Alaska Department of Corrections: An Administrative Review

November 13, 2015

Dean Williams and Joe Hanlon

Contents

Purpose, Scope and Limitations of This Review

On August 10, 2015, Governor Bill Walker appointed Special Assistant Dean Williams and former FBI agent Joe Hanlon (the Review Team) to conduct an administrative review of the Alaska Department of Corrections. Several high-profile inmate deaths, along with concerns expressed by lawmakers and the public, sparked the Governor's concern. The Governor asked the Review Team to identify areas of concern and offer recommendations for improvement. This report constitutes the Review Team's response. The Review Team is the author and is responsible for its content.

This review should not be read as a comprehensive dissection of the Alaska Department of Corrections. Rather, a review is a snapshot in time, with inherent limitations. Additionally, while we attempt to acknowledge what is going right at the department, this review is naturally focused on what is wrong within the agency in order to identify and inform pathways for improvement.

The Review Team was granted wide latitude to discuss facts and perspectives gleaned through the course of this review. We are required to keep some information confidential to protect sources and security procedures, to avoid potential targeting of individuals, to respect the sensitivities of affected families, and to protect the legal and due process rights of state employees. With consideration for these limitations, the Review Team's guiding principle has been to tell the truth as best it can be determined, and to provide perspective on our findings. Where conflict arises between transparency and privilege, we err on the side of disclosure.

Review Process

The review occurred over a period of 11 weeks and included but was not limited to

- Site visits to the state's 13 correctional facilities, training academy, four of eight halfway houses (operated by GEO group - two in Anchorage, one in Nome, one in Bethel) and one of 12 community jails (Kotzebue);
- In-depth interviews with all superintendents and six assistant superintendents;
- Individual and group interviews with approximately 150 facility staff;
- Interviews with or correspondence from approximately 40 current and former inmates;
- Approximately 25 meetings with public or agency members;
- Review of 11 sets of videos on 11 cases (one case had 70 videos, of which we reviewed a sample)
- Gathering and cursory review of all department policies;
- Review of 22 case files on inmate deaths; and
- Review of approximately 30 emails from staff and members of the public who heard about the review and wanted to share their perspectives or information.

Observations

Following is a summary of the Review Team's observations concerning key aspects of department operations.

Policy Review and Updates

Correctional facilities must be guided by a set of clear and comprehensive policies detailing guidelines and procedures for both the routine and unusual circumstances that may arise in the prison and probation context. The Review Team began by requesting and reviewing the department's written policies. Such policies cover everything from emergency procedures to filing protocols to dietary guidelines.

The department has approximately 200 policies available for public review, and another 23 restricted-access policies; the latter are considered sensitive because they relate to security procedures.

Of the 23 restricted-access policies, 18 have not been updated since 2002; six of these were last updated in the 1980s. Of the non-restricted policies, approximately one-third have not been updated since 2002, and many have not been updated since the 1980s. The suicide prevention and awareness policy was last updated 20 years ago.

Conditions change over time as a result of changing laws, changing physical facilities, evolving public mores, and understanding of best practices. Ideally, policies reflect current conditions, practices, laws and values. When policies become stale, a gap develops between the rules and the reality. The result is a lack of meaningful guidance that opens up room for arbitrary decision-making. This is unfair to both staff and inmates. In addition to operational problems, stale policies send a message to staff that policies are peripheral to daily operations, when they should be integral to every action and decision.

Organizational Structure of Facilities

Under the current organizational structure, superintendents of Alaska's correctional facilities do not supervise all employees staffing their facilities. Most medical and mental health staff report to a manager or director in the department's central office. Consequently, while the superintendent of each facility is morally and legally responsible for all lives within the facility, the superintendent does not have line authority over personnel who have significant responsibility for keeping inmates and staff safe.

This organizational structure has significant implications. In nearly every facility the Review Team visited, the topic of "who is responsible for what" arose in interviews with line staff and management. Chains of command that circumvent the superintendent soften the command-and-control aspect of leadership. A divided command structure can lead to routine problems such as:

- Difficulty resolving competing demands among staff;
- Difficulty in conflict resolution;
- Challenges in scheduling staff to meet facility needs;
- Lack of ownership by superintendents regarding provision and quality of medical and mental health care to inmates; and
- Difficulty forming a cohesive team when employees report to different supervisors.

Negative consequences of this divided command structure became evident when the Review Team investigated several deaths that occurred in department facilities.

This divided command structure also creates an artificial distinction between inmates classified as "mental health inmates" and those designated "security inmates" (i.e., malingerers or sociopaths). This can create a perception that staff can pass off responsibility for certain inmates rather than promoting a sense of collective responsibility and accountability.

Solitary Confinement

Solitary confinement can be loosely defined as physical and social isolation for at least 22 hours within a 24-hour period, repeated for more than one day. Solitary confinement, also known as segregation, is used in Alaska's correctional facilities for three main purposes:

- Punitive segregation for rule or criminal violations;
- Administrative segregation – requested by a prisoner to be removed from the general population; or
- Segregation for mental health management or suicide prevention.

