For female inmates: Applies biblical teachings to practical life lessons.
- Hope 29:11: For female inmates. Biblical based program to address addictions.
- Women's Issues: Cognitive behavioral therapy for female inmates.
- Conflict Resolution: For female inmates.
- Yoga: Exercise class for female inmates.
- Abigail's Journey: Assists women and low-income families to reach independence through self-sufficiency.
- Montgomery County Ex-Offender Re-Entry: provides re-entry support to inmates.
- Alcohol and Other Drug Peer Support: Provides one-on-one sessions with inmates to discuss substance abuse issues, provides education regarding available community resources and assists in setting up referrals/services upon release.
- Vivitrol Availability: The facility has secured contract for samples of vivitrol medication for use by opioid addicted offenders. If an inmate is interested, NaphCare provides programming to educate them on medical assisted treatment and provides a formal

medical assessment. NaphCare will also provide the first Vivitrol injection prior to release.

- A volunteer GED tutoring program is provided by the University of Dayton and offered from August through May of each year. The tutoring program provides GED instruction and testing and varies in number of participants from 3 to 20 inmates.

A daily schedule of program activities is provided by the Program Coordinator/Chaplain. Weekly program attendance statistics were also provided from November 2016 to June 2018. During that time weekly program attendance typically ranged between 200 and 400 inmates.

The facility has attempted to address substance reentry planning and case management through alternative funding sources. In 2018 Sheriff's Budget requested an Inmate Outreach Coordinator; however, this position was not funded by the County. The Sheriff's Office has since secured funding for this position from an alternate source, and is working on recruiting and filling the position. The position will develop and maintain links with community human services providers, and other agencies and organizations.

Two case manager positions are funded by an Alcohol, Drug Addiction and Mental Health Services (ADAMHS) contract with Samaritan Behavioral Healthcare. Two additional case managers were provided through a Bureau of Justice grant that expired in September 2018. Also, the jail is working with the Wright State School of Professional Psychology to develop a parenting class for offenders.

However, given limited funding levels, there are no full-time jail staff assigned to provide support to the programming needs of the inmates other than the Program Coordinator/Chaplain and two recreation officers. There is no funding for in-house substance abuse or other comprehensive educational programs.

Jails of this size typically have counseling staff responsible for assessing inmate needs and assisting them in conducting group and individual counseling as well as case management. By comparison, the Berks County Jail in Pennsylvania houses nearly 1,200 inmates and has 16 counselors on staff who are responsible for both conducting the initial risk/needs assessment as well as providing individual and group counseling. The Lucas County, Ohio jail has over 400 inmates and has 17 counselors dedicated to both initial classification and case planning for inmates. Without the funding for these staff, Montgomery County is unable to provide services such as conducting risk/needs assessments nor offer a significant amount of case management and treatment programming. Inmate risk/needs assessments such as the Level of Service Inventory-Revised (LSI-R) or the Ohio Risk Assessment System (ORAS) are beneficial in identifying offenders' risks of reoffending and pinpoint specific treatment needs that can reduce these risks.

## **RECOMMENDATIONS**

- 1. The budgetary limitations of the jail have a direct impact on the number and scope of programs provided and the lack of program staff on board. Jails of this size typically have a contingent of counseling and program staff dedicated to coordinating and delivering effective programs to the inmate population.**
- 2. Jail staff should be commended for offsetting the lack of funded programs through the recruitment of a large number of volunteer-directed programs as well as the development of targeted programs supported through alternate funding sources.**
- 3. Funding should be provided to significantly increase counseling and program staff and to provide evidence-based programming for counseling and addiction recovery. Further partnering with outside community organizations for provision of services is also recommended. A screening process should be introduced for volunteers offering programs within the Jail.**

## 12. Compliance

**SCOPE OF INQUIRY:** Are there sufficient processes in place for inspections and audits, both internally by Sheriff's personnel and externally by state and national auditing entities, to ensure compliance with laws, policies, and local and national standards?

### **OHIO DEPARTMENT OF REHABILITATION AND CORRECTIONS BUREAU OF ADULT DETENTION**

The Bureau of Adult Detention is responsible for auditing to ensure local jail compliance with Minimum Standards for Jails in Ohio. In accordance with ORC 5120.10 and OAC 5120:1-7-01, the Bureau is responsible for:

- Creation of minimum standards for jails
- Investigation and supervision of county and municipal jails and workhouses.
- Inspection of jails to ensure compliance with the "Minimum Standards for Jails in Ohio".
- Approval of plans for the renovation or new construction of jails, workhouses, and municipal lockups.
- Assistance with acquiring funds for the construction and renovation of county, multi-county/municipal jails or workhouses.

The Bureau conducts, at a minimum, an annual review of jail performance in Montgomery County with regard to compliance with the minimum standards referenced above. The most recent Bureau audit reviewed for this report was conducted in 2016. The audit focused on selected standards in the following areas: reception and release, classification, security, housing, sanitation, environmental conditions, communication, visitation, medical and mental healthcare services, food service, recreation and programming, inmate discipline, administrative segregation, grievance, staffing, and staff training. During that audit the census at the jail was 791 inmates. The audit indicated that the recommended housing capacity for the jail is 443 based upon total living space and requirements, thus indicating that the facility was severely overcrowded at that time.

The Jail was determined to be in compliance with the majority of the Ohio Minimum Standards. Issues identified as noncompliant mostly relate to overcrowding and insufficient living and recreation space. Additionally, noise levels exceeded recommended decibel levels and evening lighting levels did not meet standard requirements. The audit made clear that standards noted as



Essential Standards were in total compliance. A total of eight important standards were found not in compliance. The audit suggested that a plan of action be developed to come into compliance with all standards.<sup>6</sup>

## **GRAND JURY INSPECTIONS**

Ohio Revised Code (ORC) 2939.21 requires grand jurors to visit the County jail on a quarterly basis to examine its condition and inquire into the discipline and treatment of inmates, their habits, diet, and accommodations. They shall report on these matters to the Court of Common Pleas in writing. The Clerk of Court of Common Pleas shall then forward a copy of the report to the Ohio Department of Rehabilitation and Corrections.

