



Critical Analysis of Emergency Preparedness

Self-Audit Materials



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Critical Analysis of Emergency Preparedness Self-Audit Materials

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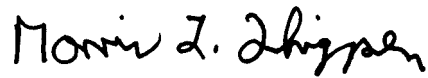
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FOREWORD

Emergency preparedness is a crucially important topic for every state department of corrections and for every correctional institution. Large-scale inmate violence or a natural disaster can threaten the lives of both institutional staff and inmates. In hours, a major emergency can cost a state tens of millions of dollars and result in many years of litigation. The negative publicity surrounding a major institutional crisis can also be overwhelming and almost interminable.

Emergency preparedness is often not afforded the priority that it needs and deserves. In some cases, this may be due to complacency. In other cases, it happens because establishing a comprehensive system of emergency preparation and emergency response is not easy. It requires budget, time, equipment, interagency coordination, and long-term management attention.

Over the last several years, the National Institute of Corrections has frequently provided technical assistance to state and local agencies or institutions to help evaluate their emergency readiness. To extend this assistance to more agencies, NIC sponsored the development of self-audit materials to guide agencies and institutions in rigorously examining their own emergency preparedness. The materials, contained in this document, may also provide a “wake-up call” to the institution or department that has not given adequate attention to this area. We hope the materials are of value in averting and preparing for emergencies.

A handwritten signature in black ink that reads "Morris L. Thigpen". The signature is written in a cursive, slightly slanted style.

Morris L. Thigpen, Director
National Institute of Corrections

PREFACE

After working with prisons and jails throughout this country and Canada for over 20 years on institutional emergencies, several conclusions seem self-evident. The most positive is that the level of awareness and sophistication about large-scale crises, disasters, and other emergencies has increased dramatically, perhaps exponentially. Twenty years ago, it was rare to find an institution or a department of corrections with trained hostage negotiators and common to find institutions that conducted no fire drills. Today the opposite is true.

This monograph is a testament to how far American correctional institutions have come with regard to emergency preparedness, and in how short a time. The idea of detailed, comprehensive self-audits of institutional and departmental emergency systems would have been overwhelming to most departments of corrections as recently as the 1970s. The reaction to these materials as they were piloted in draft form by a cross-section of departments of corrections was entirely positive, and no department said “we don’t care” or “this is not a high priority for us.”

It is also most encouraging to us that we can chronicle a developing recognition of the central role of prevention in avoiding some emergencies, and in minimizing the impact of those that cannot be avoided. Institutions that are run safely, reasonably, and constitutionally are less likely to face large-scale disturbances, and disturbances that do occur are less likely to produce deaths or serious injuries. Good emergency preparedness and a philosophy of early intervention can resolve incidents before they reach crisis proportions.

In spite of these most positive trends in the field, some serious problems are also obvious. Some institutions and departments continue to rely almost exclusively on the belief that “it can’t happen here.” That, of course, is simply not true. Just in the last several years in this country, large prisons have had to be evacuated on short notice to distant locations, prisons were entirely lost to natural disasters, riots were started by things as basic as water shortages, prisons were threatened by major fires and chemical spills, and others lost “fence-to-fence” to inmate violence. It can happen here, and prison authorities are obligated to their communities, their staff, and their inmate populations to work to prevent such situations, but also to be well and realistically prepared.

A second obvious problem is equating prison emergencies with riot and hostage situations. In many prisons, the risk of loss of life is higher from fire or natural disaster than from inmate insurrection. It does not make sense to have a tactical team that is a “10” in a prison where fire safety is a “2” and there is no plan for earthquake or tornado. Some institutions that practice hostage rescue operations in worst-case scenarios do not know where the nearest HAZMAT team is located, or what its capabilities are. Prisons must prepare for a broad range of natural and man-made emergency situations and not allow the dramatic qualities of riot and hostage takings to result in tunnel vision.

Another consistent problem in the field is institutions that have detailed emergency plans that are not practical or that exist only on paper. It is still frequent to find institutions where staff at the shift command level have almost no familiarity with the institution’s emergency plans, with the contents of the armory, or with mutual aid agreements. In some prisons, the emergency plans read impressively, but they reference equipment, terms, procedures, and capabilities that simply don’t exist. That can be particularly dangerous, since the appearance of good emergency plans can create a false sense of security that deflects efforts at improvement.

Finally, there are agencies and institutions that are not adequately prepared for emergencies and readily acknowledge the crucial importance of this area, but will not commit the resources, the time, or the management attention to do what is needed. Good emergency preparedness is not cheap or easy to attain, and once developed it must be maintained or it will quickly deteriorate. However, it is simply a “you can pay now or you can pay later” proposition.

It is our hope and belief that these self-audit materials can help overcome many of these problems. A thorough evaluation of the strengths and weaknesses of existing emergency preparedness is the sensible starting point for any major change in a departmental or institutional emergency system, and these self-audit materials are designed to accomplish that goal. Just as NIC heightened awareness in prisons concerning security reviews with publication several years ago of model security audit materials and subsequent training seminars on conducting security audits, we believe the Institute’s publication of this monograph and the emergency self-audit checklists will raise the standard for prison emergency preparedness nationally.

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This monograph was produced by a project funded by the National Institute of Corrections. The project would not have been possible without the efforts of a number of individuals and active participation from several correctional agencies.

William R. (Doug) Catoe, Jim Henderson, and Lanson Newsome served as project consultants. They worked on the initial development of these materials and later participated in field tests of the materials in three state departments of corrections. Doug, Jim, and Lanson brought many years of hands-on prison experience and wisdom to this project, along with a keen appreciation of the intricacies of prison emergencies.

The Alaska, Nebraska, and Texas Departments of Corrections each participated in the field validation of the draft self-assessment materials. They gave the project staff and consultants free access to two of their institutions for a traditional, external expert assessment of emergency readiness so that the results could be compared and contrasted with an earlier assessment done by their own staff using these materials in draft form. There were improvements in the self-audit materials that would not have occurred were it not for the opportunity to conduct field tests in such widely diverse agencies and institutions, and we are indebted to them and their staff for their generous assistance. We also thank the Colorado, Florida, Illinois, Kentucky, and Missouri Departments of Corrections for evaluating preliminary versions of these materials.

Our project manager at NIC was Dan Russell of the Prisons Division. Dan was not only our administrative monitor, he was also an active participant contributing to this project from his own background as a longtime correctional professional and a former state director of corrections. Dan's assistance, guidance, and patience were invaluable.

Nancy Sabanosh, NIC's publications editor, was tireless in her pursuit of typographical errors, stylistic inconsistencies, and less than clear rendition. However, her editorial contributions, large and small, went beyond these areas and improved the logic, organization, and coherence of the entire monograph.

The Director of NIC's Prisons Division, Susan Hunter, maintained close involvement with this project from its initiation and contributed to the substance of the monograph as well as providing administrative direction. The project staff is also grateful to NIC's Anna Thompson, who reviewed each draft of this monograph and provided thoughtful critique and suggestions.

LETRA's Dr. Cynthia Barry served as a senior project staff member, bringing some 20 years of experience developing prison emergency systems. Kimberly Bland Wiseman, Sarah Wada, and Jenine Lambert were LETRA's office managers for the project, typing and formatting this monograph and providing office support throughout.

Finally, much of the expertise reflected in this monograph has come from lessons learned -- some of them painfully -- by staff at correctional institutions throughout this country in the 25 years since Attica. It is important to acknowledge that these self-audit materials constitute a body of knowledge about large-scale crises in prisons that has grown and developed from the practical experiences of a great many correctional professionals.

Jeffrey A. Schwartz, Ph.D.
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Section 1

INTRODUCTION

Emergency Preparedness is a central, even critical issue throughout American corrections. That fact is so obvious as to need little explanation. Today almost every public agency must have emergency plans and even private businesses are turning to disaster preparedness and business-recovery planning. Prisons, however, are not like other public agencies. They are responsible for the safety of large numbers of individuals who are usually locked up and cannot protect themselves against many kinds of emergency situations. Further, and perhaps ironically, it is the very people who are locked up and whose safety must be assured who are themselves the source of the most frequent and the most serious of prison emergency situations. Finally, the first priority for every prison is community protection, which means that even in the chaos of a major emergency, prisons must ensure against escape.

It is also obvious that no prison is immune from large-scale emergencies. A minimum-custody facility housing short-term inmates may have a very low risk of riot and disturbance situations, but a minimum-security designation is no shield against fire, earthquake, chemical spill, or staff walkout.

A complicating factor is that the twin risks that an emergency will happen and that it will go badly are heightened by population overcrowding and decreases in staffing levels and other resources, as well as by the recent trend towards elimination of some programs that help stabilize prisons (e.g., earned good time). Those conditions are ubiquitous in American corrections, with the result that most state prison systems are in a more precarious position with regard to major emergencies than they were 10 or 15 years ago.

If the fear of large-scale crises is widely acknowledged, and if the dangers presented by major emergencies are recognized as realistic, does it not follow that almost all state prison systems would commit serious time, resources, and thought to emergency preparedness? In fact, that is not the case. "Why" it is not the case is not so simple.

One reason that most prison systems have not placed high priority on emergency preparedness is that it does not seem as pressing as day-to-day pressures until there is an actual emergency. Second, most people still judge emergency situations by whether they came out well rather than whether the staff performed properly, the right training and equipment were in place, the policies proved valid, etc. That is, in too many systems there is no serious scrutiny or review unless a situation has produced tragic results. Third, effective comprehensive emergency preparedness is demanding and difficult to achieve. Fourth, some traditions in corrections work directly against effective emergency preparedness. These traditions include management by personality rather than by procedure and policy; separate emergency plans for every likely type of emergency with no requirement that the various plans be integrated or consistent with each other; a deep-rooted belief that the only prison emergencies that really matter are riots and hostage situations; and, finally, an equally deep-seated belief that every emergency situation will be different, so that planning really doesn't matter very much.

Effective planning plays a crucial preventative role with regard to the occurrence of major emergencies. That is, good planning may prevent some situations from occurring in the first place (planned disturbances, some kinds of fires, some types of hostage incidents). More commonly, effective planning can result in early intervention so that small and localized crises are resolved before they can escalate into major emergencies that threaten the entire institution. The lack of effective emergency preparedness not only means that a major emergency may go more badly than necessary, but also that a major emergency may be more likely to occur than is necessary.

If a state department of corrections does not have the level of emergency preparedness that it wants or needs, "assessment" is the logical first step. If the management staff of an institution or department can be involved in evaluating the strengths and weaknesses of their own emergency policies, procedures, plans, equipment, etc., that may be all the motivation required for staff to begin to overhaul and revamp their emergency systems. The only choice that administrators have had, if they wish to evaluate their own state of readiness for large-scale crisis situations, has been to either ask their own people to conduct the evaluation or to contract with outside consultants. If one's own staff are used, they may lack the objectivity to point out areas in which "the Emperor has no clothes."

Even if they are objective, they may not notice obvious problems because they have lived with those problems for so long that they think they are a natural state of affairs. Staff from within a particular state department of corrections are also unlikely to recognize the breadth of alternative solutions that may be available if one were to look across the 50 state corrections systems. Then too, if the evaluation is conducted internally, politics and personalities can be expected to play roles.

If external consultants are engaged, there is another set of serious problems. First, consultants cost money and a serious evaluation may be expensive. Second, some consultants are very good with fire prevention and firefighting systems, others are quite specialized with regard to CERT and SWAT teams, and still others are experienced at training hostage negotiators, but very few people in the country have in-depth experience and expertise with the entire gamut of comprehensive emergency preparedness systems. Third, outside consultants may be seen as “walk-through experts” and not taken seriously. Fourth, consultant reports are sometimes used politically rather than constructively.

Since many departments of corrections rely heavily on self-audit procedures in other areas of their operations, it follows that a well designed self-assessment instrument to analyze emergency preparedness may be extremely useful. Thus, development of a detailed, comprehensive self-assessment instrument for evaluating emergency preparedness in both state departments of corrections and individual correctional institutions was the primary goal of this project. Other goals were to create case studies of emergency preparation, policy, response, and the like from actual emergency situations; to test the components of the new self-assessment materials to ensure practicality, effectiveness, general adaptability, and general acceptance by the field; and to validate the final materials prior to publication by comparing the results at demonstration sites in several state departments of corrections with the results obtained by two or more experienced emergency preparedness consultants analyzing those same demonstration sites.

The first step in this project was to contact a large cross-section of the state departments of corrections, asking if they would be willing to participate at some level in this project. Of the 21 agencies contacted, 20 agreed to participate and 1 declined.

The 20 state DOCs were asked to supply sample institutional emergency plans, departmental emergency policies and plans, and reports of recent large crises and emergencies. The project staff prepared summaries and synopses of the various materials sent by the state DOCs, and this material was the basis for the initial meeting of the project staff, the three project consultants, and the NIC project monitor. Project staff also prepared initial draft emergency preparedness audit checklists (one for individual institutions and one for departmental use) for review at that three-day meeting. Based on the sample emergency plans, the incident reports, critical incident reviews, and the draft self-assessment materials, the project staff and consultants developed preliminary trial versions of the self-assessment materials. In the trial versions, the institutional self-assessment checklist and the departmental self-assessment checklist were each produced in separate volumes.

The trial versions of the self-assessment materials were sent to five states (Colorado, Florida, Illinois, Kentucky, and Missouri). Each agreed to administer the institutional self-assessment materials to one maximum-security and one medium-security prison and to administer the departmental self-assessment materials at the agency level.