Solitary confinement in Alaska is widely used as a jail within a jail or to keep inmates safe from other inmates. Some superintendents report their segregation cells are maxed out.

Department policy on punitive segregation states that low-to-moderate infractions (e.g., indecent exposure; lying; failing to abide sanitation rules; malingering; feigning illness, injury or suicide attempt) can net an inmate 20 days of solitary confinement. More serious infractions can result in longer segregation sentences.

In practice, this policy is interpreted differently at different facilities. In one facility, inmates are allowed to work off punitive segregation time by doing chores around the facility. Another superintendent said all punitive segregation should be dispensed equally, with little room for interpretation of the rules.

Solitary confinement is a blunt tool. Many states along with the federal government are reviewing their segregation policies and practices. Negative psychological impacts are well documented.[1] The Review Team received many comments and concerns from the public about this issue; many said their loved ones devolved under the weight of isolation.

One example of questionable use of solitary confinement the Review Team encountered involved four 17-year-old inmates. The inmates were admitted to an adult correctional facility at age 16 after they were involved in an escape at a juvenile facility where staff had been assaulted. All four juveniles have been in solitary confinement since their admission to the adult facility approximately 11 months ago. They reported they are not receiving educational services and their out-of-cell time constitutes time in the hallway with a rare visit outside the building in a cage-type area.

Solitary confinement of 16- and 17-year-olds raises questions about our approach to young offenders in the adult system, as well as our approach to segregation generally. Research shows segregation is

[1] For example, see "Solitary Confinement and Risk of Self-Harm Among Jail Inmates," Kaba, F. et al., *American Journal of Public Health*, March 2014, v. 104, n. 3. Available at: http://ajph.aphapublications.org/doi/pdf/10.2105/ajph.2013.301742

particularly psychologically harmful to developing adolescents.[2] The United Nations Rules for the Protections of Juveniles Deprived of their Liberty, adopted in 1990 with U.S. support, outlaws solitary confinement for juveniles in correctional facilities.[3]

There are costs to the state as well. We have not analyzed Alaska data, but other jurisdictions report it costs 50 percent to 300 percent more to house an inmate in solitary confinement than in the regular population. Because solitary confinement can hinder positive social and psychological development, overuse of segregation can undermine the state's goal of reducing recidivism.

In light of these issues, many jurisdictions are reviewing their policies on solitary confinement. The federal Bureau of Prisons published a review of its solitary confinement policies and practices in December 2014 as a result of widespread concerns about the moral, social and economic implications of segregation.[4]

Solitary confinement is a legitimate and important tool for responding to certain safety and security threats to inmates and staff. A review of Alaska's policies and practices on solitary confinement is warranted to ensure it is being used sparingly and appropriately.

Administrative and Criminal Investigations

Integral to this review is the question of whether the department can appropriately investigate itself in cases of possible administrative or criminal misconduct. The Review Team reviewed the department's response to seven incidents involving inmate deaths, as detailed in the Case Studies section of this report.

The Review Team found flaws in the internal investigation process that included:

- Untrained and inexperienced investigators
- Questionable prioritization – a focus on minutiae while overlooking critical pieces of evidence
- Insufficient effort and resources given to investigations
- Ambivalence about whether and what personnel action should be taken
- Inconsistent personnel actions depending on "circumstances"
- History of lax personnel consequences for serious incidents
- Unguided labor relations involvement

It's worth noting there was no formalized death investigation policy until a year ago. The existence of a policy represents progress, but significant work is required to strengthen the policy and process.

[2] See American Academy of Child and Adolescent Psychiatry policy statement and references cited there: https://www.aacap.org/aacap/policy_statements/2012/solitary_confinement_of_juvenile_offenders.aspx
[3] See http://www.ohchr.org/EN/ProfessionalInterest/Pages/JuvenilesDeprivedOfLiberty.aspx
[4] "Federal Bureau of Prisons: Special Housing Unit Review and Assessment," CNA Analysis & Solutions, December 2014. http://www.bop.gov/resources/news/pdfs/CNA-SHUReportFinal_123014_2.pdf

In the course of reviews, the Review Team unexpectedly discovered errors in two Alaska State Troopers investigations of inmate deaths. Important witnesses were not interviewed, and critical video evidence was missed or incorrectly interpreted.

Without thorough and competent fact-finding in investigations of serious incidents such as prison deaths, the public loses confidence in the safety and fairness of our prisons, families are denied answers, and the corrections system is deprived of opportunities to analyze and improve its practices.

Administrative investigations

The Review Team discovered several incidents of lax or informal consequences for apparent employee misconduct. Multiple interviewees independently volunteered information about several cases.

Case 1 involved an incident in which a correctional officer assaulted an inmate with an object in violation of staff policy. The allegations were corroborated by video footage of the incident. Law enforcement investigated the case and referred it to prosecutors for screening. As of this writing, it is under review by the District Attorney.

Despite these indications of misconduct, the department had not conducted a personnel investigation into the correctional officer in question, and the human resources manager had no knowledge of the case when the Review Team noted it.

Case 2 occurred during the course of our review. A correctional officer accused an inmate of assaulting the correctional officer. The correctional officer wrote up the alleged incident, and the write-up resulted in the inmate's being sent to segregation and triggered a disciplinary process that included loss of "good time" for the inmate. The correctional officer went to the hospital and filed a workers' compensation claim.