Six of the most recent grand jury reports were reviewed to determine the opinion of the grand jurors as to the condition of the jail with regard to the above-mentioned issues. Participating grand jurors are asked to rate the following as either “good”, “adequate” or “poor”: inmate accommodations, inmate activities and treatment, inmate meals, condition of jail, general cleanliness, inmate discipline, and inmate grievance process. There is also a section on the form for comments or suggestions. The majority of the ratings reviewed fall into the category of either good or adequate. There are few poor ratings. The main concerns referred to the condition of the physical plant and maintenance. Plumbing issues, roof leaks, and airflow concerns were registered by a number of the jurors. Also, in a few instances concern was raised about the need for more mental health programming and services. The inspections do seem cursory and are conducted by citizens who generally have little knowledge of correctional operations. Nonetheless, it appears that the quarterly inspections are occurring as required according to the Revised Code.

## **COMMISSION ON ACCREDITATION FOR CORRECTIONS (CAC) OF THE AMERICAN CORRECTIONAL ASSOCIATION (ACA)**

Accreditation by the American Correctional Association is the gold standard when measuring correctional performance. The standards were first issued in 1974 and are revised and updated annually to ensure that the best possible practices are included. The standards require correctional organizations to meet performance-based objectives. This is done through the establishment of policies and procedures which guide practices consistent with the national standards. The determination of accreditation is an elaborate process that tests the professionalism and performance of correctional organizations. Facility staff must prove to the reviewers/auditors that the practices stated in policy are actually carried out by staff on a daily basis, and there are over 300 standards to meet in the process. The standards relevant to the Montgomery County jail are the Performance Based Standards for Adult Local Detention Facilities, Fourth Edition (4-ALDF), which were established in June 2004 and are updated annually.

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<sup>6</sup> Bureau of Adult Detention letter to Sheriff Phil Plummer, Subject: 2016 Annual Jail Inspection, Stephen Holland, State Jail Inspector.

The Montgomery County Jail is an accredited facility, meaning that it has passed all mandatory standards and at least 90% of the remaining non-mandatory standards. Accreditation award letters were reviewed for the 2013 accreditation and for 2017, the most recent. The Audit Report indicated that the facility complied with 59 mandatory standards and 275 non-mandatory standards. Thirteen standards were in noncompliance at the time of the audit. Accreditation was awarded because the facility met 95.4% of the non-mandatory standards.

Noncompliant standards mainly were due to overcrowding at the facility and the inability of the facility to meet space requirements for cell size and recreation areas. Certain standards related to the housing of juveniles were noncompliant as well. A standard related to daily recreation for inmates was also found in noncompliance. The facility's action plan was to hire an additional recreation officer to ensure that inmates received out-of-cell time consistent with the standards' requirements. Another standard found in noncompliance was a requirement to provide an orientation program for new health care staff. An action plan was developed to address the deficiencies in all noncompliant standards other than those related to overcrowding and physical plant deficiencies.

The audit did reveal some concerns registered by staff members regarding use-of-force cases that are now in litigation, the condition of the physical plant (plumbing leaks, mold, air flow) and staffing deficiencies resulting in inadequate staff supervision of inmates. Inmates registered complaints about the physical plant conditions, availability of recreation, adequacy of the law library, and medical care. These concerns were noted, but didn't affect the accreditation. Overall the audit was successful and the facility was awarded accreditation in March of 2017.

### **NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE ACCREDITATION (NCCHC)**

The National Commission on Correctional Health Care is a nationally recognized agency that grew out of a program begun at the American Medical Association in the 1970s. NCCHC developed standards for providing healthcare in correctional institutions. These are recognized as the premier standards guiding healthcare provision in corrections. In 2017 NCCHC conducted an audit of healthcare at the Montgomery County Jail under its 2014 Standards for Health Services in Jails. On June 30, 2017 accreditation was awarded with verification of corrective action on certain standards. Formal accreditation was granted on December 19, 2017 once all conditions were met. Healthcare is currently provided at the jail by a private company, Naphcare.

### **PRISON RAPE ELIMINATION ACT (PREA) AUDIT**

The Federal Bureau of Justice Assistance (BJA) administers the Prison Rape Elimination Act program, which is designed to improve safety of inmates and detainees in jails and prisons across the United States. BJA and other interested parties developed national standards designed to reduce inmate sexual victimization. A facility must comply with 38 standards in order to successfully pass the audit. The standards cover reporting and responding to incidents of sexual misconduct, investigating the misconduct, having in place a system for disciplining staff and

inmates involved in misconduct, providing medical and mental health care to victims, and collecting and examining data related to PREA violations.

The Montgomery County Jail was audited pursuant to the PREA standards in November 2014 and was found to be in compliance with all relevant standards.

## **INTERNAL INSPECTIONS AND AUDITS**

According to standard 4-ALDF 2A-12, supervisory staff are required to conduct a daily patrol of all areas occupied by inmates. Additionally, unoccupied areas are to be inspected at least weekly. The standard also requires that patrols and inspections be documented. According to standard 4-ALDF 2A-13 revised in 2007, written policy, procedure and practice require that the chief security officer or designee conduct at least weekly inspections of all security devices, noting the items needing repair or maintenance. Inspections are reported in writing to the warden/superintendent and/or chief security officer. 4-ALDF-2A-06 calls for the facility administrator and designated staff to visit the facility's living and activity areas at least weekly to encourage informal contact with staff and inmates and to informally observe living and working conditions.

Montgomery County addresses these standard requirements in Jail Manual policy JM 3.9.1 Subject: Searches and Inspections, a policy effective November 13, 2017 issued by Sheriff Phil Plummer.

Section I.1 and 2 call for facility administration visits by the Jail Administrator or Assistant Jail Administrator and the Housing Sergeant to the living and common areas of the jail at least weekly "to encourage informal contact with staff and prisoners and to informally observe living and working conditions". The Major and captains of the Montgomery County Jail stated that the weekly facility walk-throughs do take place, and it was noted that one captain in particular conducts even more frequent visits within the institution. This was corroborated by correctional officers on post. These walk-throughs are not documented as they are considered informal. But captains indicated that they report any observations that need follow-up action.

Section H.1 of the policy mandates that sergeants conduct a daily walk through and "complete a Daily Inspection Sheet for each floor or housing unit documenting any concerns or problems and the corrective actions taken". Three inspection sheets produced during the month of May, 2018 provided evidence for the daily walks. The Daily Inspection Sheet provides a space for comments for each area of the institution and also notes the time the sergeant entered the unit, the time he/she departed, and further notations of any actions taken. The reports suggest that the main focus of the inspection is to note maintenance issues that need to be corrected. There are no notations in the three reports reviewed of inmate security issues.

