Blue Ribbon Commission

Presentation by Aaron B. Zisser,
Expert Consultant to the Commission
Overview

- Background
- Scope and activities
- Best practices
- Summary of findings and recommendations
BIO: Aaron B. Zisser

- U.S. Dept. of Justice, Civil Rights Division, 2009-2015
  - System reform / “Pattern or practice” cases
  - Corrections, human services, education
  - Focuses: restrictive housing, mental health, use of force
- Americans with Disabilities Act (ADA)
- Prison Rape Elimination Act (PREA)
- Commission on Persons with Disabilities
Scope of Review

• Department of Correction’s (DOC) grievance and complaint procedures

• Focus: use of force and serious misconduct

• Related topics
  • Other means of discovering excessive force / serious misconduct
  • Incidental to consultant review

• Best practices and professional standards
Activities: Jan. 12 - Feb. 20

• Site visits, document review - 1/14, 1/19
• Information request - 1/24
• Document review - 2/1- 2/4
• Interviews - Jan. 14, 19, 28-29, Feb. 3, 5, 11-12
• Review of best practices
  • Tour of juvenile facilities - 1/29
  • Interviews - 2/2, 2/10
Best practices

• U.S. Constitution / ADA
• DOJ settlements
• Other facilities
• PREA Standards
• Juvenile standards
• American Bar Assoc.
• American Correctional Assoc. (ACA)
• ACA mental health
• Civil Rights of Institutionalized Persons Act
• DOC’s own policies
Commendable policies and practices

- PREA video
- PREA manager
- Grievance forms*, boxes*
- No restrictions*, no deadline
- Respectful, transparent*
- Tracking timeliness*
- Internal Affairs Unit (IAU) investigations*
- Audit unit*
- Incident data* - administrative staff
- Jail Observer Program*
Overview of findings and recommendations

• FINDING 1: “Grievance” vs. “complaint” → Flaws at every stage of grievance and complaint process
• FINDINGS 2-7: EACH stage of grievance and complaint process
• FINDING 8: Other related serious concerns
• FINDING 9: Independent oversight
• FINDING 10: Implementation of recommendations
Finding 1: Grievance vs. Complaint

**Purposes of a Functioning Grievance System**

**Policy:**
- Internal problem-solving
- Due process and access to administration
- Continuous review of policy and procedure / monitoring problem areas
- Written documentation of inmate concerns

Identifying serious abuses?
Recap: Complaints vs. grievances

What is a “grievance”? 
Can address “any conditions of confinement”; “an inmate complaint* arising from circumstances or conditions relating to his or her confinement.”

What is a “complaint”? 
1. Allegation of staff misconduct
2. Can be made to staff, e.g., via grievance process, or to IAU
Recap: Complaints vs. grievances

The Jail has 23 categories of grievances. But there are really TWO major categories of grievances:

1. Programs and services
2. Staff misconduct = complaint

And they must be handled differently at every stage.
Best practice: TWO Categories of Grievances, TWO Procedures

Program/service

Grievance process

Staff misconduct = “complaint”

Internal Affairs Unit
(also receives complaints directly)

“Minor” or clearly unfounded or exonerated

Jail, w/ possible corrective action/counseling

“Major” and not clearly unfounded or exonerated

Full IAU investigation
Finding 1: Grievance vs. Complaint

DOC grievance process

Verbal

Written

Box

Deputy

Resolved

Sergeant

Resolved

Lieutenant / Captain

Resolved

IAU

Discip.
Finding 1: Grievance vs. Complaint

FINDING 1: The Jail fails to properly distinguish between the two categories of grievances - ordinary grievances regarding conditions and grievances alleging staff misconduct, or “complaints.”

a. Results in critical failures at every stage of grievance process.

b. Entire process therefore requires revision and ongoing internal and independent oversight.
Finding 1: Grievance vs. Complaint

Minor vs. major / grievance vs. allegation

Culture of minimizing / us vs. them / non-accountability
Recommendation 1: The critical distinction between the two basic types of grievances should guide the Jail’s approach at every stage, as well as the scope of independent oversight.

a. Staff and inmates should be trained on the distinction, though inmates should be able to submit complaints through the grievance process.

b. Procedures must be viewed as a means of oversight of inmates’ rights and of Jail and staff accountability.
Findings 2-7: Each stage of grievance and complaint process
Finding 2: Inmate education
Finding 2: Inmate education

FINDING 2: The Jail provides grossly inadequate information to inmates regarding the options they have for addressing staff misconduct and other serious concerns, such as sexual misconduct by other inmates. Information is disjointed, haphazard, and incomplete.
## Finding 2: Inmate education