Once completed, the audit materials were returned to the project staff for review, with the agency retaining copies for its own use. Phone interviews with the individuals who actually completed the self-assessment checklists and with top administrators at the institution and agency level were used to develop more detailed information about the length of time the forms took to complete, problems in administering the audit, suggestions for change in the materials, and the perceived practicality and impact of the self-assessment materials.

The phone interviews revealed that two of the five states had decided to distribute the draft materials much more widely than initially planned. The Missouri DOC sent the draft materials to all of its state prisons to be completed, and the Illinois DOC distributed the materials to six rather than two institutions. In general, the reactions to the draft self-assessment materials were most positive. While there were many specific suggestions for additions or small changes, no major problems were encountered. The estimates of the time necessary to conduct the self-audit of emergency preparedness ranged from a low of 4 hours to a high of 1-1/2 days. The self-audit checklists were generally seen as clear and easy to understand. The most frequent general reaction to using the draft materials was that it had been an eye-opening experience to actually document how many important emergency provisions were not fully developed or in place. No institution or department was generally negative about the experience.

The reactions and materials from these field trials in the five participating agencies were then used to modify the self-assessment materials and create a new draft that was then reviewed by the project consultants and the NIC project monitor. Their changes and additions were incorporated into the final draft version of the materials, which was then retested for practicality, accuracy, and usefulness by means of a validation study. Three state DOCs (Alaska, Nebraska, and Texas) had been chosen for the validation study -- from among the 20 agencies volunteering their participation -- to provide a diverse cross-section of the state DOCs. They represented small, medium, and large agencies, three different geographic areas of the country, urban and rural prison settings, and quite small to quite large individual institutions. Alaska is also one of the few states with a combined jail and prison system.

The general plan for the validation study was to compare the results obtained with the self-assessment materials with the results obtained by a traditional emergency preparedness evaluation conducted by experienced consultants. In each of the three states, one maximum-security institution and one minimum- or medium-security institution were identified. The state then administered the self-assessment materials at the two institutions and at the departmental level. Within one week after the self-assessment materials were completed, one of the senior project staff members and one of the three project consultants conducted an onsite evaluation of emergency readiness, touring each of the two identified institutions and reviewing institutional emergency plans as well as departmental policies, emergency equipment, emergency staffing and specialists, etc. At the end of each onsite evaluation, project staff members reviewed the results of their findings with top departmental and/or institutional managers. These findings were then compared and contrasted with the results of the self-audits that had been completed previously.

In general, the two methods of evaluation, onsite consultant tours and review, and the self-audit materials, produced remarkably consistent results. Institutions that had little emergency readiness were quickly identified as such, whether by consultant review or by self-assessment. Similarly, institutions that had made a substantial commitment to emergency preparedness and done a lot of work on emergency issues were consistently shown to be in a much better state of readiness by either method. Further, the two methods tended to agree at a much more detailed level. For example, if an institution had no provision for hostage negotiators and no tactical capacity for hostage rescue, these problems were evident in both the self-assessment results and the consultant evaluation results.

Some important differences between the two methods did emerge. The self-audit checklists proved to be more detailed and thorough than consultant evaluation. Even when two experienced consultants spend a full day reviewing a moderate-sized institution, they would not have time to inquire about every area covered in the self-assessment checklists. It was also inevitable that they would skip some details that the checklists contain. On the other hand, the consultant evaluation proved superior at identifying areas where things were in place but substandard, or where appearance and reality differed sharply. A third substantial difference was observed at institutions where the management was only minimally concerned about emergency issues. In these situations, a review meeting with outside consultants appeared to motivate management to seriously consider the results of the evaluation, while the self-assessment materials did not. These latter findings underscored the fact that self-audit procedures will not be effective unless management is committed to honest and demanding evaluation.

An additional result of the validation study was recognition that sending departments two separate volumes, one for institutional audits and one for departmental audits, was repetitive and potentially confusing. A decision was reached to combine the checklists into a single document that would also include introductory materials, instructions for using the checklists, the case study material, etc. The institutional and departmental self-audit checklists are given in Section 2.

Section 3 presents case studies of recent prison and jail crises around the United States and some of the lessons learned. As the field trials and then the validation study progressed, the project staff was also culling through critical incident reviews and reports from major emergencies. The case studies eventually selected for inclusion reflect both the diversity of emergency situations that may threaten prisons and the wide range of lessons that can be drawn from the experiences of others. Some of the case studies were abstracted from lengthier reviews that were originally prepared for NIC special issue seminars on hostage and riot situations. Other case studies were written for this project using source material obtained from the agencies involved. In one instance (Fire in a New Institution), the case study is based primarily on phone interview data because the information available from reports was minimal. In all cases, the “lessons learned” sections at the end of each case study were prepared specifically for this project and were reviewed by the agency involved in the incident. The case studies published here are included with their permission. The case studies are highly condensed summaries. They do not present all aspects of each situation, and the interested reader is encouraged to review original reports and other source documents for more information.

The problem with many emergency plans is they are so cumbersome and contain so much lengthy reference material that they are not helpful during an actual emergency. Section 4 presents a Model Organization of Institutional Emergency Plans, which illustrates a practical and logical order for the elements of a plan. The model organization attempts to place the highest priority items earliest and to relegate the lengthy but necessary reference material to the later sections of the manual. Some state departments of corrections (Oregon, Arkansas, and Pennsylvania among others) have in the last several years changed to a markedly different system, organizing emergency plans into three volumes instead of the traditional one large volume.

The model is based on the concept of a single, generic, comprehensive emergency plan with supplemental appendices for the various types of specific emergencies. Many correctional agencies have moved to this concept in recent years, in preference to the more traditional approach of developing separate and distinct emergency plans -- and different emergency manuals -- for each type of potential emergency. It must be emphasized that the model emergency plan organization presented cannot be all-inclusive for every institution or department. There may be crucial sections of a specific institution’s current emergency plan that are not reflected in this model; that does not imply that those sections are wrong or irrelevant. The model presented is intended to demonstrate organization and style and should not be construed as controlling with regard to content. That is an agency and an institutional decision. The Model Organization of Institutional Emergency Plans, and the succeeding Model Emergency Plan: Representative Sample Sections, are primarily taken from the Oregon DOC. As this is written, Oregon’s institutional emergency plans appear to represent the state of the art.

In considering various styles of emergency plans, it is important to remember that an institution’s emergency plan is simply a reflection of the underlying emergency system. No matter how well written or professional looking the plan is, it will be useless if it does not accurately portray the underlying policies, equipment, training, procedures, and staff specialists that are in place. (Actually, a plan that does not correspond to what is in place may be worse than useless, since it offers an illusion of preparedness where none exists.) Thus, good preparedness does not begin with an emergency manual; the manual should be an end product.

There are frequent references in this monograph to an “emergency preparedness system,” and a clear implication that every DOC and institution should have a system of emergency preparedness and response. In fact, most DOCs do not have such a coherent, identifiable system; instead, they have an assortment of procedures, directives, and expectations that have evolved over many years, often by happenstance. A true system of emergency preparedness begins with a set of emergency policies that specify, among other things, an emergency organizational structure. The emergency organizational structure is integrated not only with the emergency policies, but with emergency procedures, emergency equipment, specialized staff functions, external agency agreements, training, risk assessment, prevention activities, and more. A good system will also be practical, simple, checklist driven, and field tested. There are few truly comprehensive emergency preparedness systems that were originally designed to fit correctional institutions.

Section 5 provides two “selected” bibliographies. Neither bibliography is annotated or complete, as a thorough literature review was beyond the scope of this project. Two bibliographies are included because it is important that the reader recognize that there is a large and potentially helpful body of literature outside of corrections that deals with emergencies and disasters. In corrections, the literature dealing with emergencies, disasters, and crises is most often referred to as “emergency preparedness.” Outside of corrections, the same topics are often referred to as “the disaster literature” or, more specifically, under topics such as “disaster planning” and “crisis response.” This is a burgeoning literature area, particularly in the last 20 years, with contributors about equally divided between practitioners and academics. It is of particular interest that there is now a growing body of behavioral research dealing with studies of disaster preparation, reaction to emergencies, and the like.

Emergency situations in correctional institutions have all of the challenges and complexities of community emergencies with the added risks of offender violence and escapes, and they are also more frequent than community emergencies. In spite of this, there has been neither the tradition nor the funding to support behavioral research on institutional emergencies, and the correctional practitioner who specializes in this area would do well to stay abreast of the growing body of theory and research that exists outside of corrections and deals with emergencies and disasters.

The corrections literature on emergencies is quite extensive and is unusual in that a rather large portion of the most important information is not in traditional journal articles or published books. Some of the illuminating documents are attorney general reports, in-house critical incident reviews, legislative staff reports, blue ribbon commission findings, and the like. The reader who wants to obtain everything in one specific area of this literature may have to telephone and write for copies of various documents as well as reviewing more typical library sources.

Section 2

SELF-AUDIT CHECKLISTS

HOW TO USE THE SELF-AUDIT CHECKLISTS

***ALL MANAGERS WHO WILL BE INVOLVED WITH
THE SELF-AUDIT OF EMERGENCY PREPAREDNESS
SHOULD READ THESE INSTRUCTIONS THOROUGHLY
BEFORE PROCEEDING.***

The intent of these self-audit materials is to help a state department of corrections or an individual institution evaluate its state of readiness to contend with a major emergency.

There are two different assessment documents (self-audit checklists). One is for department-wide use and the other is for an individual institution. Make sure you have the right document.

These checklists are not all-inclusive. There are many details that are not in the checklists. That does not mean that they may not be important to an individual agency. There may also be large issues that are not represented in the checklists, but that are crucial to a given agency or institution. The ultimate decision about what is important in emergency preparedness must be the province of each individual department or institution.

Similarly, the fact that the institution does not have some of the items that are on the checklists does not necessarily mean that the institution is wrong or in jeopardy. If the institution has thoughtfully decided not to purchase certain equipment or not to include certain policies or procedures, there may be an excellent reason for that decision. Again, the decision must be that of the institution or department. Conversely, if there are items on the checklists that the institution has decided are important but has not complied with, or if there are items that the institution has never considered, then the checklists may serve a useful purpose in stimulating action or a review of new possibilities.

A word is in order about minimum-security facilities. It is recognized that a minimum-security facility will typically have a somewhat different set of risks for emergency situations than would be true of a large maximum-security institution. (Hence, the importance of good risk assessment as a starting point for emergency preparedness.) Low-security facilities may have much lower risk of large-scale disturbances or planned hostage incidents than would be the case at larger institutions. Thus, it is understandable that many minimum-security institutions choose not to maintain their own tactical teams. Riots, hostage incidents, large-scale racial battles and the like may not be as likely, but they are certainly possible, and the institution that does not have its own tactical team is still obligated to know, in advance, who would provide a tactical team if it became necessary. Further, a small or minimum-security institution may have a larger risk of loss of life from some kinds of emergencies, such as fire or tornado, than many large high-security institutions. The point is that most of the items in the self-audit checklist are relevant for the small or minimum-security institution as well as the large, even though staff at the small institution may be responsible for multiple functions in an emergency, and the institution may be much more dependent on external resources.

For the institution or department that wants to initiate a thorough ongoing review of emergency preparedness, it is hoped that the checklist will provide a framework for such a review. However, if the self-audit is not going to be done in a serious, demanding and rigorous manner, it should probably not be done at all. A review that “glosses over” problems or fails to report deficiencies can create an illusion of security and may be more dangerous than no review at all.

The manner in which a department or institution approaches this audit is most important. If it is viewed as if it is going to provide grades or a score card, then that will be transmitted to subordinate staff and the audit process will probably not be constructive. It should be emphasized that this is a self-audit designed to help the department or institution review a critically important area. It should be a source of ideas and constructive change rather than criticism.

The old computer adage about “garbage in, garbage out” holds true for this self-audit. If it is not done carefully and accurately, the results will be misleading. If the person(s) conducting the self-audit is unsure about an item, he or she should look it up, or go and check it out, or leave it blank. It defeats the purpose of this audit if the person conducting it begins to guess about items or to assume that things are a certain way.

During their development, these self-audit materials were subjected to extensive field testing. One factor emerged during that field testing that correlated very strongly with the degree to which the self-audit process proved useful to the department or institution involved. That factor was whether the institution or department held a management meeting at which the results of the self-audit were carefully reviewed. Without such a management meeting, a department or institution might conduct a careful self-audit, but never discuss or fix those items found to be substandard or completely missing. It is strongly encouraged that a high-level management review meeting, including all of the appropriate managers and administrators, be planned as an integral part of undertaking this self-audit. It should be scheduled to take place immediately after the checklist has been completed.

This audit is not intended to take days or weeks to complete. In field testing, estimates for the time necessary to complete one of the two checklists ranged from 4 hours to 1-1/2 days, typically with one or two staff members assigned.

The last sections of this manual are not essential to completing the self-audit. Rather, they are intended to provide additional background about disaster preparedness in general and institutional emergencies in particular. They are intended to be thought-provoking and to provide a source of new ideas and approaches, as well as some of the lessons learned from crises and disasters elsewhere.

What will actually be needed to conduct a self-audit? First you will need one or two assigned staff members of appropriate rank. The assigned staff will need between one half day and two days of time if the audit is completed on a full-time basis. They will need access to all areas of the institution as well as access to staff who manage specialized functions in an emergency (CERT team leader and hostage negotiators). Much of the audit will involve review of a broad range of policies, procedures, and other written documents. The self-audit will not require any specialized equipment or unusual resources.