Section H.3 mandates the completion of a Weekly Inspection Sheet for each floor or housing unit, documenting any security issues, cleanliness issues, and maintenance issues, and relays the information to the pertinent departments. Four Weekly Inspection Reports were reviewed that cover the month of August, 2018. The reports, in an electronic format, call for the reporting

sergeant to note the condition of each housing unit, identifying security, cleanliness and maintenance issues. The reporter is required to note the condition of the area in a number of categories as either “acceptable”, “excellent”, “not applicable”, or “requiring maintenance”. Similar to the daily inspection process, the main focus of the reports is to identify maintenance problems that exist in the aging physical plant. There were few notations regarding security issues that may exist.

## **SUMMARY AND RECOMMENDATIONS**

**The policies and procedures drafted by the Sheriff and his staff are consistent with and compliant with national standards, and have received accreditation by two respectable national accrediting agencies. Furthermore, the facility is inspected at least annually by the Bureau of Adult Detention of the Ohio Department of Rehabilitation and Corrections. Recent audits are favorable and suggest compliance with standards and best practice in corrections. The PREA audit also suggests that proper systems are in place to prevent and investigate sexual misconduct in the jail.**

**The audits also point out a number of areas where corrective action should be taken to ensure ongoing compliance with standards and best practices. These issues noted above will require ongoing attention.**

**The sergeant’s daily and weekly inspections comply with the policy and standards; however, it would be useful to use these tools to also identify security issues that need attention and action. The reports reviewed here seem to lack that focus**

- 1. Areas identified in the ACA audit report that require corrective action should be further addressed. In particular, inmates should be provided with recreation on an ongoing basis. At a minimum, inmates in segregation should receive one hour out-of-cell recreation daily.**
- 2. Consideration should be given to documenting the Jail walk-throughs by administrators. These walk-throughs can provide useful information for the Jail Administrator and the Sheriff indicating facility conditions, staff issues and the mood of inmates and the overall climate of the facility.**
- 3. It appears from examining the daily and weekly sergeant’s reports that the main focus is currently on maintenance and cleanliness issues. It is suggested that an increased focus on security issues be considered. Ensuring that the sergeants are examining security devices, perimeter security, security equipment, fire safety and inmate issues would contribute to the overall security of the facility.**
- 4. The deficient areas related to juvenile offenders should be addressed. The facility is not equipped to provide direct supervision for youthful offenders, nor does it have in place specialized housing, programs, services, or a specialized classification program for youthful offenders. Because the facility is overcrowded and available**

**physical space is needed for adults, it is recommended that the County make alternative arrangements for housing youthful offenders in an ACA compliant housing unit at an alternative location.**

# 13. Compilation of All Recommendations

## JAIL FACILITY

The current facility has the following serious issues:

*Inadequate capacity.* The State of Ohio has determined that the current facility has a housing capacity of 444 beds, roughly half the average daily population managed at the facility. The current level of crowding makes monitoring inmates and the delivery of services extremely difficult.

*Poor design.* The design of the linear units makes effective inmate supervision impossible. The pod units have a decent design, but the level of crowding there likewise makes supervision difficult. There is no ability to maintain adequate sight and sound separation for juveniles housed at the facility.

*Inefficient Operations.* The booking area is not sized or designed to facilitate the processing of the current volume of offenders entering the facility, and does not allow for appropriate management of offenders with special needs.

*Lack of Program Space.* Existing program space in the pod units has been converted to dormitory housing. There is virtually no other dedicated program space in the facility, and no space for private treatment of inmates. The medical unit lacks adequate examination rooms and no examination rooms are available on the housing units.

*Physical condition.* Facility building systems are deteriorating and will require increasing levels of funding to assure ongoing operation of the facility.

The Montgomery County Jail facility does not provide a minimally adequate environment for staff or inmates. Renovation or remodeling to address the many problems with the facility is neither practical nor cost-effective. The County should commence planning for the ultimate replacement of this building with a modern correctional facility that can house offenders in a humane manner, provide needed program services, and afford staff and inmates a safe environment.

In the meantime, to improve environmental conditions in the current facility, it is recommended that adequate maintenance and janitorial staff be added to the Jail staff, including a full-time plumber, a 24-hour maintenance crew, and additional janitorial staff to supplement inmate workers.

## **JAIL OPERATIONS AND STAFFING**

As noted in the Staffing report, we recommend the creation of essential intermediate levels of supervision within the Jail. This would include:

1. reestablishing the lieutenant rank to act as shift commanders overseeing correctional operations of their assigned shift. Two lieutenant posts should be created, one to serve as the Second Watch Commander (Day Watch), and the second as the Third Watch Commander (Evening Watch). This will add a level of command to take control of and manage the two most active operating watches and oversee the sergeants functioning as the floor supervisors.
2. staffing sergeant positions according to the relief factor requirements, to ensure that two sergeants are available on each shift, one to manage Booking and the other to manage Housing Operations;
3. establishing a civilian corrections supervisor rank, which would report to a sergeant. This civilian position would also provide career and promotional opportunities within the corrections officer ranks that may help retain civilian corrections staff and improve employee morale.

As noted in the Staffing section of this report, there are staffing shortfalls impacting the efficiency of operations and the adequate supervision of the inmate population.

4. It is recommended that a position of dedicated Receiving Officer be reestablished and staffed on a regular basis, to ensure that search and processing of inmates is carried out efficiently and consistent with good security practices. Staffing this post also takes the pressure off booking and first floor staff from having to multitask, and reduces the risk of a security breach in the booking area and holding cells.
5. It is recommended that a position of dedicated Classification Officer be established. Because of the volume of intakes occurring throughout the day, the presence of a dedicated Classification Officer reduces risk of disruption and violence in the institution. This position should be filled on each of the three watches and not routinely combined with other booking or jail duties.
6. It is recommended that staffing be increased in the Linear Units to ensure that two officers per floor are available during peak activity periods to supervise those units.
7. It is furthermore recommended that staffing be increased in the Pod Units so that during peak activity there is an officer available as a Rover between Pods A and B, and another between Pods C and D.
8. The workload in the Security Control requires adequate staffing on both second and third watches. It is recommended that the Security Control post be staffed with two officers on second and third watches.