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<th>Content</th>
<th>Format</th>
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<td>No</td>
<td>Minimal re grievance</td>
<td>Outdated, distractions</td>
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<td>Y/N</td>
<td>Yes</td>
<td>Complete</td>
<td>Distractions</td>
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<td>N/A</td>
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<td>No</td>
<td>Numerous omissions</td>
<td>No ToC</td>
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<td>Postings / notices</td>
<td>Y/N</td>
<td>No</td>
<td>Incomplete, outdated</td>
<td>Torn, small, misplaced</td>
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</table>
Finding 2: Inmate education

**Rule book - omissions**

- PREA, updated speed dial list
- “Complaint” procedure / Internal Affairs Unit
- Deadlines - filing, response
- Exhaustion of administrative remedies
- Jail Observer Program (JOP)
- Accommodations re grievances
- Table of contents
## Finding 2: Inmate education

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<th>Complete?</th>
<th>Specific issues</th>
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<td>Almost never posted</td>
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<tr>
<td>IAU and JOP</td>
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<td>N/A</td>
<td>Almost never posted</td>
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<td>ADA</td>
<td>No</td>
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<td>Contact has died</td>
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<td>Speed dial lists</td>
<td>Y/N</td>
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<td>Not near phones, torn, outdated</td>
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</table>
Recommendation 2: Inmate education

Recommendation 2: Complete and accurate information should be readily available and routinely updated.

b. Postings should be organized, properly located, and difficult to tear or remove.
c. Videos shown free from distraction, Q&A opportunity.
Finding 3: Filing methods
Finding 3: Filing methods

FINDING 3: A sufficiently confidential means of submitting grievances has not been readily available to inmates.

a. No clear plan for boxes’ proper placement or use, staff unclear on procedure and purpose.

b. Grievance forms not available in some key areas.

c. Belief (and policy) that grievances must be submitted to officers.

d. Inconsistent and unclear deadlines.
Recommendation 3: Filing methods

Recommendation 3: Inmates should have ready access to confidential means of submitting grievances and complaints.

a. Develop clear plans for placement of boxes and other filing methods; inmates should participate in planning process.
b. Clarify that inmates may submit grievances to any staff member.
c. Make grievance forms available in medical units, other areas.
d. Make deadlines consistent across policies (other than PREA).
Finding 4: Review and response
### Finding 4: Review and response

<table>
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<tr>
<th>Issue</th>
<th>Best Practice</th>
<th>Jail’s Practice</th>
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<tbody>
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<td>Can accused officer review, respond, “resolve”?</td>
<td>No</td>
<td>Yes</td>
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<td>Written guidance?</td>
<td>Yes</td>
<td>No</td>
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<td>Training for officers?</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Timely response?</td>
<td>Yes</td>
<td>Yes/No</td>
</tr>
<tr>
<td>Inmates notified of delay?</td>
<td>Yes</td>
<td>No</td>
</tr>
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</table>
Finding 4: Examples

Inmate grievance July 2015: “Attitudes and slamming door are not grievable offense.” - Deputy response (supervisor “concurs”)

Inmate grievance Sept. 15: “I ... was placed into a holding cell and strapped inside of a chair ... . The sergeant ... came into the cell choked me, and grabbed my penis (he was alone). ... He stated, ‘who’s going to believe you over me?’ He laughed at me and left.”

Response: “You are falsifying information for personal gain.”
Finding 4: Review and response

FINDING 4: Grievances frequently yield inappropriate, incomplete, and delayed responses.

a. Accused staff respond to grievances.

b. Such responses often are inappropriate and even intimidating.

c. Custody Input forms are subjective and can be used to retaliate.

d. Deadlines for responses are inconsistent, not always followed, not binding on Custody Health, and, for PREA, far too long.

e. Inmates do not receive notification or explanation of delays.
Recommendation 4: Review and response

Recommendation 4: Responses to grievances should be appropriate, complete, and timely.

a. Training on handling misconduct grievances as IAU complaints.

b. Accused staff should not handle the grievance.

c. Timely responses, including from Custody Health, notification of delays, and shortened deadline for PREA grievance response.
Finding 5: Referral for investigation
Finding 5: Examples

Use of force Dec. 2013 in mental health unit

- IAU summary of supervisor report: “IM [X] was laying face down in a pool of blood ... from a two inch laceration to IM right eye area.”

- IAU summary of employee report: “Deputies . . . threw two to three punches with a closed fist striking IM [X] on the face,” resulting in stitches and hospitalization.

- IAU learned of this via a complaint filed on inmate’s behalf.
Finding 5: Examples

Use of force July 2015

• Employee summary: “I grabbed the back of [inmate’s] top shirt with both hands ... and pinned him up against the break room door.”