A supervisor became suspicious and reviewed relevant video footage of the alleged incident, which showed the correctional officer's report to be false. Management reversed its finding and dropped discipline against the inmate, but did not call for any disciplinary action except "retraining" for the correctional officer who fabricated the incident.

After our Review Team reviewed the video footage and related evidence, and questioned management, management dismissed the correctional officer. The human resources manager was not personally aware of this case until the Review Team became involved.

Our interviews suggested there is a perception that "HR is out of the loop." Some suggested the physical location of human resources staff – in a separate building from the department's main state offices – contributes to this dynamic.

In addition, we received independent, credible reports of two instances of significant management misconduct. In both cases, managers were quietly transferred to new positions with no formal discipline. The lack of meaningful consequences for these management failings – widely evident to staff – erodes morale and lowers the bar for employee conduct.

Relationship with Department of Law

A recurring theme reported to the Review Team by former and current Corrections employees was concern about the level of involvement by Department of Law in Corrections policies and operations. Law is also sometimes a chokepoint for approval of policy updates.

Managers and line staff repeatedly referenced Law when asked the reason for various policies and operational decisions.

Law's overarching tendency is to protect the state against liability. For example, according to interviewees, Law expressed concerns that documenting all the facts around an inmate death might make it easier for the state to be found financially liable for the death.

The state has a valid interest in avoiding unnecessary litigation and loss. In the long-term, the most effective way of reducing the state's liability is to avoid the mistakes that create such liabilities. The primary goal of investigations should be to learn from mistakes so the underlying problems can be fixed.

Leadership Challenges

Corrections staff expressed considerable frustration to the Review Team about management, and suggested that trust has eroded in recent years. The reasons and history are subject to debate, and it is not possible within the scope of this review to assess or assign blame for the troubled relationship between Corrections management and line staff. Regardless of the reasons, mistrust runs deep and hinders optimal functioning of the department.

While some managers greeted this review process as an opportunity to learn and improve, others in leadership met the effort with suspicion and defensiveness.

Title 47 Protective Custody Admissions

Alaska Statute 47.37.170 provides for temporary protective custody of an individual who is incapacitated by alcohol or drugs in a public place. The statute calls for individuals to be placed in an appropriate health facility or their own homes; if these are unavailable, the statute allows placement of intoxicated individuals in state or municipal detention facilities.

This provision states that an intoxicated individual must be released from jail when:

- A treatment or medical facility becomes available,
- The individual is no longer intoxicated or incapacitated, or
- A period of 12 hours expires, whichever occurs first.

Title 47 holds have a significant impact on Alaska's corrections system. Correctional officers must admit, supervise, and release those detained under the statute. Individuals detained under Title 47 are often medically unstable. In one recent case, an individual was "cleared" from a hospital with breath alcohol content (BrAC) of .508, more than six times the legal limit for driving under the influence. In this case, the jail challenged the release of the individual to its care, and succeeded in delaying transfer until the individual's BrAC was .350.

Another department employee detailed a case in which an individual with a BrAC of approximately .5 was dropped off at the jail by law enforcement over objections of Corrections staff, who did not believe the individual was medically stable. Corrections staff refused to admit the individual and called emergency medical services.

Our review of other videos and records suggests these cases are not anomalies.

The Review Team also found widespread misunderstanding among corrections staff about what Title 47 holds require. Many staff erroneously understood the 12-hour period as a minimum or mandatory time period rather than a maximum length of protective hold. In addition, several nurses reported to the Review Team their understanding that Title 47 holds were not part of their core responsibilities.

Placing responsibility on prisons for the safety and wellbeing of medically unstable individuals puts a significant burden on corrections staff, puts the affected individuals at risk, and elevates liability exposure for the prison system.

Training and Evaluation

Currently, new correctional officers can be placed in a correctional facility before attending the state's Correctional Academy in Palmer, which provides a mandatory 6-week Basic Correctional Officer Academy. One correctional officer worked for ten months before going to the academy.

The Review Team received considerable feedback from correctional officers about the academy. The training was generally highly regarded, but correctional officers reported their perception that there is the "academy way" and the "real way" things are done in the facilities. This gap between the way things are supposed to work and the way they actually work erodes professionalism and conveys a message that the rules don't really matter. Many trainees expressed a desire to see facility-based correctional officers at the academy integrally involved in their training.

Some correctional officers reported to us that they had not been evaluated in five years or more. Many also reported that they had not had refresher courses or training updates in many years. For example, many said their CPR certification had lapsed.

Case Studies: Deaths in Correctional Facilities

This review was sparked by several inmate deaths within Alaska correctional facilities. The Governor's desire is to learn from the past in order to improve future practice. The Review Team had intended to carefully review approximately 25 recent deaths in correctional facilities. Two deaths occurred during the actual review period. Our plan shifted as a result of these unexpected and unfortunate events, and we focused on the two recent deaths as well as two particularly instructive cases from the past 18 months. We conducted more cursory reviews of an additional 20 recent deaths in custody.