9. The ground floor is a critical area of the institution as it provides an avenue for contraband flow and a potential escape route if not properly supervised. The Ground Floor post has been unoccupied for some time and presents a security risk. It is recommended that the Ground Floor post be staffed on a regular basis on all three watches. It can be combined with laundry supervision when that post is staffed.
10. It is recommended that a post be created on the active second and third watches to oversee the medical clinic area as well as the medical cells. This will add security and safety for the medical staff and patients in this area. Similarly, a medical escort post should be added on third watch to address the escort issue noted above. This escort post will also allow more efficiency in inmates being evaluated and treated by medical and mental health staff.
11. Staffing according to the established relief factor would ensure that critical posts are staffed at all times. The immediate first step is to hire sufficient staff to bring staffing to the authorized level. Additionally, the posts listed on the three watches, which constitute the Security Staffing Plan, need to be staffed on an ongoing basis. In order to accomplish this, the additional positions need to be funded and operational strength raised to 151 positions, consisting of 137 correction officers, 11 sergeants (exclusive of the Transportation and Courts sergeants), two captains and one major. This is the operational strength needed to adequately staff the three watches as they are designed.
12. Staffing the Jail at the level recommended will also curtail the excessive user of overtime. Additionally, consideration should be given to meeting with collective bargaining agents to develop a fair system of overtime distribution when forced overtime is required. This would include having senior officers participate in working forced overtime shifts, as well as the less senior employees
13. To address the issue of employee turnover, steps should be taken to improve employee job satisfaction and morale. We recommend conducting an exit interview for all correction officers who resign, to identify those factors that lead to employee turnover.
14. Addressing staffing, forced overtime, and workload issues described above are likely to have a positive impact. The creation of a civilian corrections supervisory rank, also mentioned above, could provide incentive and promotional opportunity for correction officers. Additionally, training and good supervisory practices can also assist. Consideration should be given to establishing a working group of management and labor to address these issues and identify steps that can be taken to improve retention and attract more candidates for correction officer positions.
15. We recommend that the Sheriff's Office consider more focused recruitment efforts for corrections staff, including continued focus on minority recruitment.



16. Jail management should consider an ongoing review process of the indicators and data collected as a management tool to assess individual and facility performance. A formal review process and analysis can be useful in making improvements to overall operations.
17. It is further recommended that a post-incarceration survey and/or independent oversight/hearing board (ombudsman) be established to receive feedback from inmates incarcerated at the Jail to ensure adequate services are being provided or offered, treatment options are relevant for inmate needs, allegations of inhumane treatment or excessive force are thoroughly investigated, and risk management factors are identified that could be liabilities to the Jail and Montgomery County.

## **STAFF TRAINING**

1. The Jail's training programs for all levels of staff appear consistent with national standards. The Field Training Officer training practices are thorough and complete. However, some form of enhanced incentive should be established for the important FTO positions.
2. Correctional staff should receive regular updated training on cultural competency, trauma-informed policing, implicit bias, and interpersonal communication skills as part of the annual 40 hours of in-service training. (Additional training recommendations are included in the Use of Force report.)

## **CLASSIFICATION**

1. The Classification Officer position should be staffed on each watch as a dedicated position focusing entirely on the classification of inmates. This will require proper staffing of booking and release responsibilities in order to free the Classification Officer from those duties. A supervisor should be designated as the Classification Supervisor to oversee the classification process, ensuring that all jail inmates reside in a safe environment without real or implied evidence of inappropriate segregation. The Classification Supervisor would be responsible for ongoing review of the classification system, which includes monitoring policy and procedure compliance, as well as an ongoing review of the objective point-based classification instrument. In light of the recent allegation of segregated housing for African-American females, the supervisor should also monitor that race or ethnicity are not factors in the classification process.
2. The supervisor and classification officers should conduct a periodic audit of the classification system. This will require data collection on classification outcomes and a review of the objective point-based instrument to determine if it is effective, valid and reliable. The number of overrides should also be tracked and evaluated as part of this process. Additionally, the audit should examine overall compliance with the policy/procedure regarding classification to ensure that initial classification and reclassification requirements are being complied with.

3. We recommend that the Classification Officer conduct an in-person interview with each inmate as an additional factor to consider while making the classification decision. Interviews can be helpful in identifying risk factors that may affect the inmate's incarceration such as enemy issues, gang affiliations, and medical/mental health issues. The interview can also be useful in assessing programmatic needs and making referrals to treatment programs.
4. A staff member should be designated to conduct weekly reviews of inmates being held in Administrative Segregation to assess their ongoing need for segregated housing, and to ensure that they are receiving treatment and services as appropriate. Inmates maintained in segregated housing should also be classified on a periodic basis. A review process can also serve as a productive tool to set goals and provide incentives to inmates to improve their behavior leading to their transition to general population.

The Housing Plan discussed above is challenging and doesn't adequately provide for the proper housing of certain categories of inmates. The linear units are not designed for housing male inmates considered security risks, nor are there adequate accommodations for different categories of female inmates and juveniles in the facility. Specialized housing for mentally ill offenders is lacking, and the holding cells in the Booking Area have by default become housing for suicidal inmates and seriously mentally ill inmates. The Administrative Segregation cells have also become a last resort option for inmates with mental illness.

1. We recommend that planning for the renovation and/or replacement of the facility should take into account the need for housing options for the various categories of inmates, with special attention being given to close custody housing and housing of special populations.

## **USE OF FORCE**

**Use of Force Policy:** We recommend establishing a detailed jail specific policy which fully identifies specific requirements for the use of force in a correctional/jail setting be developed to replace Jail Manual Order # 3.5.1. This policy could serve as a single guide for correctional staff, detailing the appropriate use of force and related procedures. This policy should identify use of the Emergency Restraint Chair as a use of force and require that established criteria be met before placing an individual in the chair.