DIRECTIONS

1. There are two different assessment documents (self-audit checklists). One is for department-wide use and the other is for an individual institution. Make sure you have the right document.
2. Make as many copies as you need of each checklist. For example, if you will be auditing seven institutions and you want two copies of the institutional self-audit checklist for each institution, and some extras, you may want to start by making approximately 20 copies of the original. Retain the original, unmarked, for future reference and in case you need additional copies at a later time.
3. In a similar fashion, make as many copies as you need of the Non-Compliance Summary Sheet. Pilot testing of these checklists indicated that 5 to 15 copies of these pages were typically used for each audit, but you may need fewer or more, depending on the number of items determined to be “substandard,” “absent,” or “not applicable.” Note that the same Non-Compliance Summary Sheet is used for both the institutional and the departmental audit checklists.
4. One person should be in charge of the audit. That does not mean that person must conduct the entire audit alone. That person should, however, direct and supervise every aspect of the audit that he or she does not personally conduct. If the staff rank or organizational level of the person assigned to conduct this audit is inappropriately low, he or she may not be aware of some of the necessary information, and it may also send a signal regarding the importance of the audit to the department or institution.
5. The audit should be a relatively continuous activity conducted in a relatively short period of time. It is not intended that the audit take months or that the audit stop while individual items are fixed or brought into compliance.
6. Read the “Glossary of Terms”, which follow these directions, before attempting to complete the checklist. Every department of corrections has some terminology that is unique. Also, the same term may mean two different things in two different departments. In a generic document of this sort, some confusion about terminology may be inevitable, but the glossary of terms as used in the checklist should help minimize this problem.
7. For each item in the audit checklists there are four blanks to be filled in. The items do not have to be taken in the order presented in the checklists, but all items must be completed for the audit to be finished.
8. The “Status” box: For every item on the checklists, enter a “C,” “S,” or “A.” You should not make any other entry into that box and you should not enter more than one of those three letters in the box. The “C” means compliance. The “S” means substandard. The “A” means absent or not applicable.

There will obviously be items where the distinction between compliance and substandard, for example, will be a difficult judgment call. Individuals conducting this audit should attempt to be rigorous and demanding, and also consistent. Remember that an item that is checked as “compliance” will likely not be reviewed further. An item that receives an “S” or an “A” should, however, be subject to further discussion and review.

If an item in the self-audit is absent, but the institution or department has something else that serves the same purpose, the proper response is “A” (for “absent”) rather than “Compliance.” It should be left to the management review to determine whether what is in place is, in fact, comparable to, or superior to, the item asked for in this audit. Similarly, a number of places in the self-audit ask for specific written policies.

Do not check “Compliance” just because the item is understood by almost all staff as informal policy, even though it is not written. Similarly, if the item asks about written policy, do not give credit for a group of answers that may be scattered throughout procedural manuals (and of little use to staff during an emergency). Something may be done regularly, but if the question asks whether it is “required by policy,” then the answer is “Absent.”

9. The “NC No.” box: “NC No.” means Non-Compliance Number. It applies to every item that is marked “S” or “A.” Every time you enter an “S” or an “A,” you must put a new number into the “NC No.” box. When you enter a “C” in the “Status” box, you will leave the “NC No.” box blank for that item.
10. If you complete all of the items on the checklists in the order in which they are presented, then the numbers in the “NC No.” boxes will run consecutively. That is, the first time you enter “S” or “A” for an item, you will put the number “1” in the “NC No.” box. Whenever you find the next item to which you give an “S” or “A” (in the “Status” box), you will assign the number “2” (in the “NC No.” box). And so on.

Note that if you audit the items in a different order than they are presented in the checklists, it will probably be easiest to assign “NC” numbers in the order that you complete the items. That will mean that when you complete the audit, the numbers in the “NC No.” boxes will not run consecutively down the page. Either method is acceptable.

11. The “Initials” box: Print the initials of the person who actually conducted the audit of that specific item.
12. The “Date” box: Enter the date on which the audit of that specific item was completed.
13. When every item on a given page is completed, the person in charge of the audit should check “YES” at the bottom of the page, sign, and date it.
14. “Summary of Non-Compliance Items”: At the end of the checklists, you will find a page headed “Summary of Non-Compliance Items.” The purpose of the summary pages is to provide a list of items that were found not to be in compliance, along with a brief statement of the reason that the item is substandard, absent, or not applicable. These summaries should be the raw material for a thorough management review of the audit results.
15. For each non-compliance item (that is, every item except those for which a “C” was entered in the “Status” box), enter the “NC” number of the item. On the summary sheets, the non-compliance items should be presented from number “ 1” consecutively up to the highest number assigned to a non-compliance item. That is, they should be in numerical order on the summary sheets.
16. In the “Item” box, type or print a short summary of the item. This box is intended as a convenience, so that it will not be necessary to turn back to the original checklist page on which this item was found in order to know what the “NC” number actually refers to.
17. In the “Reason Absent, Substandard, Not Applicable” box, type or print a short explanation of why the item in question is substandard, absent, or not applicable. Keep the explanations as short as possible. You may “run over” into the space for the next item or two if necessary. The explanation or reason should be clear and forthright. If there is no clear explanation or reason, leave the space blank. Do not invent an explanation.
18. The rest of the summary sheet information is best completed during a management meeting held to review the audit results.

19. In the box headed "Assigned To," enter the name of the person who has been given responsibility for bringing that item into compliance. If the item has not been reviewed yet or if no action has been assigned on that item, leave that box blank.
20. The "Due Date" box should only be filled in if the "Assigned To" box is also filled in. The due date entered should be the date on which the person assigned is responsible for having completed that item.
21. The "Approved By" box should be filled in with the name of the administrator who is responsible for reviewing the audit results. Typically this should not be the same person assigned to conduct the audit. It may be appropriate for different administrators to review different non-compliance items, but in some departments and in some institutions probably one top administrator will review all issues arising from the audit. In all cases, the name entered in the "Approved By" box should be written by the person making the approval.
22. The "Approval Date" should be the date on which an administrator signed his or her name in the "Approved By" box.
23. The person in charge of the audit should enter his or her name in the space provided at the top of each of the Summary of Non-Compliance Items pages and enter the date on which each page was completed.
24. As a practical matter, it will usually be easiest to fill in the "NC No." and the "Reasons" box at the same time the individual item is audited and the checklist boxes are filled in for that item. The rest of the summary sheet ("Assigned To," "Approved By," etc.) will usually be filled out during or after a management review of the completed audit.

GLOSSARY OF TERMS

Chain of Command: A prioritized list, by job title, of the individuals who would assume command of the institution in an emergency.

Chain of Custody: Procedures and documentation that verify who is in possession of evidence, the location of the evidence, and the integrity of the evidence at every point in time.

Commander:

Initial Commander: The person in charge of the institution and the emergency at the beginning of a large-scale crisis.

Ultimate Commander: The individual, by job title, who assumes and maintains authority over the institution and the emergency once he or she arrives and is briefed. The person who remains in charge until the emergency has been resolved.

Cover Group: A group of staff sent to the location of a reported emergency, with responsibility to isolate and contain the emergency.

Critical Indicator System: Mathematical or other analytic procedure that produces a summary of the frequency of certain events and the trend of those frequencies over time. The events summarized may be grievances per month, inmate-inmate assaults per month, inmate disciplinary actions per month, percentage of inmates in protective custody by month, etc.

Deactivation Checklist: A list of actions and procedures to be followed immediately after the resolution of a major emergency.

Disturbance Control Team: A sublethal force team, or riot squad, that is trained to clear a yard or retake a cell block where there is an inmate disturbance. A disturbance control team usually trains with shields, batons, and chemical agents, but is distinguished from a tactical team that trains with firearms.

Emergency Post Orders: A job description for a specialized function that only exists in an emergency, or for a function that is different during an emergency than it is day-to-day.

EOC (Emergency Operations Center): A physical location. A situation room or “war room” set up and staffed to provide high-level administrative support in an emergency, usually at a headquarters or Regional Office. The EOC is distinguished from a Command Post, which is usually onsite and directing the operation.

ESS (Emergency Staff Services): A planned operation providing support and assistance to traumatized staff members and families of staff, during and after an emergency.

HAZMAT Team: A hazardous materials team that is trained to deal with toxic gas releases, chemical spills, etc. HAZMAT teams may be public or private and vary widely in training and capabilities.

Initial Response Checklist (Command Post Checklist): A prioritized list of actions to be taken by the Initial Commander at the onset of an emergency. It should include columns for initials and time next to each item.

Intelligence Function: In day-to-day operations, a person or persons in charge of coordinating information about certain types of security threats and problems for the entire institution. In an emergency, the intelligence function is an operation designed to help with resolution by developing information about motives, plans, identities, etc., of the inmates or victims involved.

Planned Use of Force: As opposed to “reactive use of force.” The use of force in a situation where time and circumstances allow some degree of planning, marshaling of resources, and supervisory or management review and direction.

Risk Assessment: An examination of the relative exposure to various types of emergencies. A determination of which emergencies are most probable at a given institution and identification of the most vulnerable areas of the institution.

Step-Down Plan: A plan for how an institution will return to normal operations in the aftermath of an emergency.

Sublethal Force: Force that is not reasonably expected to produce death or permanent bodily injury. Sublethal force includes use of chemical agents, pain-compliance holds, and batons.

Tactical Team: A weapons team trained for situations such as hostage rescue and firearms assault. Distinguished from a disturbance control team or sublethal force team. Many tactical teams are called SWAT*, CERT*, or some similar acronym.

Thne:“climate” or interpersonal atmosphere of an institution, sensed by experienced staff when walking through the institution,

*Special Weapons and Tactics

*Correctional Emergency Response Team

INSTITUTIONAL AUDIT CHECKLIST

Critical Analysis of Emergency Preparedness

DO NOT PROCEED UNTIL YOU HAVE CAREFULLY READ THE SECTION, "HOW TO USE THE SELF-AUDIT CHECKLISTS" AND THE DIRECTIONS.

	STATUS C S or A	NC No.	Initials	Date
I. Emergency System				
A. Is there a philosophy statement or mission statement governing major emergencies?				
B. Is there a statement of the institution's goals or objectives in major emergencies?				
C. Emergency Policies				
1. Command				
a. Does policy specify who is in initial command of the institution in an emergency?				
b. Does policy specify who is in ultimate (final) command of the institution in an emergency?				
c. Does policy specify the institutional chain of command in an emergency?				
d. Does policy state any limitations on the authority of the person in command during an emergency?				
e. Does policy specify how to change command in an emergency?				
2. Notifications				
a. Does policy specify the notifications that are to be made by the institution in a major emergency?				

(C = Compliance S = Substandard A = Absent or Not Applicable NC No. = Non-Compliance Number)

Page Complete: Y e s _____ N o _____ Auditor _____ Date _____

b. Does policy include a priority level or order in which those notifications will be made?				
c. Does policy mandate notification of Central Office/Region in the event of a major emergency?				
3. Does policy specify the role of Central Office during an emergency and the relationship of the institution to Central Office during an emergency?				
4. Use of Force				
a. Does policy differentiate between <u>planned</u> use of force and <u>reactive</u> use of force?				
b. Does policy state the conditions under which the institution may engage in the planned use of lethal force during an emergency?				
c. Does policy state the conditions under which the institution may engage in the planned use of sub-lethal force during an emergency?				
d. If planned use of lethal force is necessary, does policy state who will use such force?				
e. If planned use of sublethal force is necessary, does policy state who will use such force?				
f. Does policy specify minimum standards (training, equipment, etc.) for individuals who may engage in planned use of lethal force?				
g. Does policy specify minimum standards (training, equipment, etc.) for individuals who may engage in planned use of sublethal force?				
5. Public Information				
a. Does policy identify who at the institution will deal with the media during an emergency?				
b. Does policy specify who at the institution has the authority to release information during a major emergency?				

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	STATUS C, S, or A	NC No.	Initials	Date
c. Does policy explain how media operations will be coordinated between the institution and Central Office/Region during an emergency?				
d. Does policy identify who will be in charge of rumor control during an emergency?				
e. Does policy identify who will be responsible for communicating with the local community in an emergency?				
6. Training				
a. Does policy provide minimum requirements for training all staff in emergency preparedness?				
b. Does policy provide additional minimum requirements for training staff at shift command level and above?				
c. Does policy include specific requirements for training various staff specialists (negotiators, PIOs, etc.)?				
d. Does policy provide standards for both initial and annual/refresher training for various groups				
e. Does policy specify training standards for inmates (fire evacuation, tornado, etc.)?				
7. Deviation from Policy				
a. Does policy identify which individuals have the authority to violate/deviate from policy?				
b. Does policy outline responsibilities of a staff member if he/she is ordered to violate policy in an emergency?				
8. Does policy require that one individual at the institution have overall responsibility for emergency preparedness?				
9. Evacuation				
a. Does policy require detailed plans for <u>offsite</u> (out of compound) evacuation?				

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Page Complete: Yes _____ No _____ Auditor _____ Date _____

b. Does policy require detailed plans for an <u>onsite</u> (out of buildings) evacuation?				
II. Emergency System Review				
A. Audit Procedure				
1. Does the institution conduct an annual review or audit of its emergency preparedness system?				
2. Does that review or audit team include individuals from outside the institution?				
B. Emergency Tests/Drills				
1. Is there a standard for how often the institution must run emergency tests/drills?				
2. If yes, has that standard been met during the last 12 months?				
3. Are monitors always assigned to evaluate emergency tests/drills?				
4. Are written evaluations of every test/drill required from those monitors?				
5. Are recommendations required as part of each monitor's evaluation?				
6. Are the monitors' evaluations and recommendations of emergency tests/drills routinely reviewed and approved by someone in authority?				
7. Does policy require that some emergency tests/drills be conducted on evenings and weekends?				
8. Is there a requirement that emergency tests/drills be based on a wide variety of emergency scenarios?				
III. Prevention of Major Emergencies				
A. Management Philosophy				
1. Is prevention of major emergencies stressed at management meetings?				