The Review Team struggled with the knowledge that disclosure of details may cause renewed pain to loved ones of the deceased. We have tried to contact family members but have not been able to locate all of them. One family member was very encouraging and just wanted the truth told. We hope others

feel the same way. We extend our heartfelt condolences to the families of those who died in state custody.

Inmate Suicides

Preventing suicide in correctional facilities can be challenging. Many inmates have complex and co-occurring medical, mental health, and substance abuse needs, not all of which have been diagnosed or properly managed. It can be difficult to determine whether and when inmates present a threat to themselves, and it's impractical and intrusive to put every inmate on suicide watch. The Review Team was told the department's suicide prevention policy has been rewritten but awaits approval.

The Review Team reviewed three recent cases of inmate suicides.

Case 1: An inmate with mental health diagnoses was admitted to a correctional facility for a probation violation. The record reveals several indications of the inmate's eroding mental state. In the days before his suicide he filed multiple "request for interview" forms expressing concern about his safety both from others and himself. The inmate's cellmate reported to Troopers that he told correctional officers several times that his cellmate needed help. The cellmate was moved in the evening for unrelated reasons. The inmate hung himself early the next morning while he was alone in his cell. Staff response to the suicide, when discovered, followed proper policies and protocols.

Case 2: An inmate had been in custody four days when he told staff he tried to kill himself two days earlier with a sheet and almost lost consciousness. Staff referred him to the facility's mental health services. He was screened by contract mental health staff, but was not placed on suicide precaution status. Two days after the screening, he hung himself with a sheet. Staff response was swift and appropriate once the suicide was discovered.

Case 3: An inmate serving a parole violation sentence reported anxiety, depression and weight loss. The inmate's cellmate discovered he was trying to hang himself with a shoelace, and immediately alerted correctional officers. A correctional officer immediately secured the unit and then walked to the cell but did not enter. Another correctional officer arrived at the cell door within one minute but did not enter the cell. Approximately 45 seconds later two more officers arrived and entered the cell and rendered aid. The inmate initially survived, but was taken off life support two days later.

These cases should drive and instruct the suicide policy under revision. For example, general policies require that two correctional officers be present before a correctional officer enters a cell; this policy appears to have caused the delay in aid witnessed in Case 3 above. The Review Team believes immediate response is warranted in cases of active suicide where there is no conflicting safety or security threat.

The Review Team suggests a **fundamental reset is needed to establish a system-wide expectation of zero suicides**. There have been no suicides in the state's juvenile justice facilities in 20 years. This is not an accident; it's the result of a conscious prioritization and corresponding policy changes following a string of suicides in juvenile facilities in the 1980s.

Suicide prevention should be a clear and compelling priority. The attitude should be that any suicide is unacceptable.

Other Inmate Deaths

The Review Team looked into four recent inmate deaths and the investigations into them in an effort to glean insight from these experiences.

Case 1: Anchorage Correctional Complex, April 4, 2014: Devon Mosley

There are many complicating factors surrounding Mr. Mosley's death, and the Review Team spent considerable time reviewing the records. A synopsis of events follows:

- On March 16, 2014, Mr. Mosley was admitted to Anchorage Correctional Center on a fugitive-from-justice warrant. He had violated conditions of parole from California. He had a history of mental health problems.
- On March 20 Mr. Mosley challenged a correctional officer to a fight and made menacing statements. Mr. Mosley was taken to segregation, where he remained until his death.
- Over the next few days Mr. Mosley exhibited unusual behavior and threatened to kill himself. Pepper spray was used to stop self-harm behavior.
- Referrals to mental health were not well documented. One correctional officer told the Review Team that a blunt conversation with mental health staff did not go well; the officer was told they were fed up with Mr. Mosley's behavior and he was essentially the correctional officer's problem.
- In one interaction, Mr. Mosley was sprayed with pepper spray in his cell. Correctional officers reported they sprayed Mr. Mosley because he pulled away from correctional officers who were trying to un-cuff him. The video reveals Mr. Mosley had fallen down before he was sprayed, and posed no immediate threat. He is in his cell with the door closed. After he was sprayed, correctional officers left the cell for several minutes and Mr. Mosley attempted to decontaminate using toilet water.
- On March 22, segregation logs note, "Mosley was tearing clothes and trying to break the camera; was sprayed when he did not comply."
- On March 23, video shows Mr. Mosley naked, with only a suicide blanket and no mattress. Nothing else is in the cell.
- On March 24, video shows Mr. Mosley naked except for a suicide smock.
- On March 25 and 26, video shows Mr. Mosley with his clothes and a mattress.
- On March 25, California correctional officers arrived to transport Mr. Mosley to California. Based on his condition, the officers refused to accept custody of him.
- On March 27, the Anchorage District Attorney faxed dismissal paperwork from California to the Alaska Correctional Center. The paperwork was not processed, and was lost. Mr. Mosley was apparently free to be discharged at that time.
- On March 27, Mr. Mosley was naked with only a blanket and no mattress. The record notes Mr. Mosley had tried to destroy his mattress and flood his toilet. The Review Team had difficulty finding this documentation.