• Supervisor summary: “[Deputy], who is a training officer, was trying to get out of writing a report. He mentioned that he did not take the guy down to the ground, and therefore, no report was needed. ... I am going to be very careful with him regarding any incidents, and his reporting of them.”

• Verbal counseling
Finding 5: Examples

Employee report Nov. 2015

• Deputy performed strip search, saw item in inmate’s rectum, pulled it out of the inmate.

• Supervisor’s summary: “I told [Deputy] he must review and follow” policy on cavity searches. “I explained ...: ‘If the inmate refuses to remove the item, staff shall NOT attempt to remove the item. This would constitute an unauthorized Physical Body Cavity Search.’”

• No documentation re discipline
Finding 5: Examples

Inmate grievance Dec. 2015

• Deputy called him “faggot/maggot” twice
• Response: “The above false accusations did not occur.”
• Lieutenant: “Supervisor conducted investigation - unfounded.”
Finding 5: Referral for investigation

FINDING 5: Allegations of serious misconduct and incidents involving serious uses of force, other serious misconduct, and failure to report a use of force often are not referred for investigation.

a. No clear criteria as to which types of use of force and other misconduct should be automatically referred.

b. Unclear process for ensuring IAU investigation of alleged sexual misconduct.
Finding 5: Referral for investigation

**Reasons for non-referral:**

1. General lack of prioritization / distinction / guidance
2. Failure to identify PREA-prohibited conduct or PREA allegation
3. Referral to Sheriff’s Office leadership before criminal referral
4. Defer to Command staff experience / training → full discretion
5. Lack of clear policy for referral from Jail Crimes to IAU (e.g., allegations of sexual misconduct)
Finding 5: Referral for investigation

Policy

IAU ... to conduct thorough and impartial investigations or directly assist other Divisions in the investigation of ...:

1. Any allegation or complaint of conduct ....
2. Any situation in which a person has been seriously injured or killed by any member of the department.
Best practice: Referral for investigation

Program/service

Grievance process

Staff misconduct = “complaint”

Internal Affairs Unit
(also receives complaints directly)
Best practice: Referral for investigation

Uses of force that could be automatically referred for IAU/criminal investigation:

- Serious injury or hospitalization
- Injuries to the face or the genitals
- OC spray or OC spray delivered via certain methods
- Level 4 / Level 5 (Less lethal / lethal), e.g., “personal body weapons,” other weapons
Recommendation 5: The Jail should automatically refer to IAU and the Jail Crimes Unit

i. every allegation of unnecessary or excessive use of force, sexual harassment (defined broadly), or sexual abuse

ii. every use of force that qualifies under strict criteria

iii. failures to report a use of force
Finding 6: Investigation
“IM [X] was laying face down in a pool of blood ... from a two inch laceration” (Dec. 2013)

• Complaint made directly to IA Dec. 2013
• No interviews, i.e. of the inmate, witnesses, officers
• No check on prior complaints against officers
• Received Dec. 2013, closed June 2014
Finding 6: Investigation

Internal Affairs Unit
(also receives complaints directly)

“Minor” or clearly unfounded or exonerated
Jail, w/ possible corrective action/counseling

“Major” and not clearly unfounded or exonerated
Full IAU investigation
Or Preliminary Inquiry
Finding 6: Investigation

Jail referrals vs. inmate complaints: Investigated very differently

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<th>Source of complaint</th>
<th>Type of investigation</th>
<th>Adequate?</th>
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<td><strong>JAIL COMMAND</strong></td>
<td>Full / formal investigation</td>
<td><strong>Generally, YES</strong></td>
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<tr>
<td><strong>INMATES</strong> (or on inmate’s behalf)</td>
<td>“Preliminary inquiry”</td>
<td><strong>NO</strong></td>
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Finding 6: Investigation

FINDING 6: IAU investigations into serious inmate allegations are often inadequate and unduly slow.

a. IAU reviews nearly all inmate excessive-force allegations through “preliminary inquiries,” which almost always halt prematurely without full fact-finding.

b. Preliminary and full investigations, including interviews, often take too long to complete.
Finding 6: Examples

Inmate complaint re use of force Oct. 2014

• IAU requested employee reports (ERs) Oct. 2014.
• IAU follow-up email requesting ERs Mar. 2015 (2 mo’s later)
• IAU spoke with Lt. May 2015 (2+ mo’s later).
• ERs submitted because of the IA inquiry.
• Inmate’s credibility questioned, but no interviews with staff or witnesses, no check on prior complaints.
• Closed July 2015
Inmate complaint re use of force Dec. 2013

• “IM [Z] has distorted and fabricated details of the incident ..., possibly for the intent to gain some sort of benefit.”