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Page Complete: Yes _____ No _____ Auditor _____ Date _____

	STATUS C, S, or A	NC No.	Initials	Date
2. Do managers consistently review prevention issues with subordinates?				
3. Does management stress early intervention in problem situations?				
4. Does management stress the need for frequent, open communication between staff and inmates?				
5. Does management monitor staff/inmate communication issues?				
6. Does management aggressively monitor the "tone" (climate) of the institution?				
7. Does each institution top manager visit and review all areas of the institution at least bi-weekly?				
8. Are visits by institution top managers to various areas of the prison documented?				
B. Are all staff trained to recognize the traditional signs of impending trouble (stockpiling commissary items, more racial grouping than usual, etc.)?				
C. Does the institution use a "Critical Indicator System" (mathematical/statistical charting of trends in inmate grievances, assaults, etc.)?				
D. Is there an institution-wide formalized intelligence function?				
E. Classification				
1. Is there an objective inmate classification system?				
2. Is the classification system followed rigorously?				
3. Is there a system that identifies high-risk inmates (escape risks, racists, violent psychotics, assault risks, etc.)?				
4. Is there an intelligence file containing names and pictures of those inmates likely to plan serious violence or likely to become inmate leaders during an insurrection?				

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Page Complete: Yes _____ No _____ Auditor _____ Date _____

F. Security				
1. Does the institution do random urinalysis testing of inmates for illegal drugs?				
2. Does the institution perform random cell searches for contraband?				
3. Is there a minimum standard for the number of random cell searches performed in a given time period?				
4. Has that cell-search standard been met during the last 12 months?				
5. Is there a log for the institution or for each area that lists all random searches of cells or areas of the prison?				
6. Does the institution perform random security inspections of cells (bars, locks, vents, etc.)?				
7. Is there a minimum standard for the number of random security inspections of cells performed in a given time period?				
8. Has that cell security inspection standard been met during the last 12 months?				
9. Is there a log for the institution, or for each area, that lists all random security inspections?				
10. Are day-to-day security issues monitored closely and regularly by managers and supervisors?				
11. Are staff consistently held accountable for security lapses through the use of corrective actions, remedial training, counseling, or discipline?				
12. Is security equipment organized and maintained in good working order?				
13. Are there inspections of the internal and external areas of each housing unit on a daily basis?				
14. Are such daily housing unit inspections logged or otherwise documented?				

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Page Complete: Yes _____ No _____ Auditor _____ Date _____

15. Is there a standard specifying the frequency of security inspections of the security perimeter; vehicle and pedestrian entrances, gates, and sally ports; and visiting areas, control centers, and administration areas?				
16. Are all of those security inspections logged or otherwise documented?				
17. If there is such a standard (item 15, above), has the institution met that standard for the last 12 months?				
18. Is there a security inspection/review of tool control and key control at least monthly, and are such inspections/reviews documented?				
G. Inmate Grievance System				
1. Is there an inmate grievance system?				
2. Is the grievance system certified or reviewed and approved by an outside agency such as the U.S. Department of Justice or the courts?				
3. Does management stress the importance of treating all inmate grievances seriously?				
4. Does management regularly review the substance of inmate grievances?				
5. Is there a monthly summary of all grievances including subject, area of institution, and numbers upheld and denied?				
IV. Institutional Emergency Plans				
A. Does the institution have a single, comprehensive emergency plan (versus individual plans for various emergencies)?				
B. Did the institution's emergency plan go through a formal approval procedure, and is it signed and dated?				
C. Has the institution's emergency plan been formally reviewed during the preceding 12 months?				
D. Does the plan include a distribution list showing locations and/or individuals who have copies of the plan?				

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E. Is each copy of the plan identified by a unique number or letter, and is there an inventory system for the copies?				
F. Does the emergency plan include a procedure for documenting changes and updates to the plan?				
G. Checklists				
1. Does the plan include an initial response (Command Post) checklist?				
2. Does the plan include a deactivation checklist?				
3. Does the plan include job-specific checklists (emergency post orders)?				
4. Does the plan include procedures for specific types of emergencies?				
H. Is the institution emergency plan carefully and thoroughly tailored to that specific institution?				
V. Risk Assessment				
A. Does the institution emergency plan include a section on risk assessment?				
B. Is the section on risk assessment specific to that institution?				
C. Does the risk assessment include identification of those emergencies judged most likely to occur at that institution?				
D. Does the risk assessment identify institutional "hot spots"?				
E. Does the risk assessment include evaluation of the security of control centers, armory, emergency generators, and perimeters?				
F. Does the risk assessment include provisions for mitigating those risks that could be reasonably reduced?				
VI. Preparation				
A. Emergency Notifications				
1. Are home phone and pager numbers of key staff immediately available in the main control room and shift Commander's office?				

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Page Complete: Yes _____ No _____ Auditor _____ Date _____

2. Are home phone and pager numbers available for staff specialists (PIOs, negotiators, etc.) as well as for top managers?				
3. Are key staff phone numbers available separately from phone numbers for a general staff recall?				
4. Are general staff recall phone procedures organized by geographic proximity to the institution?				
5. Is there a system to minimize the number of calls the control center must make in an emergency (e.g., phone trees)?				
6. Are there phone lines that can be restricted to outgoing calls only in the event of an emergency?				
7. Has the institution considered rapid-dial or auto-dial equipment to assist with emergency staff recalls?				
B. Plot Plans				
1. Are plot plans/blueprints for every area of the institution available in the Command Post?				
2. Do plot plans show location and type of all emergency utility cutoffs (electric, water, gas, oil, etc.)?				
3. Do plot plans show all secondary fire access doors?				
4. Do plot plans show the size or volume of all rooms and buildings in the institution in case gas must be used?				
5. Do plot plans show emergency access routes for various areas of the institution in case of a hostage incident or insurrection?				
6. Do plot plans show all fire extinguishers, standpipes, and fire hose locations?				
C. Is there a switch that allows staff to disable all inmate access to pay phones and/or outside phone lines?				
D. In an emergency, can staff easily cut off inmate access to television?				
E. Are all roofs painted with numbers or letters for helicopter identification?				

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Page Complete: Yes _____ No _____ Auditor _____ Date _____

F. Are all buildings labeled with large letters or numbers on all sides for immediate identification by outside agency staff?				
G. Are staff emergency-notification lists (next of kin) updated annually?				
H. Are staff emergency-notification lists reasonably available to the Commander in an emergency?				
I. Is an inventory of serious staff medical conditions reasonably available to the Commander during an emergency?				
J. Is a list of staff blood types reasonably available to the Commander in an emergency?				
K. Is there a written plan for dealing with inmate families that may come to the institution during an emergency?				
L. Is there a plan for providing phone information on the status of individual inmates during a lengthy emergency or evacuation?				
M. Is there an inventory of staff foreign language skills (including sign language) available to the Command Post?				
N. Is there a group of staff trained in search and rescue?				
O. Are there written procedures for Command Post security during an emergency?				
P. Is there a plan for operating food service during a major emergency?				
Q. Is there an emergency plan for facilities maintenance or engineering?				
VII. Staff Specialists				
A. Tactical Team (weapons capacity, hostage rescue, etc.)				
1. Does the institution have a tactical team?				
2. If the institution does not have its own tactical team, have clear, detailed arrangements been made with an external tactical team?				
3. Is the tactical team structure and minimum size specified in writing?				

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Page Complete: Yes ___ No ___ Auditor _____ Date _____

	STATUS C, S, or A	NC No.	Initials	Date
4. Is the tactical team currently at or beyond minimum strength?				
5. Does the tactical team have an identified leader and assistant leader?				
6. Are the minimum training standards for the tactical teams specified in writing?				
7. Is the tactical team currently in compliance with its minimum training standards?				
8. Is there a medical person (nurse, med tech, etc.) attached to the tactical team?				
9. Is there a video operator attached to the tactical team?				
10. Are minimum equipment standards specified for the tactical team?				
11. Does the tactical team's equipment currently meet those standards?				
12. Does the tactical team train with command-level staff and negotiators?				
13. Does the tactical team practice with a wide variety of scenarios?				
14. Are tactical team members available by pager?				
15. Does the tactical team include snipers?				
16. Are snipers trained to work with spotters?				
17. Are team members' leave and vacation schedules tracked to guarantee team availability?				
B. Disturbance Control Team (baton, gas, riot formations, etc.)				
1. Does the institution have a disturbance control team?				
2. If the institution does not have its own disturbance control team, have clear, detailed arrangements been made with an external disturbance control team?				
3. Are the disturbance control team structure and minimum size specified in writing?				

(C = Compliance S = Substandard A = Absent or Not Applicable NC No. = Non-Compliance Number)

Page Complete: Yes _____ No _____ Auditor _____ Date _____

4. Is the disturbance control team currently at or above minimum strength?				
5. Does the disturbance control team have an identified leader and assistant leader?				
6. Are the minimum training standards for the disturbance control team specified in writing?				
7. Is the disturbance control team currently in compliance with its minimum training standards?				
8. Is there a medical person (nurse, med tech, etc.) attached to the disturbance control team?				
9. Is there a video operator attached to the disturbance control team?				
10. Are minimum equipment standards specified for the disturbance control team?				
11. Does the disturbance control team's equipment currently meet those standards?				
12. Are all team members current with baton training?				
13. Are all team members current with chemical agent training?				
14. Have all team members had training in mass arrest techniques?				
15. Are all team members current with CPR and first aid training?				
C. Hostage Negotiators				
1. Does the institution have its own trained negotiators?				
2. If not, does the institution have detailed arrangements with external negotiators that would be used in an emergency?				
3. If the institution relies on external negotiators, do the arrangements guarantee the availability of the negotiators to the institution on a 24-hour basis, and with an acceptable response time?				

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Page Complete: Yes _____ No _____ Auditor _____ Date _____

4.	Is there a written standard for the minimum number of negotiators available to the institution?				
5.	Does the number of currently available negotiators meet this standard?				
6.	Is there an identified chief negotiator and assistant chief negotiator?				
7.	Are there minimum standards for initial and refresher training for negotiators?				
8.	Do all of the institution's negotiators currently meet these training standards?				
9.	Is the working structure of the negotiating team specified in writing?				
10.	Do the negotiators have a portable audiotape recorder?				
11.	Do the negotiators have a throw-phone?				
12.	Do the negotiators have preprinted negotiation log forms?				
13.	Is negotiator availability guaranteed by tracking leave and vacation schedules?				
14.	Do the negotiators train with the command-level staff and with the tactical team?				
D. Public Information Officer (PIO)					
1.	Does the institution have an identified PIO?				
2.	Is there at least one alternate or assistant PIO?				
3.	Are there minimum training standards specified for the PIO?				
4.	Does the PIO meet these training standards?				
5.	Is there a written overview or description of the institution available for distribution to the media in an emergency?				
6.	Is there a procedure for logging and returning media phone calls in an emergency?				

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Page Complete: Yes ___ No ___ Auditor _____ Date _____

7. Are there written procedures for identifying and escorting media personnel in an emergency?				
8. Do procedures exist to establish an 800 information line during an extended emergency?				
9. Is the required equipment available for the identified media center during an emergency (podium, easel, microphone and sound system, departmental seal, phone jacks, etc.)?				
VIII. Training				
A. Do new security staff receive at least 8 hours of training on the emergency plan and emergency procedures?				
B. Does this training include hostage situations, riots, disasters, and other emergencies?				
C. Do new civilian (non-security) staff receive at least 4 hours of training on the institution's emergency plan and on emergency preparedness?				
D. Have all institution staff at the level of shift Commander and above received at least 20 hours of formal training on emergency preparedness?				
E. Have all institution staff at the level of shift Commander and above participated in command post exercises?				
F. Have all institution staff received at least 4 hours of training on emergency situations during the last 2 years?				
G. Has the institution conducted emergency exercises or simulations during the last 2 years that involved external (mutual aid) agencies?				
IX. External Agency Agreements				
A. Does the institution have written agreements for assistance during an institutional emergency with external agencies?				
1. State police?				
2. Local police?				
3. Local sheriff?				

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Page Complete: Yes _____ No _____ Auditor _____ Date _____

	STATUS C,S,orA	NC No.	Initials	Date
4. Nearby correctional institutions (including county jails, federal prisons, Immigration and Naturalization Service facilities)?				
5. National Guard?				
6. State/federal emergency management agency?				
7. Local fire department?				
8. Nearest hazardous materials (HAZMAT) team?				
9. Local phone company?				
10. Utility company(ies)?				
11. Local hospitals?				
12. Ambulance services?				
B. Does <u>each</u> written external agency agreement include:				
1. Emergency contact names and 24-hour phone numbers?				
2. Services the agency can provide?				
3. Equipment the agency can provide?				
4. Restrictions on assistance?				
5. Reporting (staging) locations?				
6. Command relationships?				
7. Provision for annual review of agreement?				
8. Provision for involvement of the external agency in emergency simulations and drills at the institution?				
9. Provision for the institution to provide assistance in the event of a community disaster?				
X. Emergency Equipment				
A. Is there a comprehensive inventory of emergency equipment?				
1. Is such an inventory available to the command post?				