- On March 28, Mr. Mosley was still naked with only a blanket and no mattress. Facility management approved an order allowing only finger food, suicide gown, and no mattress, to be reviewed in 14 days.
- From March 29 to April 4, Mr. Mosley was naked with only a blanket in his cell.
- The department's investigation indicates that no medical or mental health staff checked on Mr. Mosley during this period, and that while segregation logs were signed, it appears no walk-throughs or inspections were done.
- At one point there is food thrown at Mr. Mosley.
- Segregation logs indicate Mr. Mosley did not shower for seven days.
- Segregation logs do not indicate whether Mr. Mosley or other inmates requested a phone call.
- Mr. Mosley appeared to die at 1117 on April 4. Staff noticed at approximately 1310.
- The only staff disciplined were line staff who did not fill out accurate logs on the day of Mr. Mosley's death.

The Review Team notes the following observations about events surrounding Mr. Mosley's death:

- In at least one case, pepper spray was used when it did not appear to be necessary.
- Mr. Mosley was clearly suffering from growing mental instability. He appears to have received very little in the way of mental health care.
- Mr. Mosley's unacceptable condition for transport to California appears to be a missed opportunity to reflect on what was happening to him.
- Mr. Mosley was naked for many days in a row, and was moved in the hallway unclothed. This is an unacceptable standard of care.
- The apparent disregard for Mr. Mosley's condition was profound. Video footage shows his physical condition deteriorating. The last note in his medical file was March 24. The last note in his mental health file was March 25. In a March 28 incident nursing staff apparently saw Mr. Mosley, but no notes reflect this.
- According to the department's review, management staff inspections of the segregation unit were cursory or non-existent.
- Segregation logs indicate there were days when every inmate in the module declined to come out for exercise or to shower. This strikes the Review Team as highly irregular.
- Anchorage Correctional Complex's failure to process Mr. Mosley's discharge paperwork and release remains unexplained.
- The Review Team notes that the department made real effort to review and reflect on Mr. Mosley's death, and to properly document relevant events. Unfortunately, the resulting fix seems incomplete. Informal and under-the-radar movement of a key staff member took place without any real action to address serious performance flaws.
- Mr. Mosley's family seemed to suffer more than necessary because the department immediately established a litigious defense position. Some staff told the Review Team they wanted to talk to the Mosley family but management cautioned against it.

Case 2: Anchorage Correctional Complex, January 27, 2015: Larry Kobuk

Mr. Kobuk was admitted on January 27 at approximately 22:45 (10:45 p.m.) on criminal charges related to vehicle theft and eluding the police. The following chronology is based on the Review Team's interviews and review of relevant video footage and documents. Some of the video included audio; some did not.

At 2246 (10:46 p.m.) Mr. Kobuk is brought into the booking area.

At 2251 an Anchorage Police Department officer can be seen talking to him.

At 2317 Mr. Kobuk is taken to the magistrate room until 2328.

At 2332 Mr. Kobuk is screened by a nurse. He tells the nurse he has cardiomyopathy and takes medication. He refuses to provide a breath alcohol sample.

At 2333 Mr. Kobuk is searched by correctional officers. Anchorage police tell correctional staff they need the two sweatshirts Mr. Kobuk is wearing.

At 2336 Mr. Kobuk says he is not giving them the sweatshirts.

At 2337 Mr. Kobuk is moved to a booking cell where four correctional officers place him face down. They remove his handcuffs and over the next few minutes remove his clothes.

At 2341, a correctional officer begins to remove the last sweatshirt with scissors.

Through this process, correctional officers have been on Mr. Kobuk's back while two Anchorage police officers and a nurse stand outside the cell observing. The police officer reported that he heard Mr. Kobuk yell several times that he couldn't breathe. Three of the correctional officers involved said Mr. Kobuk told them he couldn't breathe.

At 2344 the last sweatshirt is cut off. A correctional officer looks at Mr. Kobuk's face in an apparent attempt to see if he is breathing.

At 2345 the correctional officers leave the cell. Mr. Kobuk is still face down with his hands behind him, and does not move.

At 2346 (1.5 minutes later) correctional officers enter the cell and attempt to rouse Mr. Kobuk with ammonia.

At 2348:45 Mr. Kobuk is pulled out to the booking lobby where life-saving efforts begin.

The Review Team makes the following observations about Mr. Kobuk's death and the resulting investigation:

- Policy 811.05 infers that a prisoner's property should not be turned over to law enforcement without a search warrant. However, in practice there was an understanding that the

department aims to help law enforcement. Subsequent to Mr. Kobuk's death, the department issued a memo calling for staff to adhere a stricter interpretation of the policy.

- Regarding Mr. Kobuk's statements that he couldn't breathe, the department took the position that "methods employed during the restraint process were not found to be excessive." The Review Team notes that policy 1207.1 calls for "force to decrease to a reasonable level when compliance with orders is obtained or resistance/aggression is terminated." An inmate with a reported heart condition might warrant decreased force or more opportunities to comply without use of force.
- There does not appear to have been a clear and immediate safety threat such as an assault or attempted escape to warrant the level of force used.
- There was no personnel investigation in this case.
- While some of the Review Team's conclusions about Mr. Kobuk's death differ from the department's conclusions, the Review Team notes sincere effort by several individuals in management to vet the issues surrounding his death.