Topics that jail leadership should consider for inclusion in the policy include:

1. A statement at the beginning of a Use of Force Directive that sets forth general principles:
  - the force used shall always be the minimum amount necessary, and must be proportional to the resistance or threat encountered;
  - the agency has a zero-tolerance policy for excessive and unnecessary force;

- the best and safest way to manage potential use of force situations is to prevent or resolve them without the need for physical force, including the practice of de-escalation methods and Interpersonal Communication (IPC) skills;
  - force shall not be used as punishment or to intimidate or threaten a detainee.
  - the use of excessive force is expressly prohibited and shall result in discipline of the involved staff.
  - an explicit requirement that staff may use force only when reasonably necessary to:
    - prevent physical harm to staff, visitors, detainees, or other persons, as a last resort and where there is no practical alternative available;
    - prevent or stop the commission of crimes, including riot, assault, escape, or hostage taking;
    - enforce facility rules, policies, regulations, and court orders where lesser means have proven ineffective and there is an immediate threat to the safety of persons or the security of the facility, or an immediate need for compliance, or prevent serious destruction of property.
2. An explicit prohibition on the following:
- the use of force to punish, discipline, assault, or retaliate against a detainee;
  - the use of force in response to a detainee’s verbal insults, threats, or swearing;
  - the use of force after control of a detainee has been established;
  - provoking detainees to commit an assault in order to justify use of force;
  - the use of unnecessarily painful escort or restraint techniques;
  - causing or facilitating detainee-on-detainee violence, or otherwise exposing detainees to an unreasonable risk of being assaulted by other detainees;
  - pressuring or coercing detainees, staff, or non-Department staff to not report use of force.
3. A discussion concerning using the minimum amount of force that appears reasonable, and escalating the force only if necessary, to stop or control the detainee. (This discussion can include the force continuum that the Sheriff’s Office has adopted in its current policy.)

4. The use of verbal techniques, de-escalation methods, and Interpersonal Communication skills (IPC) designed to diffuse the situation if time and circumstances permit. Use of force avoidance procedures should be outlined in policy.
5. A requirement to limit the use of force, if time permits, until a warning or command has been given and the detainee has had time to comply with it before applying force.
6. A requirement that medical attention be provided to staff and detainees injured during the use of force incident as soon as practical after an incident.
7. A requirement that no staff involved in a use of force incident participate in escorting the detainee away from the scene, including to the medical clinic or holding area except in extraordinary circumstances when there is no reasonable alternative.
8. Include provisions and procedures for planned use of force, such as cell extractions.
9. Include requirements and specific criteria for when less than lethal weapons such as oleo capsicum and the Taser may be used, and include that these weapons should only be used as a last resort after all options of lesser force have been considered and determined to be not practicable.
10. A policy that recommends limiting or avoiding the use of force on special needs population and juveniles, if feasible.
11. A requirement that correctional staff summons medical staff to examine detainees as soon as possible after a use of force incident.
12. A requirement that correctional staff document detainees' injuries or alleged injuries through photographs and/or video.

**Use of Force Procedures:** The Use of Force procedures that are outlined in the Sheriff's Office General Orders Manual and Jail Manual lack specificity for correctional staff and do not address several areas which have been identified as potential sources or allegations of inappropriate and/or excessive use of force. We recommend the Sheriff's Office employ the following procedures to provide additional safeguards against allegations of misconduct.

13. Provide clear guidance and training to all Jail supervisors on what is and is not considered a use of force incident.
14. Require all evidence from a use of force incident, including electronic and physical evidence, be preserved, secured, and maintained appropriately so it cannot be deleted, destroyed, or tampered with.
15. Create a cultural competency among all correctional staff that involves utilizing proven de-escalation methods and communication skills to limit or avoid the use of force.

16. Clearly communicate to all jail staff that inappropriate or excessive force incidents will not be tolerated and will be thoroughly investigated for any wrongdoing.
17. Protect any correctional officer, staff member, or inmate who reports or alleges inappropriate or excessive use of force by another correctional staff member.
18. Establish an Ombudsman process or civilian review panel that routinely reviews the Jail's use of force incidents, including all applicable reports, videos, photographs, and documentation, to build and maintain a degree of transparency and trust with the community.

**Use of Force Procedures Analysis:** Recent use of force incidents in the Jail suggest that current use of force procedures analysis may be inadequate or lacking. We recommended the Sheriff's Office adopt additional practices to ensure adequate use of force analysis, accountability of staff's reported force incidents, and transparency with use of force incidents. These recommendations include:

19. Establishing minimum monthly random supervisory review of Jail surveillance video cameras of common locations where use of force incidents occur and document the review;
20. Requiring mandatory review of all video footage involving use of force incidents by at least one supervisor and one command staff member and document the review;
21. Collecting data on the detainees involved in use of force incidents to determine whether substance abuse, mental health issues, special needs, or other similar extenuating circumstances were factors in the detainee's behavior;
22. Determining if services were identified that could benefit this detainee's behavior to prevent future force responses.

**Use of Force Training:** The Sheriff's Office provides correctional staff initial training, academy training, and in-service training on use of force procedures and policies. In addition to this training, we recommend the Jail also:

23. subscribe to and provide all correctional staff with monthly legal updates on search and seizure, arrest law bulletins, and/or use of force cases or incidents;
24. provide a minimum of four hours training on proper use of force techniques, Jail policy on force incidents, de-escalation methods, Interpersonal Communication skills, or similar training as part of correctional staff annual in-service training.

**The Emergency Restraint Chair:**

25. To comply with the spirit of the ACA standard and the Sheriff's Office Jail policy, placement in the restraint chair should explicitly be considered a use of force situation

and should only be applied in those cases where no other reasonable alternative is available, such as placement in a segregated cell or attempting to diffuse the situation through communication with the detainee by the supervisor or mental health clinician. The use of the device is a last resort after considering other options.

26. As noted in the Training Outline used for annual in-service training, serious medical conditions can occur during the restraint process. Precautions need to be taken to ensure that medical staff examine an individual and review medical records prior to placement, or shortly after placement when time does not otherwise permit, to determine whether the individual has any medical and/or mental health issues that could be further complicated by placement in the restraint chair.
27. Inmates should not be held in the chair for more than two hours, consistent with most correctional policies regarding the use of this device. In any situation when an individual is held in the chair beyond two hours, medical staff need to be involved and the individual's arms and legs must be exercised to ensure proper circulation.
28. The use of non-lethal weapons (e.g. Taser, pepper spray) on any detainee secured in a restraint chair should be explicitly prohibited.
29. Each case where the restraint chair is used to control a detainee should be examined to determine if proper procedures were followed and the criteria of dangerousness to self or others, or the destruction of property were met, and other techniques were proven to be ineffective to gain compliance. In order to achieve this, it is recommended that each case of restraint chair use be deemed a use of force, and use of force reporting procedures, including subsequent review by superiors, be conducted. Limiting the use of the chair to those cases where there are no other viable options to gain control will ensure compliance with ACA standards and reduce risk of liability.
30. An annual review of the Use of Force policy should be conducted, including the restraint chair policy, to ensure it complies with common correctional facility procedures and protocols.

