

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

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



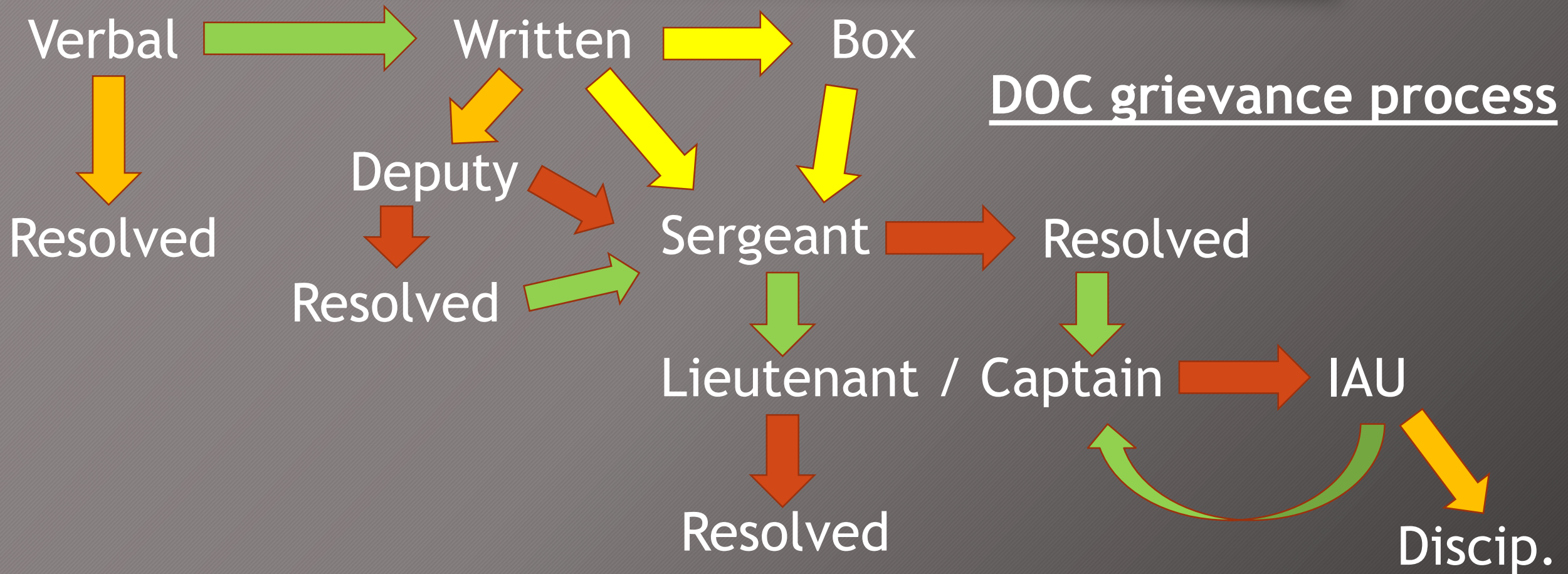
Jail, w/ possible corrective
action/counseling

“Major” and not
clearly unfounded
or exonerated



Full IAU investigation

Finding 1: Grievance vs. Complaint

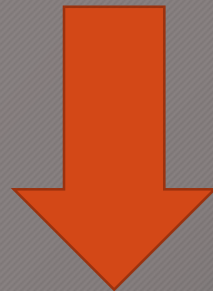


Finding 1: Grievance vs. Complaint

- 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: Grievance vs. Complaint

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

Materials	Provided?	Adequate?	Content	Format
Orientation video	Y/N	No	Minimal re grievance	Outdated, distractions
PREA video	Y/N	Yes	Complete	Distractions
Orientation Q & A	No	N/A	N/A	N/A
Inmate rulebook	Yes	No	Numerous omissions	No ToC
Postings / notices	Y/N	No	Incomplete, outdated	Torn, small, misplaced

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

POSTINGS / NOTICES			
Posting	Displayed consistently?	Complete?	Specific issues
PREA	No	No	Disjointed; policy
Grievance procedures	No	No	Almost never posted
IAU and JOP	No	N/A	Almost never posted
ADA	No	Y/N	Contact has died
Speed dial lists	Y/N	Y/N	Not near phones, torn, outdated

Recommendation 2: Inmate education

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

- a. Completely revise orientation video, rule book, and many of the postings.
- 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

Issue	Best Practice	Jail's Practice
Can accused officer review, respond, "resolve"?	No	Yes
Written guidance?	Yes	No
Training for officers?	Yes	No
Timely response?	Yes	Yes/No
Inmates notified of delay?	Yes	No

Finding 4: Examples

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

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

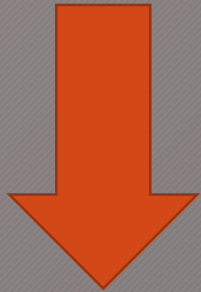
Policy

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: Referral for investigation

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



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

Source of complaint	Type of investigation	Adequate?
<u>JAIL COMMAND</u>	Full / formal investigation	Generally, YES
<u>INMATES</u> (or on inmate's behalf)	"Preliminary inquiry"	NO

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

Finding 6: Examples

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.

Grievances 2015					Yr End totals by category
	1st Qtr	2nd Qtr	3rd Qtr	4th Qtr **Note	
ADA	6	2	7	5	20
Admin. Booking	12	5	6	8	31
Classification	24	32	53	35	144
Commissary	11	15	20	16	62
Dental	3	4	4	6	17
Environmental Conditions	21	17	17	35	90
Food Services	8	3	8	13	32
Laundry	9	5	6	10	30
Law Library	0	0	0	1	1
Mail	38	18	26	26	108
Medical	90	77	96	76	339
Mental Health	4	1	7	5	17
Other	51	43	60	65	219
Other Services	17	17	13	10	57
Other staff conduct	77	50	73	29	229
Phone	3	5	13	1	22
Policy	0	1	0	0	1
PREA	0	0	2	1	3
Pro Per	9	10	5	2	26
Programs	0	8	2	1	11
Property	42	32	21	20	115
Sundeck	1	0	0	1	2
UOF	10	6	10	5	31
Visits	4	6	0	0	10
Total inmate grievances	440	357	449	371	
Total per Year		1617			

Recommendation 7: Internal oversight / quality assurance

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: Other serious issues make oversight especially critical

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: Implementation

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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