Case 3: Lemon Creek Correctional Center, August 14, 2015: Joseph Murphy

Mr. Murphy was admitted on August 13 at 1850 (6:50 p.m.) on a Title 47 protective hold. This means he was deemed incapacitated by alcohol or drugs in a public place, and was detained for the protection of his health and safety. He was medically "cleared" from Bartlett Hospital with a breath alcohol concentration of .165 and was placed in a cell with a camera shortly after admission. He remained in the cell through the night. He had no cellmates. We provide a synopsis of events based on video footage (no audio), interviews with staff, and related documents:

At 0520 on August 14 Mr. Murphy is awake and no longer appears to be impaired. [Note that under Title 47, he is to be released when he is no longer incapacitated, or when 12 hours have elapsed, *whichever is earlier*.]

At 0552 Staff 1 stops by the cell as Mr. Murphy appears to be yelling. According to Staff 1, Mr. Murphy complained of chest pain. Staff 1 claims to have offered to call emergency medical services and says Mr. Murphy declined.

At 0556 Staff 2 responded to Mr. Murphy banging his cell door and yelling. According to Staff 2, Mr. Murphy said he was having chest pains but showed no outward signs of distress. Staff 2 reports telling Mr. Murphy he would be out in an hour and if he needed emergency medical services, staff would gladly call.

At 0602 Staff 3 responded to Mr. Murphy banging his cell door and yelling. According to Staff 3, Mr. Murphy said he needed his pills but did not say what they were for. Staff 3 reports telling Mr. Murphy that his banging was agitating, and he should knock it off, suck it up, and he would be getting out soon.

At approximately the same time, Staff 4 reports hearing an inmate and Staff 3 yelling "f--- you" at each other. Staff 4 reports hearing the inmate saying he needed medical care, and heard Staff 3 say, "I don't care, you could die right now and I don't care." This was followed, according to Staff 4, by more "f--- you's." Staff 4 later identified the inmate as Mr. Murphy.

At 0605 Mr. Murphy begins pacing the cell, periodically banging on the cell door. He appears to be sweating.

At 0608 Mr. Murphy gets on his hands and knees and periodically bangs on the door.

At 0612 Mr. Murphy stands, starts walking while patting his chest and periodically banging on the door.

At 0619 Mr. Murphy collapses on the floor and his body stiffens with legs in the air, then relaxes.

At 0631 Staff 2 delivers breakfast tray to Mr. Murphy's cell and notices Mr. Murphy on the floor.

At 0634 Staff 3 enters the cell and places his hand on Mr. Murphy's throat, apparently checking for a pulse.

At 0637 Staff 1 enters and begins chest compressions. Staff 2 enters and takes over after about one minute. Life-saving attempts continue.

At 0647 EMS arrives and takes over life-saving measures.

At 0719 EMS halts life-saving measures.

The Review Team draws several observations from Mr. Murphy's case:

- At 0550 Mr. Murphy did not appear to be intoxicated and should legally have been released at that time. As noted earlier, there appears to be a widespread misconception that the 12-hour hold is a *minimum* period of detention when the law states it is the *maximum* period of detention.
- There was ambivalence over the appropriate personnel action for Staff 3. Labor Relations staff at the Department of Administration recommended a lower sanction; the Department of Corrections recommended a higher sanction. The Department was aware at the time of the Review Team's interest in the case.
- There were no personnel actions for Staff 1 and Staff 2, one of whom had medical training.
- Staff 4, a critical witness, was not interviewed by the Alaska State Troopers and is not mentioned in the Special Incident Report written by Corrections.

Case 4: Fairbanks Correctional Center, August 26, 2015: Gilbert Joseph

On August 26 at approximately 2345 (11:45 p.m.), Mr. Joseph was admitted to Fairbanks Correctional Center on a Title 47 protective hold. The community service patrol reported that Mr. Joseph had been drinking hand sanitizer. Staff was unable to get a breath alcohol reading. Mr. Joseph was in the facility with two cellmates for about three hours before he died.

The Review Team was notified of the death on August 27. On September 1 we received initial records related to the death, including what we understood to be all relevant video footage. An initial timeline of events provided by facility management indicated there had been no suspicious or aggressive behavior toward Mr. Joseph.

On September 2, the Review Team briefly reviewed the videos. The video was grainy but revealed assaults on Mr. Joseph by a cellmate. On September 3, Mr. Williams, the reviewer, noted the discrepancy to FCC management.

FCC management expressed surprise, and followed up by soliciting supplemental reports from other facility staff.

Later on September 3, the Alaska State Troopers forwarded its death investigation report to the Review Team. The report indicated no acts of aggression toward Mr. Joseph had been observed.

Over the next few days the Review Team questioned the three members of Corrections' investigation team. None had observed the assaults on Joseph when they reviewed the video footage.

The Review Team took steps to ensure both investigative teams (Troopers and Corrections) reviewed the evidence again.