## **INMATE GRIEVANCES**

1. Establish an independent Grievance Coordinator for the facility who is responsible for monitoring the grievance process, ensuring legitimate access to complaint and grievance forms, and serving as the first level of formal grievance review for all health care and non-health care grievances. The Grievance Coordinator should independently investigate the grievance and issue the first level ruling.
2. While requirements that inmates attempt to informally resolve a grievance are appropriate, the facility should establish policy and practice that allows for complaints of employee misconduct, civil rights or racial grievances, grievances related to facility

operations, services and programs circumvent the normal process and be sent directly to the Grievance Coordinator without intervention by housing unit staff.

3. Employee Complaint Forms and grievance forms should be readily available and accessible to inmates in various Jail locations without the need to request these from the officer(s) or sergeant(s) supervising the housing units.
4. Establish grievance boxes in each housing unit where inmates can confidentially submit their completed grievance.
5. Establish a grievance log, maintained by the Grievance Coordinator, that ensures all paper grievances are documented in a standardized method and addressed in a timely manner.
6. Establish a practice for health care related grievances where the HCSA is not both the informal arbitrator of the concern and the first level of formal grievance review.
7. Ensure that policy identifies that any employee complaint regarding alleged staff misconduct is immediately reported to the Jail Administrator.
8. Change Jail policy to allow inmates a more reasonable time to file an appeal. Specifically, inmates should be provided at least five days after a grievance decision to consider and file a grievance appeal. We note that the actual grievance form (Prisoner Grievance Form, Form 0042) indicates an inmate can appeal within five days (excluding weekends and holidays) but is contrary to current Jail practices.
9. Revise Jail policy to reflect that the Grievance Line actually serves as another option for informally addressing an inmate concern. Establish a practice where the Grievance Line is tested by the Grievance Coordinator on a weekly basis to ensure functionality.
10. Make employee complaint forms and grievance forms available to inmates in both English and Spanish.
11. Train staff annually on appropriate inmate grievance procedures.
12. Educate/inform inmates on the grievance procedures and employee complaint process during Jail orientation and/or in the Jail handbook.
13. Differentiate between the Employee Complaint Form, Non-Health Care Grievance Form, and Health Care Grievance Form.
14. Consider revising grievance forms to solicit more specific information from an inmate on their grievance.

## **MEDICAL HEALTH**

1. Add 1.5 LPN FTEs to comply with new NCCHC sick call standards for the timely review of sick call requests.
2. Plans for expansion or replacement of the current jail facility should include a professionally equipped examination room in each of the housing units as well as in the clinic area.
3. Create a process for triage review of sick call cases on second shift to enable identification and treatment of emergent cases.
4. Establish criteria for referrals to counseling for inmates who refuse their medication.
5. Assess current LPN job responsibilities for compliance with the Ohio Nurse Practice Act.
6. Add 4.2 RN FTEs to current intake staffing to manage health care screening dispositions currently conducted by paramedics.
7. Establish criteria for the urgency of the history and physical based on the data collected during intake.
8. Utilize peer evaluators to provide quality assurance reviews, consistent with each profession.
9. The Jail and its contracted provider for medical/mental health services should provide orientation for all their employees, to include jail facility orientation. This orientation would be a coordinated effort to train employees.
10. It is recommended that an annual institutional review of the use, secure tracking, documentation and distribution of controlled medications should occur within the correctional facility.

## **MENTAL HEALTH**

The following recommendations are listed in the order of importance as viewed by the Committee. First on the list is the facility and our recommendation to enhance the ability to offer effective and efficient mental health and substance abuse services. The second recommendation is identified as Continuity of Care, with a special emphasis on suicide prevention in the jail facility. These recommendations are suggested to enhance compliance with accreditation standards and oversight of services offered to inmates. The third recommendation is treatment of mental health and substance abuse issues. This is imperative in offering programming and services relating to ongoing continuity of care. Also, the risk of suicides in the jail and the completed suicides by recent history make this one of the most serious issues.



## **Facility**

1. Plans for expansion or replacement of the jail facility should include a confined crisis stabilization/acute psychiatric care unit. This unit would include a full capacity triage, appropriate screening for mental health issues beyond self-reporting and per National Commission on Correctional Health Care (NCCHC) standards. The design should include stays of 1 to 5 days for medical detoxification of illicit drugs, as well as stabilization of those suffering acute psychiatric episodes. The area may be dedicated inside the current facility or in a separate facility, reporting that those in active detox still total, on balance more than 50 inmates on any given day and that the administration of psychotropic medications, due to increased funding from the Stepping Up initiative has doubled in the last year. A facility such as this would, space permitting, also enable local competency restoration for defendants who currently wait in the jail for a bed in a state hospital from 2 to 5 weeks. Finally, this facility would provide a healthful solution to the suicide issues in the jail.
2. Designated space for intake, screening, mental health services and psychiatric services is necessary. This space should be private, allowing for confidentiality.
3. The use of monitored camera systems and adequate staffing are recommended for continued surveillance.

## **Continuity of Care**

4. There is a need for a comprehensive quality assurance program inclusive of regular and corrective actions. The quality assurance would encompass requirements for NCCHC auditing and reviews of medical and mental health services to ensure the provision of appropriate services.
5. Ensure that all medical and mental health providers have access to the same documentation systems. As of 1/1/19 all of the providers of care will be sharing the same system. Further, improved record keeping and sharing of the same, enable the implementation of improved discharge planning for immediate assimilation with treatment providers and physicians, medication administration, housing assistance, education and vocational training.
6. In order to improve recruitment of quality mental health staff, the facility could consider engaging local educational institutions by offering clinical rotations for medical interns/residents, and social work/counseling students. This, along with the development of a mental health treatment environment, could help to dispel negative community perceptions and improve the recruitment of staff.
7. Staffing issues have been identified by the consultants and are crucial to mental wellness addiction issues and primary medical issues in the jail. While crisis stabilization adequately staffed might solve some of these issues, ongoing medical issues as well as detection of decompensation or mental health medication and monitoring of any

developing suicidal ideations, require an enhanced clinical staff. Telemedicine provides a useful, more affordable means to enhance physician staffing. Further, attention should be given to the consultant's criticism that staffing is comprised of the "lowest acceptable level of professional credentialing for the specific job duties required, particularly regarding assessments".