(C = Compliance S = Substandard A = Absent or Not Applicable NC No. = Non-Compliance Number)

Page Complete: Yes _____ No _____ Auditor _____ Date _____

2. Is the emergency equipment inventory current within the last 12 months?				
3. Does the inventory include the location of each item?				
B. Is there a comprehensive motor vehicle inventory for the institution?				
1. Is such an inventory readily available to the Command Post?				
2. Is the vehicle inventory updated for accuracy at least quarterly?				
C. Armory				
1. Are there written policies and procedures for the armory?				
2. Is the armory currently in compliance with these policies and procedures?				
3. Is the armory secure from rioting inmates?				
4. Are armory keys restricted from inmate areas?				
5. Do on-duty staff have immediate 24-hour access to the armory?				
6. Is the armory inventoried at least monthly?				
7. Is the armory inventory reviewed by management?				
8. Is the armory inspected by a management-level staff person at least quarterly?				
9. Are ammunition and firearms inventoried?				
10. Is there a written procedure for checking out weapons and other armory equipment?				
11. Is there a procedure to ensure that an individual staff member is currently qualified in firearm and/or chemical agent use prior to issuing a firearm and/or chemical agent to that individual (except for training/range qualification)?				

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12. Chemical Agents				
a.	Considering the size of the institution, is there an adequate supply of chemical agents?			
b.	Is there an adequate variety of chemical agents?			
c.	Are all chemical agents clearly dated?			
d.	Are all chemical agents (except those for training use) within manufacturers' shelf life?			
e.	Are those chemical agents designated for training use clearly labeled as such to differentiate them from the general inventory of chemical agents?			
f.	Are an adequate number of the institution's staff current in their training in the use of all types of chemical agents available at the institution?			
g.	Is there a policy requiring immediate medical screening/treatment for offenders and staff who have been exposed to chemical agents?			
13. Firearms				
a.	Considering the size and nature of the institution, is there an adequate supply of firearms?			
b.	Are the types of firearms and ammunition appropriate for the nature of the institution and for the location and function of armed posts at the institution?			
c.	Are all firearms cleaned, inspected, tested, and sighted on a regular schedule?			
14. Does the armory contain:				
a.	Enough flexcuffs for the entire inmate population?			
b.	An adequate supply of steel restraints?			
c.	A supply of binoculars?			
d.	A supply of flashlights and batteries?			
e.	Distraction devices (flashbang grenades)?			

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f. Bomb blanket?				
g. Long-handled corner (90°) mirror?				
h. Loud hailers?				
D. Does the institution's emergency equipment include:				
1. High-visibility clothing (fluorescent vests, etc.)?				
2. Portable smoke ejectors?				
3. Portable emergency generator?				
4. Portable lighting?				
5. Cutting torch?				
6. Bolt cutters?				
7. Radios with a tactical channel?				
8. An adequate supply of riot shields?				
9. An adequate supply of helmets with face shields?				
10. An adequate supply of riot batons?				
11. An adequate supply of potable water (48-72 hours)?				
12. Fire axes?				
13. An adequate supply of gas masks?				
E. Emergency Keys				
1. Are there emergency key rings for various buildings and areas of the institution?				
2. Are emergency keys and locks color coded for quick identification (red for fire, etc.)?				
3. Are emergency keys and locks notched for night identification?				
4. Are emergency key rings soldered or welded closed to prevent removal of keys?				

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5. Do emergency key rings include a metal ring disk (“chit”) stamped with the name of area the ring accesses and the number of keys on that ring?				
F. Emergency Generators				
1. Is there an emergency generator?				
2. Is the emergency generator adequate to run the institution safely for 24 hours?				
3. Is the emergency generator secure from inmate sabotage?				
4. Are staff trained to know which systems will be run on emergency power and which will be inoperable during a main power outage?				
5. Is there battery-powered lighting in the emergency generator areas?				
6. Are the emergency generators tested at least quarterly to determine that they are in proper working order, and are such tests documented?				
7. Do all emergency generators have sufficient fuel to run for a minimum of 72 hours continuously?				
8. If the emergency generators must be started manually in the event of a main power outage, are there staff on duty on a 24-hour basis who are trained to start and operate those generators?				
XI. Locations				
Are the following locations specified in the institutional emergency plans:				
A. Command Post?				
B. Alternate Command Post?				
C. Command Post location outside compound?				
D. Media room and/or staging area?				
E. Family support area?				

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F. Inmate family area?				
G. Staff staging/reporting area?				
H. Mutual aid staging area?				
I. External traffic control points?				
J. Mass casualty/triage area?				
K. Disturbance control team dressing/assembly area?				
L. Tactical team dressing/assembly area?				
XII. Procedures				
A. Does the institution have a general procedure for responding to major emergencies?				
B. Do procedures call for audio recording in the Command Post during an emergency?				
C. Do written procedures specify who will keep a log during an emergency?				
D. Do written procedures call for double posting key perimeter locations in an emergency?				
E. Does procedure call for relieving staff from non-critical posts in an emergency?				
F. Are there written procedures for emergency counts?				
G. Are there written procedures for emergency lockdowns?				
H. Is there a standard procedure for sending staff to investigate a report of a developing emergency (a cover group)?				
I. Are there procedures that specify accounting for staff, visitors, volunteers, etc., in the event of an emergency?				
J. At the onset of a major emergency, could the institution quickly account for all staff within the institution and determine the identities of any staff unaccounted for?				
K. At the onset of a major emergency, could the institution quickly account for all visitors within the institution and determine the identities of any visitors unaccounted for?				

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L. Are emergency traffic-control procedures specified?				
M. Does procedure call for cutting off inmate telephones at the onset of a major emergency?				
N. Is there a procedure for briefing on-duty staff about the nature of an emergency?				
O. Does procedure call for informing the inmate population of emergency conditions?				
P. Is there a procedure for limiting the initial staff response to a reported emergency to avoid set-up or distraction?				
XIII. Evacuation				
A. Is there a tire evacuation plan for all areas of the institution?				
B. Does every area of the institution have a secondary evacuation route?				
C. Are fire evacuation routes posted in all areas of the institution?				
D. Are there battery-powered or emergency generator-powered fire exit lights in all living and program areas of the institution?				
E. Are self-contained breathing apparatus units (SCBAs) available in or adjacent to all living areas of the institution?				
F. Are SCBAs stored in pairs?				
G. Are all SCBAs inspected, charged and tagged at least annually?				
H. Are staff trained to use SCBAs in pairs?				
I. Are staff trained in the use of SCBAs available 24 hours a day to all housing areas of the institution?				
J. Fire Drills				
1. Are fire drills unannounced?				
2. Are all fire drills monitored?				
3. Are all fire drills timed?				

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4. Are all fire drills evaluated by monitors?				
5. Are fire drills conducted on all three shifts?				
6. Are there minimum standards for how often fire drills must be conducted in each area of the institution?				
7. Have all areas of the institution met this standard within the last 12 months?				
8. Are fire drill reports and evaluations reviewed and approved by management?				
9. Are fire drill reports and evaluation records kept in one central location?				
10. Has the local or state fire marshal approved the number, type, and location of fire extinguishers throughout the institution?				
11. Are all fire extinguishers inspected, charged, and tagged at least annually?				
12. Are all fire extinguishers at the institution currently within one year of their last inspection?				
13. Are all fire hoses and standpipes inspected, tested, and tagged at least annually?				
14. Does the institution know the actual response time for the local fire department?				
15. Does the institution have its own fire brigade (trained inmates or staff)?				
16. Has the institution considered training a fire brigade that would serve as a first-response force until the fire department arrived?				
K. Are manual unlocking devices and/or backup keys available for unlocking every living area of the institution 24 hours a day?				
L. Is there an offsite evacuation plan?				
M. If yes, does the offsite evacuation plan include:				
1. Potential destinations?				

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2. Specific transportation alternatives?				
3. Security procedures during evacuation?				
4. Which inmate records will be moved with inmates?				
5. Procedures for providing medical services during and after the evacuation?				
6. Arrangements for food at the new location?				
7. Provisions for coordinating with local and state police during the evacuation?				
8. Predetermined evacuation routes?				
9. Procedures for protection or destruction of confidential records that cannot be evacuated?				
10. Procedures for re-entering and re-occupying the institution?				

XIV. Organizational Structure

A. Is an emergency organizational structure defined in detail?				
B. Are responsibilities specified for managing the unaffected portions of the institution during an emergency?				
C. Are supervision and direction of the cover group (staff initial response group) specified?				
D. Is supervision of perimeter staff during an emergency specified?				
E. Is the responsibility for coordinating on-duty and returning staff identified?				
F. Is the responsibility for emergency equipment detailed and assigned?				
G. Is the responsibility for liaison with external agencies assigned?				
H. Is the intelligence function described and responsibility for it assigned?				

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I. Is the responsibility for coordinating emergency staff services (ESS) assigned?				
J. Are there written guidelines (emergency post orders) available for each specialized emergency assignment?				
XV. Extended Emergencies				
A. Is there a written plan for staffing in an extended emergency (beyond 12 hours)?				
B. Is responsibility for assignments and scheduling in an extended emergency assigned?				
C. In an extended emergency, is the length of shift specified by assignment?				
D. Does the plan for extended emergencies include provision for staggered relief of key positions?				
E. Does the plan for extended emergencies include arrangements for onsite bivouac of key staff?				
F. Are relief procedures specified for key staff during an extended emergency?				
XVI. Aftermath				
A. Are damage assessment procedures outlined and responsibilities assigned in the emergency plan?				
B. Are report writing and debriefing procedures detailed in the emergency plan?				
C. Is there a review and approval procedure for all reports?				
D. Is there a procedure for collection of audiotapes, videotapes, photos, and/or logs?				
E. Is there a chain-of-custody procedure for all reports, logs, photos, etc.?				
F. Is there a procedure for gathering external agency reports?				
G. Is a short-term step-down procedure required before key staff are relieved of duty?				
H. Are crime scene preservation procedures specified?				

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I. Are criminal evidence collection and preservation procedures detailed?				
J. Is immediate liaison with criminal prosecution authorities required?				
K. Is civil liability review mandated?				
L. Are medical and psychological screenings required for key and/or traumatized staff?				
M. Is a critical incident review mandated?				
N. Are critical incident review procedures specified?				
O. Is a review of insurance issues mandated?				
P. Does the emergency plan specify developing a media relations plan as part of the aftermath activities?				
Q. Do procedures specify the identification and segregation of inmate suspects and witnesses?				
R. Do procedures specify releasing information to all staff?				
S. Do procedures specify releasing information about emergency status to inmate populations?				
T. Do procedures require developing a plan for communications with the local community?				
U. Do procedures require a plan for regularly briefing Central Office and other branches of government?				
V. Do the emergency plans include procedures to prevent staff retaliation?				
XVII. Emergency Staff Services (ESS)				
A. Is there a general plan for ESS?				
B. Are responsibilities for ESS planning and development assigned?				
C. Are responsibilities for ESS during emergencies assigned?				
D. Are resources for specialized help (e.g., trauma counseling) identified?				

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E. Does the family support plan include child care provisions?				
F. Does the family support plan include transportation provisions?				
G. Does the family support plan include emergency financial assistance?				
H. Does the plan include liaison assigned to each family of hostage/injured staff?				
I. Is a family briefing area at the institution identified and separated from inmate family areas and media briefing areas?				
J. Does the plan include provision for individual and group trauma counseling after the incident?				
K. Does the plan include procedures for rehabilitating traumatized staff?				
L. Are there arrangements for secure motel/hotel family housing?				
M. Is some administrative leave mandatory for hostage/traumatized staff?				
XVIII. Medical Services				
A. Is there a comprehensive medical plan for an institutional emergency?				
B. Does the plan include mass casualties/triage?				
C. Does the plan include evacuation procedures for non-ambulatory or critically ill inmates?				
D. Is a non-infirmery location identified for mass casualties/triage?				
E. Does the institution have an emergency-equipped medical crash cart?				
F. Are there adequate numbers of portable gurneys?				
G. Are backup medical resources for emergencies identified in the community?				

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DEPARTMENTAL AUDIT CHECKLIST

Critical Analysis of Emergency Preparedness

DO NOT PROCEED UNTIL YOU HAVE CAREFULLY READ THE SECTION, "HOW TO USE THE SELF-AUDIT CHECKLISTS" AND THE DIRECTIONS.

	STATUS C, S, or A	NC No.	Initials	Date
I. Emergency System				
A. Does the department have a philosophy or mission statement specifically for managing major emergencies?				
B. Is there a statement of goals or objectives specifically for managing major emergencies?				
C. Emergency Policies				
1. Command				
a. Does policy specify initial command in an institutional emergency?				
b. Is ultimate (final) command of the emergency specified by policy?				
c. Does policy specify the chain of command in an institutional emergency?				
d. Does policy detail any limitations on the authority of the Commander?				
e. Does policy specify the requirements for a change of command?				
2. Notifications				
a. Does policy require that emergency notifications be prioritized?				
b. Does policy specify how emergency notifications are to be prioritized?				