On September 4, an email was forwarded to the Review Team reporting the discovery of a clearer video of Mr. Joseph's death. The Review Team received the new video on September 15.

The new video, taken with a higher quality camera in a reverse angle of the cell, more clearly shows the assaults observed in the first video as well as additional assaults not previously observed.

In the new video, two correctional officers can be seen standing outside the cell door while a cellmate places his hand over Mr. Joseph's nose and mouth for 1 to 2 seconds. Later, after Mr. Joseph had been pushed onto his stomach, the cellmate slides his hand under Mr. Joseph's face, possibly obstructing his airway, and holds it there for about 15 seconds.

Shortly after, Mr. Joseph is assaulted four more times on the back and can later be seen gasping for air. He appears to take his last breaths at 0135.

The Review Team makes several observations about events leading to Mr. Joseph's death:

- Mr. Joseph was highly intoxicated and did not appear to be medically stable enough to be detained in a prison setting. He was unable to walk or stand.
- Mr. Joseph's pants fell down while he was being dragged into the cell, and remained down for the duration of his stay.
- An officer appears to have seen Mr. Joseph get assaulted and went in to confront the cellmate, but did not act to prevent or intervene in further assaults.

We also observed significant discrepancies, omissions and inaccuracies in the initial reports filed by both the Troopers and Corrections. Notably:

- According to the Troopers' report, a correctional officer reported seeing Mr. Joseph's torso rise and fall at 0227 during a routine security check. Review of the second video shows Mr. Joseph took his last breath nearly an hour earlier, and the correctional officer briefly glanced into the cell at 0227.

- The Troopers' initial report, based on the first video, missed the assaults. The Trooper wrote, "I did not observe any physical acts of aggression towards Joseph or any suspicious activity in the video." According to facility staff, the Trooper reviewed that video at FCC in the company of one or more correctional officers who had been involved in the incident.
- Corrections investigators apparently also missed the assaults when they reviewed the first video.
- Both Troopers and Corrections investigators were apparently unaware of the second video, which did not surface until the Review Team became involved. It is unclear why this video, which provided the clearest evidence of what occurred, was not turned over earlier.
- No personnel investigation has been initiated at the time of this writing.

Other Observations and Considerations

We note several other issues that merit further consideration. Several are being addressed through other avenues.

Staffing Issues – Loss of Duty Posts

The loss of duty posts – correctional officer positions – dominated the concerns correctional officers communicated to the Review Team. The Alaska Correctional Officers Association provided a detailed analysis of position losses from the union's perspective. Staff reductions can have significant impacts on safety and staff morale. It will be an ongoing challenge to find a proper balance between budgetary restraint and prison safety. Working to improve relations between correctional officers and management is also critical to ensure productive working relationships.

We expect these issues to be raised and addressed as part of a significant staffing study that is underway.

Due Process Issues

During the course of this review, the State of Alaska Ombudsman's Office released three findings that pointed to violations of inmates' due process rights. The Ombudsman report provides a detailed analysis of what went wrong in those cases, and provides important lessons that the Review Team encourages the Department of Corrections to embrace.

Search Procedures of Staff

The Review Team observed a well-intentioned effort to search staff upon entering the secure section of any facility. The purpose is to deter staff from bringing in contraband that could lead to compromised security.

Actual practice differs among facilities despite what was described as a prescriptive directive. Facilities use a combination of methods such as metal detectors, hand-wanding, turning pockets inside out and light pat-downs. The department purchased large body scanners like those used in airports, but they failed and now sit as sentinels in remand areas with no purpose.

There are apparent weaknesses in the system. Some facilities search staff only upon initial arrival; the employee can leave for a break and return without a subsequent search. In some places the searches are so predictable and prescriptive that an employee wanting to smuggle in drugs would know how to avoid detection.

One practice the department might consider implementing is random urinalysis testing of employees. The Geo Group, contractor that runs most of the department's halfway houses, uses this strategy. The premise is that an employee tempted to smuggle in drugs is more likely a drug user. While this assumption has limitations, it has proven effective in the private sector. It is non-invasive, relatively inexpensive, and would provide a side benefit of discouraging staff use of illicit drugs.

The Review Team recommends the department review its current practices and search for effective practices in other secure facilities to prevent employee misconduct.

Phone Policies and Pricing

Costs and policies associated with phone calls was a source of considerable angst expressed by inmates' family members and attorneys. Interpretation of phone policies seems to vary from one facility to another. One attorney said inmates were not allowed to call his cell phone, only his office phone. This was apparently based on a telephone policy that prohibits use of phones that have options such as voice mail or message retrieval. The phone policy was last updated in 2007.

Current charges for inmates making phone calls are

- $3.75 for in-state and out-of-state collect calls up to 15 minutes
- $3.15 for in-state and out-of-state pre-paid collect calls up to 15 minutes
- $1.00 for local calls up to 15 minutes

Pepper Spray

Pepper spray (also known as oleoresin capsicum or OC spray) is used as a means to subdue or gain compliance from inmates. The Review Team observed some confusion about documentation required when pepper spray is used. In the recent past, the documentation went from a Special Incident Report (higher level of scrutiny) to an Incident Report (lower level of scrutiny). It was changed back, and pepper spray use currently requires documentation as a Special Incident Report.