8. Provide education to the 11 referring courts regarding psychiatric and mental health services available at the Montgomery County Jail. Continue the fulltime position of treatment coordinator in the jail. Encourage more transparency regarding mental health or substance abuse beds available in the community.
9. For individuals returning to the Montgomery County Jail from inpatient psychiatric treatment, there is a need for ongoing mental health treatment. Given the volume of individuals requiring inpatient treatment, the facility should consider establishing a mental health unit, a program that could address the overall fragmented care within the facility with counselors to offer individual and group counseling for follow-up.

### **Treatment of Mental Health and Substance Abuse Disorders**

10. The facility needs to provide intake, assessment, suicide evaluation, response to requests for services, mental health follow-up, monitoring of individuals in segregation or single cell tiers, and ongoing mental health care. The staff hired at the jail need to liaison with the medical and correctional staff to provide timely and integrated services.
11. The facility should consider a program where the individuals are provided an armband with their photograph and a corresponding bar code that can be scanned in order to confirm their medication prescriptions. In addition, in an effort to further prevent the diversion of medication and to ensure adherence to regimens, mouth checks must be performed for all medication administration events.
12. The facility should consider toxicology screening on all facility admissions. The cost is influential in that decision but could improve quality of care and getting inmates the treatment that they need more timely. This could decrease the number of preventable medical emergencies.
13. The facility has limited psychiatric resources. In order to increase the availability of mental health providers, they could consider the use of telemedicine. It also offers a useful, more affordable means to enhance the physician staffing.
14. The Montgomery County Jail could consider a contract with an inpatient psychiatric facility for acute treatment needs and stabilization.
15. The Jail should significantly increase discharge planning to accommodate more inmates in need of mental health and other re-entry services after release.

## **INMATE PROGRAMS**

1. The budgetary limitations of the jail have a direct impact on the number and scope of programs provided and the lack of program staff on board. Jails of this size typically have a contingent of counseling and program staff dedicated to coordinating and delivering effective programs to the inmate population.
2. Jail staff should be commended for offsetting the lack of funded programs through the recruitment of a large number of volunteer-directed programs as well as the development of targeted programs supported through alternate funding sources.
3. Funding should be provided to significantly increase counseling and program staff and to provide evidence-based programming for counseling and addiction recovery. Further partnering with outside community organizations for provision of services is also recommended. A screening process should be introduced for volunteers offering programs within the Jail.

## **COMPLIANCE**

1. Areas identified in the ACA audit report that require corrective action should be further addressed. In particular, inmates should be provided with recreation on an ongoing basis. At a minimum, inmates in segregation should receive one hour out-of-cell recreation daily.
2. Consideration should be given to documenting the Jail walk-throughs by administrators. These walk-throughs can provide useful information for the Jail Administrator and the Sheriff indicating facility conditions, staff issues and the mood of inmates and the overall climate of the facility.
3. It appears from examining the daily and weekly sergeant's reports that the main focus is currently on maintenance and cleanliness issues. It is suggested that an increased focus on security issues be considered. Ensuring that the sergeants are examining security devices, perimeter security, security equipment, fire safety and inmate issues would contribute to the overall security of the facility.
4. The deficient areas related to juvenile offenders should be addressed. The facility is not equipped to provide direct supervision for youthful offenders, nor does it have in place specialized housing, programs, services, or a specialized classification program for youthful offenders. Because the facility is overcrowded and available physical space is needed for adults, it is recommended that the County make alternative arrangements for housing youthful offenders in an ACA compliant housing unit at an alternative location.

# 14. Glossary

**ACA** American Correctional Association, an independent accrediting organization that focuses on best practices and policies for correctional facilities.

**Acuity** The level of medical attention necessary for disease management. An acuity-based staffing system regulates the number of nurses on a shift according to the patients' needs, not according to raw patient numbers.

**Administrative Segregation** Inmates are placed in solitary confinement, or Administrative Segregation, for violent or disruptive behavior. Administrative Segregation typically involves single-cell confinement for 23 hours daily. Inmates are allowed one hour out of the cell for exercise and showers.

**ALDF** Adult Local Detention Facilities, a term used by the State of Ohio to define correctional facilities which house adults.

**Competency Restoration** The process used when an individual charged with a crime is found by a court to be incompetent to stand trial, typically due to an active mental illness or intellectual disability. A criminal defendant must be restored to competency before the legal process can continue. To be considered restored and competent to stand trial, a defendant must be able to consult with his or her defense lawyer and have a rational and factual understanding of the legal proceedings.

**Culturally Sensitive Treatment** Culturally sensitive treatment emphasizes the understanding of a person's background, ethnicity, and belief system, to accommodate and respect differences in opinions, values, and attitudes of various cultures and different types of people. Cultural sensitivity also allows a person to gain and maintain cultural competence, which is the ability to first recognize and understand one's own culture and how it influences one's relationship with a client, then understand and respond to the culture that is different from one's own. The need for this understanding may be based on characteristics such as age, beliefs, ethnicity, race, gender, religion, sexual orientation, or socioeconomic status.

**Day Reporting Center** A place where select offenders report while under probation or parole supervision and can receive an array of services. Day/Evening Reporting Centers may include educational services, vocational training, treatment, and other service deliveries.

**Double-Celling, Triple-Celling** The practice of confining two or three inmates in a single jail or prison cell.

**FTE, Full-Time Equivalent** The ratio of the total number of paid hours during a period (part time, full time, contracted) to the number of working hours in that period. The ratio units are FTE units or equivalent employees working full-time. In other words, one FTE is equivalent to one employee working full-time. For example, if you have three employees and they work 50 hours, 40 hours, and 10 hours per week - totaling 100 hours. Assuming a full-time employee works 40 hours per week, your full-time equivalent calculation is 100 hours divided by 40 hours, or 2.5 FTE.

**FTO, Field Training Officer** An experienced or senior member of an organization such as a correctional facility who is responsible for the training and evaluation of a junior or probationary level member.

**HCSA, HSA** The Health Care Services Administrator, or Health Services administrator, directs the operation of the health care system within an organization, such as a correctional facility, including planning, coordinating, and supervising the functions of the health care facility and its staff. In the Montgomery County Jail this is a Registered Nurse (R.N.) responsible for the administrative support of jail health care functions.

**Housing Sergeant** The sergeant responsible for supervision of a specific housing area each shift and for maintaining the security of the facility as well as custody of the inmate population.