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	STATUS C, S, or A	NC No.	Initials	Date
c. Does policy specify who is responsible for notifying Central Office/Region?				
d. Does policy specify who is responsible for notifying other institutions within the department?				
e. Does policy specify who is responsible for notifying other branches of government?				
f. Does policy require a system for minimizing the number of notification calls from the affected institution?				
3. Does policy specify the role of Central Office/Region in an institutional emergency?				
4. Use of Force				
a. Does policy differentiate between <u>planned</u> use of force and <u>reactive</u> use of force?				
b. Does policy specify conditions under which planned lethal force may be used?				
c. Does policy specify conditions necessary for planned use of sublethal force?				
d. Does policy specify who (or which group) will engage in planned use of lethal force if necessary?				
e. Does policy specify who (or which group) will engage in planned use of sublethal force if necessary?				
f. Does policy specify minimum qualifications for individuals using lethal force?				
g. Does policy specify minimum qualifications for individuals using sublethal force?				
5. Public Information				
a. Does policy specify who will deal with the media during an emergency?				
b. Does policy identify who has authority to release information during an emergency?				

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	STATUS C, S, or A	NC No.	Initials	Date
c. Does policy clarify responsibilities and authority between the affected institution and Central Office/Region for release of public information during an emergency?				
d. Does policy specify responsibility for rumor control during an emergency?				
e. Does policy specify who is responsible for communicating with the local community during an emergency?				
6. Training				
a. Does policy provide minimum requirements for training all staff in emergency preparedness?				
b. Does policy provide additional minimum requirements for training staff at shift command level and above?				
c. Does policy include specific requirements for training various staff specialists (negotiators, PIOs, etc.)?				
d. Does policy provide standards for both initial training and annual/refresher training for various groups of staff?				
e. Does policy specify training standards for inmates (fire evacuation, tornado, etc.)?				
7. Deviation from Policy				
a. Does policy identify which individuals have the authority to deviate from policy?				
b. Does policy outline responsibilities of a staff member if he/she is ordered to deviate from policy during an emergency?				
8. Emergency Preparedness Coordinator				
a. Does policy require an individual to be responsible for emergency preparedness department-wide?				

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b. Does policy require an individual at each institution to be responsible for emergency preparedness?				
9. Evacuation				
a. Does policy require each institution to have detailed plans for onsite evacuation?				
b. Does policy require each institution to have detailed plans for offsite evacuation?				
10. Hostage Incidents				
a. Does the department have a policy statement specifying that persons taken hostage have no rank or authority and that staff will not comply with orders from a person held hostage?				
b. Is there a policy statement listing non-negotiable items?				
11. Employee Job Action				
a. Is each institution required to maintain a plan (or an appendix to a generic emergency plan) for responding to a strike or other employee job action?				
b. Is each institution required to keep its job action plan confidential and limit its distribution to a designated group of top managers?				
II. Role of Central Office During Emergencies				
A. Is there a Central Office emergency plan?				
B. Does the plan outline rules and responsibilities for various individuals?				
C. Are interagency responsibilities detailed in the plan?				
D. Does the Central Office emergency plan include a public information plan?				
E. Does the Central Office emergency plan include a resource allocation plan?				

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F. Does the plan specify how Central Office will communicate with unaffected institutions during the emergency?				
G. Does the Central Office plan outline responsibilities for communicating with the governor's office and the legislature?				
H. Does the Central Office plan include a duty officer system or other 24-hour notification method?				
I. EOC (Emergency Operations Center)				
1. Does the Central Office plan call for establishing an EOC during an emergency?				
2. Is the location of the EOC specified?				
3. Are an adequate number of telephones (or telephone jacks) at that location?				
4. Is adequate radio communication available at that location?				
5. Can an open phone line be maintained between the EOC and the institution experiencing the crisis?				
6. Are current emergency plans for each institution available in the EOC?				
7. Is the EOC equipped with diagrams of each institution?				
8. Does the EOC have broadcast and cable television, an am/fm radio, and a video recorder?				
9. Does the Central Office plan outline EOC security procedures?				
10. Is the EOC large enough for the number of individuals necessary to staff it?				
III. Emergency System Review				
A. Audit Procedure				
1. Is there a departmentally specified procedure for auditing each institution's emergency system?				
2. Has a review or audit of the emergency system been conducted at least annually?				

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	STATUS C, S, or A	NC No.	Initials	Date
3. Did the audit/review team include individuals from outside the institution?				
B. System Tests/Drills				
1. Is some minimum frequency for emergency tests/drills specified?				
2. Are institutions required to test or drill on a wide variety of emergency scenarios?				
3. Are monitors assigned to evaluate every emergency test/drill?				
4. Are written evaluations of the tests/drills required of the monitors?				
5. Are recommendations required in every evaluation of an emergency test/drill?				
6. Are the evaluations from monitors of emergency tests/drills formally reviewed and approved by a person in authority?				
7. Does policy require that some emergency tests/drills be conducted on evenings and weekends?				
IV. Institutional Emergency Plans				
A. Does the department require institutional emergency plans to be written in a standardized format?				
B. Does the department have a formal approval procedure for institutional emergency plans?				
C. Does the approval procedure for institutional emergency plans include a requirement that a Central Office or Regional Office manager review and approve each institutional plan?				

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SUMMARY OF NON-COMPLIANCE ITEMS

Critical Analysis Of Emergency Preparedness

AUDITOR: _____

PAGE _____ of _____ PAGE(S)

DATE: _____

NC No.	ITEM	REASON ABSENT. SUBSTANDARD. NOT APPLICABLE	ASSIGNED To	DUE DATE	APPROVED BY	APPROVAL DATE

Review of all items on this page completed: Yes No _____

Name _____ Signature _____ Date _____

Section 3

CASE STUDIES

**Case Study:
Hurricane Andrew and the
Florida Department of Corrections**

On August 21, 1992, U.S. Weather Service information suggested that a tropical storm named Andrew was taking a route that might hit the Bahamas and then South Florida. The Department of Corrections sent out a teletype advising managers throughout the Department to monitor the storm's progress. It also advised each facility within the Department to designate a contact person in case the threat worsened. At Dade Correctional Institution, the Superintendent directed the Duty Officer, the Shift OICs, and the Control Room officers to monitor the storm's development by weather band radio, TV, commercial radio, etc.

On Saturday, August 22, the tropical storm had strengthened into Hurricane Andrew. Its projected path continued to target Florida's southeast coast. At Dade CI, the Superintendent and Assistant Superintendent went to the institution to supervise the securing of the compound. Inmate workers were used to remove loose items from the ground or to tie down or otherwise secure equipment. The Superintendent also organized a contingency plan for a Department Heads' meeting at 9:00 a.m. the following day to discuss evacuation plans.

On Sunday morning, the hurricane was so imminent that the State Government activated its Emergency Operations Center and began to evacuate low-lying areas along the southeast coast. A meeting was called at the Department of Corrections headquarters, with key personnel beginning to prepare the facilities that were within the likely path of the hurricane. An immediate decision was to direct a small facility in the Florida keys, Big Pine Key Road Prison, to evacuate north out of the keys to Lantana Correctional Institution. That evacuation was completed without incident over the course of the next nine hours.

At Dade CI, Department heads and supervisors reported for the 9:00 a.m. hurricane preparation meeting. The Superintendent decided to evacuate the work camp (with 293 medium- and minimum-custody inmates) to the main prison unit. Two inmates were moved to a local hospital because of the seriousness of their health problems.

By mid-day Sunday, Hurricane Andrew carried winds of over 150 miles per hour and seemed highly probable to strike Florida at Florida City, which would subject Dade CI to the full force of the center of the hurricane. Dade is located 20 miles west of the coast, but it is only 6 feet above sea level, and the force of hurricane winds was expected to create a coastal water surge of 12 feet or higher that could travel many miles in from the coast. At 2:00 p.m., the Department decided to evacuate all inmates from Dade to other state institutions.

In order to accommodate the approximately 1,000 inmates from Dade CI, the Department located space at five other state prisons. Two of these potential transfer sites were then eliminated because they were themselves close to the storm's projected path and in potential danger. The Central Florida Reception Center was added to the list of receiving institutions, and all available transfer buses and vans within the Department were dispatched toward Dade CI to begin transferring 100 inmates to Glades CI, 150 to Martin CI, 450 to the South Florida Reception Center, 250 to the Central Florida Reception Center, and approximately 100 inmates to another state facility.

The Department also decided to evacuate 76 inmates from the small Copeland Road Prison to Hendry CI. The Department quickly assessed the situation as a timing problem. The Department had adequate transportation and other resources, and adequate space to house the relocated inmates on an emergency basis, but it was not immediately clear that the appropriate resources could be put in play in time to stay ahead of the approaching hurricane.

At Dade, classification staff began to sort inmate transfers by custody level and psychological profiles. The decision was made to move all close-custody inmates first, with minimum- and medium-security inmates to follow. Inmate folders and medical records were gathered and prepared for transporting along with the inmates. Vehicle security was arranged at the rear gate of the institution, and additional perimeter security was added. The institution's business manager provided security staff with maps outlining the travel routes to the various receiving institutions. Security staff were divided into teams for screening inmates, searching inmates, and escorting them to the departure area. As the last of the inmates were evacuated out of Dade, staff members at the institution began to prepare for the hurricane. Emergency supplies were gathered, and staff prepared to ride out the hurricane in the administrative offices and the medical area.

At 10:30 p.m. on Sunday, August 23, the last inmates being evacuated arrived at the Central Florida Reception Center. Approximately 1,000 inmates had been moved, all over the southern half of Florida, on short notice, without any injuries to staff or inmates and without any escapes. At Dade, the Superintendent sent staff home to evacuate their own families. A small number of staff volunteered to stay at the institution to prevent possible looting or post-storm damage. At the South Florida Reception Center, staff were called to the institution and helped maintenance staff tie down or secure equipment that was judged vulnerable to wind damage. Food and water were stockpiled within the dormitories, and handcuffs were distributed because transport to segregation housing would not be possible during the storm.

When the hurricane hit, the actual storm damage was very severe at Dade CI. At the rest of the Department's facilities, storm damage was moderate. No other facilities were rendered uninhabitable. At Dade, sections of roof were ripped away, and the wind-driven rain then soaked large areas of the facility. Windows were broken, the perimeter fence was essentially destroyed, some outbuildings were completely destroyed, and the skeleton staff that stayed at the institution was shocked at the extent of the damage.

Late Monday, August 24, some Dade staff returned to the institution from the South Florida Reception Center to try to help the remaining staff get to safety. They organized a convoy to get staff out of the institution to their own homes. The Superintendent and Assistant Superintendent toured the institution grounds with other staff, assessing the damage, and then attempted to make contact with the Department headquarters or another institution to request help. An individual correctional officer arrived from Broward CI. He had been sent to find out the status of Dade and had walked five miles to get to the institution because of the condition of the roads.

In addition to the institutional damage, approximately 400 Department staff members found that their homes had been completely destroyed by the storm. The following day, August 25, the Secretary of Corrections, along with the Assistant Secretary for Operations and the Inspector General of the Department, arrived at Dade to thank the staff for their efforts in completing the evacuation and to pledge support and assistance with the many personal problems staff were experiencing.

The following day, a meeting was held at the Department's Central Office to begin to develop plans for rebuilding the Dade Work Camp (target: 45 days) and the main prison.

On August 25, the day after the storm, the Civil Air Patrol established a radio communications post at the institution, the state's Fire Marshal arrived, and a National Guard unit set up camp on the grounds to provide perimeter security. The Department initiated a number of recovery programs, including providing free gasoline, water, ice, clothing, food, and household goods, as available, to staff. The Administrative Building of the main unit was kept open as a shelter for staff and family members who were without housing. Tools, roofing materials, electric generators, etc. were made available to employees at no charge. The Department also coordinated FEMA applications and established an 800 number for staff and their families to use in arranging assistance,

The Department began to identify temporary housing locations for homeless staff. It also made a major effort to coordinate the staff who were on special assignments to other institutions. The Department coordinated donations of money to assist the 1,000 homeless staff and families. Actual reconstruction work on Dade CI and the Dade Work Camp was initiated within 48 hours after damage assessment was complete.

Lessons Learned

1. The Department's comprehensive emergency planning system provided an appropriate framework for responding to the specifics of the hurricane.
2. With some emergencies, particularly with some types of natural disaster, the aftermath may be more challenging and more than the response to the event itself.
3. Because of the uncertainty of a hurricane's path, and the risks involved in trying to evacuate large numbers of high-security inmates, it was not practical to evacuate several institutions, nor was it practical to evacuate days before the storm hit. This placed a huge premium upon fast, clear decision making and leadership at the Department level once the storm's landfall was certain.
4. Staff performed admirably at many locations throughout the state, in spite of great stress on some individual staff members. Staff gave first priority to their duty to the Department and the state, even in cases where their homes were threatened or the fate of loved ones was uncertain. There was no scarcity of staff willing to volunteer for particularly hazardous duty, such as remaining at Dade and riding out the hurricane. Individual acts of bravery and compassion were common.
5. Inmate cooperation was apparent throughout the hurricane and its aftermath and was essential to the evacuation and to the operation of partially disabled facilities after the hurricane. The Department's commitment to keep inmates well-informed contributed to this cooperative spirit. After the hurricane, the problems of dealing with large numbers of homeless staff were more difficult in many ways, and took more creativity, than the formidable problems of repairing badly damaged facilities.
6. After the hurricane struck, communication to the most seriously damaged areas of the state was initially impossible and remained very difficult for a long time.
7. Some two weeks after the hurricane, 22 staff from Dade had still not reported to the institution or the Department. The Department instituted search teams in a matter of days to go out in the local community to find missing staff. These 22 were not located by the local search teams and further efforts were instituted to try to locate those individuals.
8. Because of the difficulty in establishing communication after a natural disaster, it makes sense to establish a date, time, and place for staff to report before they leave during an evacuation. For similar reasons, it makes sense to establish an 800 number for staff and staff family emergency assistance and to disseminate that number to staff before the actual event.
9. A mechanism for tracking employees temporarily assigned to different facilities would be a useful addition to the Department's emergency plan.
10. Unlike the experience in some flood and earthquake situations, cellular telephones were knocked out of service by Hurricane Andrew because so many transmitter and repeater locations were damaged over such a wide area.