• No explanation of why suspect intent to gain a benefit.

• No interviews with other witnesses or officers.

• No check on prior complaints against officers.

• “Unfounded,” but facts DID occur. I/M got date and staff wrong.

• Closed Sept. 2014
Recommendation 6: Investigation

Recommendation 6: Inmate allegations of serious misconduct, including excessive or unnecessary use of force, sexual harassment, and sexual abuse, should receive full investigations.

a. Investigations should include identifying and promptly interviewing all witnesses and reviewing prior complaints or incidents.

b. IAU’s staffing levels should be reviewed and enhanced.
Finding 7: Internal oversight / quality assurance
Finding 7: Internal oversight / quality assurance

FINDING 7: Data collection and reporting is hindered by outdated systems, and policies are sorely outdated.

a. Internal audit unit only recently partially revived.
b. Required grievance and complaint data not collected or reported; available grievance data not routinely reviewed.
c. Incident and grievance data is inputted incorrectly.
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Total inmate grievances: 440 357 449 371
Total per Year: 1617
Recommendation 7: The Jail should significantly strengthen its internal oversight system.

a. Significant additional staffing for internal audit unit.

b. Schedule for review of policies; prioritize policies re review and investigation of serious incidents and allegations.

c. Grievance Coordinator should have seniority and expertise to properly categorize and route; categories should be reviewed.

d. Data systems must be updated to the 21st century; track timeliness and outcomes of grievances; incident data must be accurate.
Finding 8: Other serious issues make oversight especially critical

FINDING 8: Other serious concerns exist and make it essential that the Jail improve its grievance and complaint procedures and internal oversight.
Finding 8: Other serious issues make oversight especially critical

Other serious issues

1. Staffing
2. Restrictive Housing
3. Conditions / Crowding
4. Cameras
5. PREA
Finding 8: Other serious issues make oversight especially critical

PREA Policies

- “Sexual harassment”: not defined
- “Zero tolerance”: “detention rape or sexual assaults”
- Risk of victimization or aggression: “If the results from the screening indicate a probability of victimization or sexually aggressive behavior, and an overall high level of risk, appropriate housing ... implemented”
- Data collection, investigations
Recommendation 8: Prioritize addressing other areas of serious concern, including the overreliance on restrictive housing, crowding and conditions in Main Jail South, under-staffing, and PREA deficiencies.

a. Internal and external oversight should specifically prioritize these issues, in addition to staff misconduct.
Finding 9: Independent oversight

FINDING 9: Meaningful independent oversight of the Jail does not exist, and the Jail culture does not fully embrace transparency. In light of systemic deficiencies related to safety, rights, and distrust by inmates, their families, and the community, independent oversight is essential.

a. Jail Observer Program serves an important function but is not positioned to provide rigorous oversight.

b. The state, PREA, and civil grand jury provide sporadic oversight. Independent reviews often are not fulsome.
Finding 9: Independent oversight

State review 2014:

“Some concern was raised over access to out-of-cell time and exercise, a situation that staff is addressing. Inmates assured us that medical staff was responsive to their requests and expressed no complaints about the grievance or disciplinary processes.”
Recommendation 9: Independent oversight

Recommendation 9: The County should establish an independent oversight entity that has:

i. broad scope of authority regarding inmates’ rights

ii. with the cooperation of the Sheriff, full access to Jail facilities, data, records, staff, and administrators

iii. full independence, reporting directly to the Board of Supervisors and engaging in outreach to the public
Recommendation 9: Independent oversight

**Scope of authority** - review of and reporting on:

i. grievance / complaint procedures, reviews, responses, investigations

ii. reviews / investigations of use of force and other serious incidents

iii. staff disciplinary process

iv. restrictive housing / other conditions

v. when requested or authorized, specific incidents or issues

vi. internal and external audits, policies, data regarding these topics
Recommendation 9: Independent oversight

Benefits of independent oversight

• Preventative vs. reactive
• Consolidation of oversight / keeps other scrutiny at bay
• Leader in transparency and quality improvement
Finding 10: Implementation

FINDING 10: Many of the identified issues are nuanced and require urgent attention.
Recommendation 10: The Jail and the County should immediately, urgently, and thoughtfully work to implement the Blue Ribbon Commission’s recommendations.
Questions and Answers

• FINDING 1: “Grievance” vs. “complaint” / minimization culture → Flaws at every stage of grievance and complaint process

• FINDINGS 2-7: EACH stage of grievance and complaint process

• FINDING 8: Other related serious concerns

• FINDING 9: Independent oversight

• FINDING 10: Implementation of recommendations
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