**Implicit Bias Training** Implicit or (unconscious) biases are learned stereotypes, both favorable and unfavorable, that are automatic, unintentional, deeply engrained, universal, and able to influence behavior. These biases are activated involuntarily and without an individual's awareness or intentional control, and are not accessible through introspection. Implicit bias training is designed to expose people to their unconscious biases, provide tools to adjust automatic patterns of thinking, and ultimately eliminate discriminatory behaviors.

**Inmate Sexual Victimization** Any act or behavior perpetrated on an incarcerated person which is sexually abusive, including being pressured or forced to engage in unwanted sexual acts by another inmate or staff member.

**Intake Screenings/Intake Assessments** An intake screening takes place at the time of receiving/booking when a new inmate is brought to the jail. The screening is undertaken by medical personnel, to gather information to address the inmate's immediate needs, and to determine whether the individual needs assessment. The purpose of assessment is to gather the detailed information needed for a treatment plan that meets the individual needs of the inmate. Essentially, screening is a process for evaluating the possible presence of a particular problem. Assessment is a process for defining the nature of that problem, determining a diagnosis, and developing specific treatment recommendations for addressing the problem or diagnosis.

**IPC** Interpersonal communication

**ISU** The Inspectional Services Unit of the Sheriff's Office is responsible for investigating all use-of-force incidents in the jail to determine the appropriateness of the use of force and whether any employee violated departmental directive or policy.

**Jail Administrator** The Jail Administrator is the top administrator of the jail, responsible for all jail operations, supervising all personnel, ensuring public safety and the well-being of the inmates. He reports to the Sheriff and is directly responsible for the effective operation of the jail.

**Jail Body Scanner** The full-body scanner allows a non-intrusive scan to see if there is something in or on a person that a pat-down might miss, such as a firearm or cell phone, a needle in a pocket, or a small baggie of drugs inside a body cavity. The scanner can detect metal, plastic, organic and inorganic objects, whether hidden externally or internally. The scanning process takes about 10 seconds. During that period, an x-ray image is generated that shows the entire body and all contraband that may be hidden.

**Kite** In jails and prisons, a kite can refer to notes written by inmates to other inmates, or notes written to jail personnel to register a complaint. Most commonly it refers to any written request from an inmate, to file a complaint or to request medical or other services.

**Linear Cells/Linear Unit** Jail cells with a linear construction, with multiple-occupancy cells and dormitories aligned along corridors. They are designed to operate with a minimum of staff, using closed-circuit television and/or audio surveillance to augment staff supervision and control of the inmates. The design provides little contact between inmates and staff. Supervision is affected by intermittent staff patrols of the jail corridors and technology.

**NaphCare** Established in 1989 in Birmingham, AL, NaphCare is an organization that partners with correctional institutions nation-wide to provide a comprehensive array of health care services.

**National Commission on Correctional Health Care (NCCHC)** The mission of the National Commission on Correctional Health Care is to improve the quality of health care in jails, prisons, and juvenile confinement facilities. NCCHC establishes standards for health services in correctional facilities, operates a voluntary accreditation program for institutions that meet those standards, produces and disseminates resource publications, conducts educational conferences, and offers a certification program for correctional health professionals.

**Non-Adherence** Non-compliance with medical advice or treatment.

**Noncompliant Standards** Established or recognized standards with which an institution is not in compliance.

**Nurse Practitioner (NP)** A registered nurse who is qualified through advanced training to assume some of the patient care duties and responsibilities previously provided by a physician.

**OC** Oleo Capsicum (pepper spray)

**ODRC** Ohio Department of Rehabilitation and Corrections, which oversees all correctional facilities and jail operations within the State of Ohio.

**OMSFSJ** Ohio Minimum Standards for Full Service Jails, established by the State of Ohio for minimum standards required by the Ohio Administrative Code for full-service correctional facilities.

**Ohio State Nurse Practice Act** This defines and regulates the scope of nursing practice in Ohio, and enforces rules for technicians, community health workers, and advanced nurse practitioners.

**PREA – Prison Rape Elimination Act** Federal legislation established to provide protections for inmates from being sexually victimized while incarcerated.

**Pre-Release Transitional Services** Transitional services begin prior to release, to assist inmates with arrangements for a smooth transition back into the community by addressing matters such as housing, clothing, transportation, medical and mental health treatment, identification and after care programs.

**Psychotropic Medications** Any drug capable of affecting the mind, emotions, and behavior.

**Registered Nurse (RN)** A nurse who holds a nursing diploma or Associate Degree in Nursing, has passed the national exam administered by the National Council of State Boards of Nursing (NCSBN), and has met all the other licensing requirements mandated by their state's board of nursing.

**Sick Call** An inmates' opportunity to make a daily request for health care service.

**Stepping Up Initiative** A national initiative to reduce the number of people with mental illnesses in jails, engaging sheriffs, jail administrators, judges, community corrections professionals, treatment providers, people with mental illnesses and their families, mental health and substance use program directors, and other stakeholders.

**Suicide Attempt** A person tries to commit suicide but survives.

**Suicide Gestures** An apparent attempt to cause self-injury without lethal consequences and generally without actual intent to commit suicide. A suicide gesture serves to attract attention to the person's disturbed emotional state, attract attention, gain sympathy, or achieve some goal other than self-destruction.

**Suicide Watch** An intensive monitoring process used to ensure that a person cannot attempt suicide. Institutionalized persons are placed on suicide watch when they exhibit warning signs that they may be at risk of committing bodily harm or fatal self-injury.

**TASER** A brand of conducted electrical weapon which fires two small barbed darts intended to puncture the skin and remain attached to the target. The darts are connected to the main unit by thin insulated copper wire and deliver electric current to disrupt voluntary control of muscles, causing temporary paralysis. The TASER is a less-lethal force option used by police to subdue fleeing, belligerent, or potentially dangerous people.

**Telemedicine** Technologies and services to provide patient care through secure video visits online.

**Trauma-Informed Policing** A mindfulness approach which explicitly acknowledges the role trauma plays in the lives of others, enhancing police officers' understanding of trauma and its effects.

**Vivitrol** A non-addictive, once-monthly treatment to prevent relapse in opioid dependent patients by blocking opioid receptors in the brain.

**Wireless Duress** A wireless panic alarm, sometimes referred to as a panic alarm or wireless panic button, used to protect employees and staff from assault or other hazards.





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