11. When a large-scale evacuation of inmates is anticipated, it is useful for the Department to authorize an emergency inmate processing and receiving policy, so that the receiving institutions have flexibility in intake procedures.
12. Inmate medical records should, whenever practical, accompany inmates in an evacuation to the receiving institution. As a backup, it is helpful if some basic inmate medical information is available in a database or online that can be accessed from any institution.
13. Lack of potable water will become a crisis for an institution long before food delays or cold food may produce serious problems. It is also far easier to arrange for emergency food from external sources than for quantities of potable water during a community-wide emergency. Be prepared to move food items from one facility to another and, if possible, have at least one vehicle (24-foot truck, for example) designated for food service use only.
14. Emergency plans should include provisions for an expert team that can evaluate food items for contamination and spoilage in the wake of a natural disaster.
15. The Department may be in a difficult position to issue paychecks in the absence of attendance and leave records. It is also challenging to distribute paychecks to employees in the aftermath of a community-wide disaster. In such emergencies, arrangements need to be made to pay in cash rather than paychecks. Even in situations such as electronically transferred funds, bank accounts may not be available such as the case was in Florida during the aftermath of Hurricane Andrew.
16. Emergency purchasing authority may be an absolute necessity following a large-scale disaster.

Case Study:
The April Fools' Day Riot
Kirkland Correctional Institution
Columbia, South Carolina

Kirkland Correctional Institution is a medium-custody campus-style facility located on the outskirts of the capital city of Columbia, South Carolina. When opened in 1974, it was designed to house 448 inmates in single cells. Subsequently, a 96-bed psychiatric hospital and 25-bed infirmary were added. Because of a rapidly expanding inmate population, the facility had double-bunked all of the general population cells. Only the psychiatric hospital and Unit D were single-celled. On the night of April 1, 1986, the institution had 951 inmates. Thirty-seven employees were on duty.

In spite of the overcrowding, the institution was viewed as a well run facility with generally good staff and inmate morale. Only one area in the institution was an exception to this. Unit D was a former general population housing unit that had been converted to a segregation unit. It also contained a protective custody section housing approximately ten inmates.

Compounding these problems was the increasingly violent nature of the inmates being assigned to Unit D. In 1985, as part of a consent decree in a system-wide conditions of confinement suit, South Carolina Department of Corrections (SCDC) had to discontinue use of the segregation facility that for over 25 years confined approximately 100 of the most violent, assaultive inmates in the system. These inmates were dispersed to other segregation units throughout SCDC, including Kirkland's Unit D. In response to several incidents, including the stabbing of an officer by an inmate who had managed to get out of his cell, the Warden had ordered additional hardening of unit D. This work was in progress on April 1, 1986.

Construction crews, consisting of inmate workers and a civilian foreman, had fabricated a very heavy steel chest in which they stored tools being used in the renovation. This chest was located in a fenced area adjacent to Unit D. The employees in the area were confident that the tools were secure and that the chest was impregnable under any conceivable circumstances.

At approximately 7:00 p.m., a Unit D inmate in a special eight-bed bay housing the most disruptive inmates asked an officer to bring him some aspirin. When the officer returned, another inmate who had gotten out of his cell confronted the officer with a knife and threatened to kill him unless he gave the inmate his keys. The officer yelled for help, but the three other staff members in the building did not hear him. He threw the key ring on the floor and when the inmate bent to pick it up, the officer ran out of the wing. The inmate then used the keys to release the other 32 inmates in that wing of the building. The officers in Unit D reported an emergency to the institutional control center and a Sergeant and six officers were dispatched to assist them. By the time they arrived, the situation was out of control, and they locked themselves into the unit control center.

After rampaging through the wing for several minutes, the inmates broke the padlock on the fire exit door and gained access to a fenced recreation yard and weight-lifting equipment outside the building. Using a weight bar, they broke two more locks, gained access to the other wing of the building, and released the prisoners there. The officers in the building had retreated to the protective custody section of the building where they replaced a padlock and barricaded themselves in with the protective custody inmates.

About 30 minutes after the incident began, inmates began to climb the fence surrounding the unit's recreation yard, thereby gaining access to the yard of the institution. They also gained access to the heavy steel box containing the construction tools being used in the unit's renovation. After a short time, they broke the large hasp and distributed sledge hammers, crowbars, bolt cutters, grinders, and power saws. The inmates then began to disperse into the general population area of the institution and attack the other housing units. Although staff in these units had been alerted and secured their building, the rioters, using the construction tools, were able to break into every one of the housing units and release the inmates.

Within 45 minutes to one hour from the initial confrontation, approximately 700 inmates were loose within the institution and 22 employees were trapped inside. Several employees in the general population units were hidden by inmates.

Personnel in the central control room began notifying key institutional staff as soon as they learned of the problem in Unit D. The first off-duty staff person to arrive was the Captain. He immediately placed the few remaining officers that were available on the institutional perimeter. He also posted a Sergeant to the roof of the administration building with a radio and a shotgun. His orders were to prevent inmates from leaving the housing area gaining access to the industries, kitchen, psychiatric hospital, infirmary, and administration buildings. Approximately 15 minutes after the Sergeant assumed his post, several groups of inmates began moving toward these areas. The Sergeant fired one shot over their heads, and the inmates ran back to the housing unit area. Thereafter, rioting was confined to the housing units and the school/library building.

The Captain ordered two officers from the psychiatric hospital to report to the operations area with the intention of also placing them on roofs. While enroute, however, the officers were seized, handcuffed, and beaten by a group of approximately ten inmates. One officer was struck on the arm with a crowbar, but neither was seriously injured.

Shortly after his arrival, the Captain directed the control center to call the agency Director of Security to request all available assistance. Before departing for Kirkland, the Director of Security made calls to activate all Columbia area emergency teams and have them report to Kirkland. By approximately 8:15 p.m., a Command Post had been established in the Warden's office. Present were the Warden, the Commissioner, the Deputy Commissioner for Operations, the Regional Administrator, the Director of Security, and the Captains of the REP, Sit-Con, and CERT teams. Inmates had begun setting fires in the office areas of the housing units and in the school/library complex. At approximately 8:10 p.m., units from the Columbia Fire Department arrived, but were not allowed into the facility.

At approximately 8:45 p.m., the Command Post received a call from an inmate who stated that he had two hostages he wished to turn over. After consultation, the Regional Administrator met inmates at the back door of the administration building. With them were the two officers, still handcuffed, who had been seized upon leaving the psychiatric hospital. The two officers were released and taken to the infirmary. The two inmates walked back into the institution.

During the course of the evening, telephone contact had been maintained between the Command Post and the officers barricaded in Unit D. Since sufficient personnel were not available to go inside the institution and the staff in Unit D did not seem to be in imminent danger, they were told to remain where they were. At approximately 9:10 p.m., the Command Post received a call from the Sergeant in command in Unit D, who stated that a large group of original rioters had come back to the unit and were aggressively trying to break into the building with torches and heavy tools. The Sergeant stated that it was only a matter of minutes before the rioters would get into the building and gain access to the staff and the protective custody inmates. The rioters had also set tires around the building and the smoke was becoming intense.

At that time, 35 REP team members had been mobilized, equipped, and were ready for action. While this was far less than would have been preferred, the situation in Unit D left little choice. The squad, equipped with shotguns, was ordered to go out a side door of the administration building and proceed to the back of Unit D. There, they would cut the recreation yard fence and enter the building through the rear entrance. A short delay took place when it was discovered that some of the REP officers had been issued buckshot instead of birdshot as called for in policy.

The deployment went as planned. The REP team took control of Unit D and also took custody of approximately 75 inmates who had gone to an area near Unit D to avoid the rioting. The inmates who had been trying to break into the building retreated into the general population area. Staff rescued from Unit D estimated that the REP team arrived approximately two minutes before the rioters would have gotten into the building.

At approximately 9:45 p.m., the decision was made that sufficient forces were available to retake control of the remainder of the institution. A squad of 40 shotgun-equipped REP officers was deployed to the yard. At approximately 10:15 p.m., the first units of the Columbia Fire Department entered secured areas of the institution and began extinguishing the fires.

Approximately 500 inmates were moved to the large recreation field. A confrontation at the recreation gate nearly developed when there was some delay in getting the key to the gate. Officers on the scene "racked" shells into the chamber of their shotguns and the inmates quieted. A smaller group (approximately 100 inmates) was moved to the recreation yard at Unit D. During building searches approximately 100 inmates were found locked in their rooms. The institution was considered under control by 11:30 p.m.

Trapped employees were rescued during this process. Most in the general population housing units had been sheltered by inmates. One officer changed into inmate clothing and made his way to safety through a crowd of rampaging inmates. All rescued employees were given a medical examination and debriefed by Sit-Con team members. Particular attention was devoted to determining the condition and location of other staff members still within the facility, identification of inmate participants, description of inmate weapons, and the disposition of keys and other security devices.

Around midnight, a damage assessment was conducted by security and engineering personnel. It was determined that inmates could be safely secured. Of major importance was the lack of damage to the kitchen/cafeteria.

Throughout the night approximately 30 inmates on the recreation yard had been trying to instigate resistance to movement back to housing units. These were primarily inmates who had been in Unit D. They were identified and slated for transfer later that morning.

The last eight inmates to be taken from the field had been identified as ringleaders of the riot. They were removed without force from the field at approximately 6:00 a.m. and transferred immediately to another institution.

The institution was locked down by 6:30 a.m. By approximately 7:30 a.m., most of the 96 Emergency Response Team members from institutions other than Kirkland were sent off duty.

An institutional shakedown was conducted on the morning of April 2, with others following on April 8 and April 11. The institution remained on lockdown until the morning of April 3.

An initial damage estimate by the Columbia Fire Chief was approximately \$1.5 million. Subsequent detailed examinations revealed that structural damage to the school/library building was not as severe as first feared. As a result of this and extensive use of inmate labor, final repair costs were reduced to approximately \$800,000.

Media were briefed regularly throughout the night by SCDC's Public Affairs Director. The Commissioner of SCDC held a press conference in the Warden's conference room. In the early afternoon of April 2, press and television crews were allowed to film damage inside. News coverage was generally very favorable.

Seven inmates who had assisted staff were transferred for their protection. Ultimately, 34 inmates were indicted for rioting, inciting a riot, and hostage taking. Thirty-two of these either pled or were found guilty, with sentences ranging from 6 months to 15 years consecutive to current sentences.

In a review one year after the riot, it was found that only 1 of the 22 employees trapped in the institution had left the agency, a far lower turnover rate than for employees in general. Subsequent to the riot, a detailed post-trauma program was developed by SCDC, incorporating the lessons learned at Kirkland. This program remains in place and is now mandatory for employees who are seriously assaulted, taken hostage, or participate in inmate executions.

Lessons Learned

1. At the time of the riot, South Carolina DOC had realistic emergency plans in place at each of its institutions, as well as a wide tactical team (REPT) capacity. Staff were familiar with the emergency plans, and there was an orderly response to the Kirkland riot, rather than the chaos which is so often seen in the early part of an institutional emergency.
2. There were no serious injuries at Kirkland, even though rioting inmates controlled most of the institution for hours. This is likely related to the pre-riot conditions and climate at the institution, which were generally good.
3. The entire institution might well have been lost were it not for the decisive action of the on-duty staff and the Captain, who was the first manager reporting back to the institution. Some on-duty staff were able to close off some areas of the institution and barricade themselves in temporarily secure areas which contributed to containing the spread of the riot.
4. It was crucial that staff immediately developed a contingency plan for rescuing the officers trapped in Unit D in the event that the rioters tried to reach them or the protective custody inmates in the same area. These contingency plans were improved and updated as time passed and as additional resources became available. When word came from the officers trapped inside Unit D that the rioters were attempting to get into the unit with cutting torches and other heavy equipment, the tactical unit was able to mount a rescue almost immediately.
5. A thoughtful, well-designed crisis counseling program for staff hostages can make the difference and allow most staff hostages to return to work successfully.
6. Psychological screening should be required by policy for all staff who have been held hostage or who have been subjected to traumatic conditions during an institutional emergency.
7. Even if there is a large-scale insurrection, the media coverage can be generally positive if the media are dealt with quickly, responsively, fairly, and frequently, provided also that staff handle the insurrection in a competent and professional manner.
8. When inmates help staff hide or otherwise protect staff during a riot, management must later be sensitive to protecting them from retaliation by other inmates.

**Case Study:
Riots at Camp Hill
State Correctional Institution***

The Pennsylvania State Correctional Institution at Camp Hill was constructed in 1937 as a juvenile facility. As a result of a 1975 Attorney General ruling that Camp Hill was no longer suitable for juvenile commitments, it was designated in 1977 as an adult male institution. Camp Hill's institutional function was modified to serve as one of three diagnostic and classification centers. The prison was originally accredited and reaccredited by the Commission on Accreditation for Corrections in December 1984 and October 1987, respectively.

Six general population cell blocks were located at the southwest side of the facility. Four cell blocks located on the northeast side of the facility were used for a general population unit, a restricted housing unit, a special needs unit and a diagnostic center. Designed for juvenile offenders, the original cell walls consisted of hollow core glazed block. The walls and ceilings were not reinforced with steel stabilizing rods or mesh. Program and support service buildings -- including an infirmary, eight modular dormitory units, a chapel, an education building, a food service building, a gymnasium, an auditorium, and a laundry -- were located between the housing areas. Camp Hill's administrative building and central administration building for the Department of Corrections were located on the compound outside the security perimeter.