There is evidence that staff is not uniformly aware of the current standard. One lieutenant at a large facility erroneously told the Review Team the current policy requires only an Incident Report.

"Cop out" Prison Slang

The Department uses the term "cop out" in reference to a form used by inmates to request medical help or counseling. There are "cop out" slots where inmates deposit the forms.

The use of such a term seems unprofessional and directly implies that a request for help is an expression of weakness or giving up. Words are important and should be used with care.

Inmate Health Care

Inmate health care is a challenging and costly issue. Prison populations have high rates of physical and mental health problems, including alcohol and substance abuse and related disorders. The state is responsible for the provision of services to inmates in its custody. Cost containment efforts will become increasingly important as the state's budget outlook tightens.

Quality of care is critically important. Many have observed that the corrections department is the state's largest provider of mental health services due to the overwhelming numbers of inmates with mental health and substance abuse disorders. Finding effective ways of assessing and treating both physical and mental health conditions is critically important. Most inmates will ultimately be released. It is in the state's fundamental interest to ensure they have the best chances of success to reduce recidivism and increase the chance they will become productive, law-abiding members of society.

The provision of mental health care must be comprehensively reviewed and improved. Cost containment efforts are not necessarily contrary to quality improvement. For example, low-cost options such as community involvement and chaplaincy programs can be highly effective.

Inmate Classification System

The system the department uses to determine the level of supervision individual inmates require (i.e., close, medium, or minimum) is overly simplistic, and has not been systematically evaluated in many years. The Review Team strongly encourages the department to research inmate classification tools and develop a more sophisticated, data-driven approach.

Recommendations

Policy Review and Updates

Develop a strict guideline to ensure all department policies are updated within six months. The Department of Law should provide advice but not serve as an approval gatekeeper. Attention should be given to streamlining policies to avoid redundancy and communicate in plain English. Having policies that are up-to-date, clearly stated, and briefly stated will help close the gap between policy and practice.

Future updates to policies should be planned and executed according to a scheduled cycle.

Organizational Structure of Facilities

Develop a chain of command that puts superintendents in supervisory control of all employees within a facility. Superintendents carry a weighty responsibility in keeping staff and inmates safe. They should have full authority to supervise, direct, and control all staff within their facility.

Solitary Confinement

Establish a clear priority to reduce solitary confinement and establish benchmarks of progress. State correctional systems and the federal prison system have established goals for reducing the use of solitary confinement. Many national agencies and resources exist that could help in this effort, and concerned members of the public have offered to help. Reducing solitary confinement is compatible

with Alaska's goal of reducing recidivism. Inmates released directly from solitary confinement to the community are particularly at risk of poor adjustment.

Administrative and Criminal Investigations

Develop an independent internal investigation team that reports outside the Department of Corrections. The missteps and faulty investigations documented by the Review Team are among the compelling reasons to develop a professional internal affairs agency. Various models for such a structure can be found around the country. We believe this recommendation can be accomplished with existing resources.

Relationship with Department of Law

The Department of Law should provide advice to Corrections in policy review and development, but should not serve as an approval gatekeeper. Management at Law and Corrections should work together to strike an appropriate balance between protecting the state against liability and promoting accountability and transparency.

Leadership Challenges

Establish a functional team comprised of labor and management to address long-standing labor issues. The relationship between Corrections management and employees and their unions needs repairing. Past wrongs, both real and perceived, have created a sometimes-toxic environment. The labor-management team should establish a process for discussion and work toward incremental goals to begin to reestablish trust.

Title 47 Protective Custody Admissions

Work to change Title 47 to eliminate the practice of admitting intoxicated individuals in prison for protective custody. Developing appropriate alternatives with current resources will be a challenge, but this change would improve prison safety and reduce risk to affected individuals, prison staff and the prison system.

Training and Evaluation

Develop policies and practices that ensure correctional officer recruits are appropriately trained before assuming duty posts, and receive ongoing professional training and evaluation. All recruits should attend the Correctional Academy before being placed on the job. In addition to ensuring all correctional officers have met training requirements before placement into a stressful job, this change could send a message that the "academy way" *is* the "real way."

Involving exemplary correctional officers in providing academy training – perhaps on a rotating or visiting basis – might also help close the gap between policy and practice. Likewise, rotating academy staff through facilities might help mitigate perceptions that academy staff is removed from the reality of prison life.

The department should also develop stronger, clearer policies and practices to ensure ongoing staff training, and establish a regular schedule of evaluations for all staff. The steps are important to ensuring a workforce that is equipped to handle the challenges of the job safely and professionally.

Acknowledgments

The Review Team would like to thank the many Corrections employees who participated in this effort even when they knew it might shine a harsh light in some areas. We were impressed over and over by the dedication of many correctional officers and other employees. One superintendent wanted to own all aspects of the facility so it would be clear who was accountable. Corrections employees provide critical services to our state in a challenging environment.

We would like to thank the family members of deceased inmates who shared their experiences with us and encouraged our efforts.

We thank Governor Walker for his courage in launching us on this journey, and for his commitment to finding and sharing the truth.