The institution consisted of 1,414 single cells in ten different cell blocks. The rated capacity in October 1989 was 1,825 beds, but Camp Hill's population had reached an unprecedented level at 2,656. Camp Hill was severely understaffed. Resulting from the shift bidding procedures, the 2:00 p.m. to 10:00 p.m. shift was frequently staffed with the youngest and least experienced officers. Camp Hill's staff training programs were not in compliance with accreditation standards.

Correspondence from the Camp Hill Superintendent in September 1989 suggested that the administrative staff recognized the strain that the growing offender population was placing on the facility. In addition to describing the level of overcrowding, the correspondence outlined short- and long-term plans and resources necessary to address the crowding through increased bed space and program expansion.

Reports of an inmate disturbance at Camp Hill began to emerge in the summer of 1989. Inmates were "frustrated by overcrowding, food quality, inoperative and overcrowded showers, inadequate educational and vocational opportunities because of understaffing, and limited law library privileges." This frustration was further fueled by policy changes enacted in September 1989 that altered the procedures governing inmate family visiting days and sick line. In the weeks preceding the disturbance, inmates made verbal reports of a potential disturbance to several officers. The most specific reports indicated that members of the Fruits of Islam (FOI), a Muslim sect, were attempting to organize an institutional disturbance. In addition, some staff interviewed after the disturbance noted that inmates demonstrated unusual behavior immediately before the disturbance including changes in the dress of Muslim inmates, "en masse" requests for sick call, "intentional" misconduct by an inmate informant in order to be transferred from general population, and reduced noise and activity by inmates in the Restricted Housing Unit. There was considerable frustration prior to the incident, particularly among correctional officers, which may have contributed to the institutional unrest.

On October 25, 1989, at approximately 2:50 p.m., three correctional officers were moving approximately 500 inmates in the main stockade yard between housing Groups 2 and 3. An inmate "without provocation" reportedly struck an officer stationed at E Gate after the officer requested to see the inmate's movement pass. Officers responding to the assault were then chased and assaulted by other inmates in the yard.

*Much of the narrative in this case study was taken from the report of the Adams Commission, the Governor's Blue Ribbon Commission charged with investigating the inmate disturbances at Camp Hill.

Some inmates went back to housing units and began assaulting officers in the blocks. By 3:30 to 4:00 p.m., the rioting inmates began to set fires and loot the kitchen, commissary, and auditorium, which were accessible from the main stockade yard.

Between 3:00 p.m. and 4:00 p.m., approximately 300 inmates moved about in the main stockade field. No apparent inmate leadership was identified. Three unattended vehicles were parked in an area adjacent to the Education Building. Officers made no attempt to remove these vehicles following the assault and subsequent disturbance in the main stockade yard. At approximately 3:15 p.m., a dozen unarmed correctional officers arrived at E Gate . . . and remained near E Gate for almost ten minutes until inmates . . . sprayed them with a fire extinguisher retrieved from the cell blocks.

As the officers attempted to retreat to the control center, inmates gained access to E Gate using a key obtained from an officer taken hostage and poured through the gate and into the compound. An inmate hot wired a truck and attempted to run the vehicle through an interior perimeter gate. Unsuccessful in his attempts, he drove the vehicle wildly through the main stockade field and succeeded in breaching the inner perimeter fence but not the outside perimeter fence. Through the penetrated inner fence gate, inmates gained access to the correctional industries building, which they ransacked obtaining wood and other flammable materials used to set fires in the E Gate gatehouse and a dispensary. Inmates destroyed the culinary manager's office and caused minor damage two modular housing units, basements in two cell blocks, a kitchen, and the furniture factory. They also pillaged the commissary portion of the education building and set it on fire.

Several correctional officers who were trapped in "switch boxes" (a small room with barred windows that serves as the cell block office) in two cell blocks were taken hostage as inmates broke through the hollow block walls around the switch boxes. Hostages were paraded around the main stockade yard, as inmates threatened to beat them with shovels and other objects. One hostage was repeatedly beaten by a group of inmates directly below a perimeter tower and in full view of staff who were watching the disturbance unfold from windows in the Department's administrative building, which overlooked the main stockade yard. After some unspecified period of time, the tower officer fired his shotgun into the air to chase the inmates from the officer. In total, 18 officers and other institutional personnel were taken hostage,

Officers, approximately 100 state police, Camp Hill SERT team members, and municipal police gathered at the sally port in the rear of the facility intending to move in and gain control of the modulars, education building, and commissary while allowing inmates the opportunity to get out. They established sufficient presence to regain control of E Gate. E block was reported to be seriously damaged; H block, which still had officers inside, was burning; and the four housing units in group 1 were locked down (Administrative Log, 1989). At approximately 5:05 p.m., police regained control of the education building, the chapel, and four modular units. Inmates were moved from the modular units to the main stockade yard, where a skirmish line was established to keep inmates in the yard between two housing units.

Throughout the disturbance, inmates obtained radios, cell block keys, and personal property from their hostages. Using radios and telephones, institution representatives began to negotiate with an inmate and at approximately 6:45 p.m. a negotiation table was set up in the education building. The negotiation team consisted of six Camp Hill staff members including the Deputy for Treatment and six Muslim inmates led by a known FOI leader who had previously established contact with the Control Center via radio. Inmates focused on concerns regarding overcrowding, revisions in the family day and sick line policies, medical procedures, general condition of the facility, lack of programs, and poor staff morale. Although no concessions were granted during the 2-hour negotiation session, hostages were gradually released "as a sign of good faith."

At approximately 7:30 p.m., inmates began returning to their housing units for "lock down" pursuant to an agreement by the institution administrators to meet with inmate representatives the following day at 1:00 p.m.

At approximately 9:00 p.m., officers in a Pennsylvania State Police helicopter circling the facility where inmates had set up camps instructed them to return to their cells. At approximately 10:00 p.m., a large contingency of institutional and state police officers moved through E Gate and began to sweep the main stockade yard to secure the facility.

During this sweep, officers conducted pat down searches of some inmates as they were returning to the cell blocks from the adjoining exercise yards. These inmates, however, were not actively involved in the disturbance. There was no reported shakedown of cells in groups 2 and 3 where the disturbance occurred, and debris and weapons were reportedly strewn on the floors.

At 10:00 p.m. and again at 11:00 p.m., press announcements were released by prison officials that the facility was secured. As a result of the disturbance, 45 injuries were reported, including injuries to 36 staff, 7 inmates, 1 firefighter, and 1 state police officer.

In the early morning hours of October 26, 1989, the Superintendent, deputy for treatment, deputy for operations, and director of treatment met to assess the damage to the facility. They decided against conducting a shakedown, in part because they believed the facility was secure and also because following a previous disturbance staff retaliated against inmates during a shakedown.

All was not secure, however. Officers feared that the cell door locking systems were not working following the lockdown, as they heard cell doors being opened and closed and saw several inmates moving about the cell block between 2 a.m. and 3 a.m. October 26, 1989. Additionally, there were reports of critical damage to the locking mechanisms in the cell blocks, as some of the security panels were removed and were laying on the floors in the blocks. Supervisors and officers in the blocks suggested using padlocks and chains to secure inmates in their cells, but that recommendation was rejected by the institution administrators.

Later that morning, a damage assessment was conducted. Throughout the day, security concerns were noted as inmates were seen out of their "secured" cells. These concerns were reported to the Captain by the shift Lieutenant.

At 1:00 p.m., per the agreement reached on October 25, the institution administrators met with inmate negotiators for one hour. The same concerns noted in the first night of negotiations were again raised, with the addition of poor scheduling and lack of commissary items. Though no decisions had yet been made, at 2:00 p.m., institution administrators ended negotiations so the Superintendent could report to a pre-scheduled briefing at the Central Administration Building. Upon leaving the negotiations, the inmate representatives, apparently disgruntled about the lack of movement on their concerns, reportedly made verbal threats about "burning the institution." These threats were reported by correctional officers to their supervisor; however, it is unclear whether this information was forwarded to the administration.

Only 15 of 24 officers on the 2:00 p.m. to 10:00 p.m. shift reported for duty, due to injuries sustained in the first disturbance. No officers from the previous shift were retained, and no additional officers were called to supplement the depleted officer ranks.

At 3:00 p.m. on October 26, 1989, institution administrators conducted a press conference for local media news. In the prepared statement, the Superintendent reported that inmate negotiations had been held, further meetings were scheduled for the following day, and the facility was secure. He also stated that he did not believe the inmate negotiators were representative of the inmate population and that none of their demands had been met, the normal staff complement was on duty and no additional staff had been called in, and almost all state police had left the institution. Inmates who watched the news conference in their cells were reportedly incensed by these comments.

At approximately 7:00 p.m., while staff were distributing dinners in E and F cell blocks, inmates began to throw items from the tiers. They were observed reaching through their cell bars towards the locking devices that were left exposed by the missing security panels. After staff reported hearing inmates scream "turn your lights off," inmates from all six cell blocks located in groups 2 and 3 were seen pouring into the courtyard between the housing areas. They ran through E Gate which, despite its strategic security importance in separating groups 2 and 3 from the other housing and program buildings, was not repaired following the riot the previous day. Inmates proceeded to group 1 housing blocks and modular units and released others. Fires were started in modular units 1 through 6; the education building; and E, F, and H blocks. Five staff members were taken hostage.

As inmates proceeded through E Gate, they chased staff and non-rioting inmates, who locked themselves in the Control Center. Rioting inmates broke windows and entered the Control Center by removing a window air conditioner and set fires on the first floor. Staff and inmates trapped in the Control Center had moved to the second floor and contacted the main gatehouse for assistance. A contingency of 25 Pennsylvania State Police and a municipal police officer arrived at the front gate in response to a radio distress call from a state police officer trapped in the Control Center. After a delay at the main gate, the officers were permitted to enter the institution, established a skirmish line between the main gate and the Control Center, and used a ladder to rescue all staff and inmates from the second floor of the burning Control Center. Following the rescue, state police issued a call for assistance and attempted to move inmates back through E Gate.

Within several hours, nearly 900 state police officers arrived at the institution. Throughout the night, they attempted to sweep the institution, one section at a time, to force inmates back into the main stockade yard. Municipal police encircled the perimeter.

At approximately 10:45 p.m., state police negotiators and institution staff threw a telephone with a long cord over the fence and began talks with an inmate in K Block. Negotiations continued throughout the evening of October 26. The same issues raised at earlier negotiations were emphasized. The inmate expressed his desire to speak with the Commissioner, the Superintendent, and the Governor. While two hostages were released during the negotiations, communication decreased as the evening progressed.

At approximately 5:45 a.m., a large water cannon was used to dislodge barricades inmates had constructed at E Gate. The plan to regain control of the facility was then activated by state police. The plan included diversion and entry, use of a fire crash truck, tear gas, and warning and defensive shots as inmates resisted. Four inmates were wounded, but none were killed. The last inmate surrendered at approximately 9:00 a.m. on Friday, October 27, 1989.

Although Camp Hill had an emergency plan prior to the riot, it was not used during the event itself. The emergency plan was not well known to most staff and was not practical. It referred to equipment and procedures that were no longer in use or no longer available. It had not been tested, nor had it been reinforced through training. During the second night of rioting, 66 injuries were reported to staff and inmates. Thirty-seven individuals, including the five officers who had been taken hostage, required transport to local hospitals for treatment. No deaths resulted from the incident.

Damage from the two days of rioting at the State Correctional Institution at Camp Hill was monumental, as 15 of the facility's 31 buildings were affected:

- Six of eight modular housing units as well as a new, yet unused modular office unit were destroyed, and the two therapeutic community modular units suffered moderate damage;

- Significant damage was reported to modular units 7 and 8, the Control Center, the greenhouses, the education building, the staff dining room, H Block basement, the gymnasium, kitchens I and II, the furniture factory, and dispensary II;
- Substantial damage was noted in the group 1 cell blocks as inmates broke through walls to access the plumbing chases.

Over the two days of rioting, upwards of 100 staff were injured and 24 staff were taken hostage. Approximately 130 staff, including 70 correctional officers, took disability leave for injuries sustained during the disturbances. As noted by the Senate Judiciary Committee in 1990, "Camp Hill was on the verge of disaster, and all involved must count it fortunate that no lives were lost." The monetary loss from the Camp Hill disturbances was staggering. In estimates issued by the Pennsylvania State Police, physical plant damage was more than \$15 million and costs associated with staff overtime and disability leave were \$40 to \$50 million.

Approximately 700 inmates were transferred to other institutions on October 27 and 28. By October 29, staff began returning the remaining inmates to the cell blocks, which was completed on October 31. As locking mechanisms were unusable, cell doors were chained and padlocked. On October 30, state police and institution personnel continued to sweep the facility, its underground utility passageways, and remaining structures. The institutional count still failed to account for five inmates.

On November 1, just seven days after the first disturbance occurred at E Gate, the Superintendent was suspended. In late January 1990, the Superintendent and Deputy of Operations were terminated, and the Deputy for Treatment was transferred. The Major of the Guard had previously retired.

Lessons Learned

1. The stage for this riot was evidently set by a number of broad predisposing factors that did not directly cause the riot, but likely added to the possibility that an individual incident would escalate into a major insurrection:
 - a. Overcrowding,
 - b. Understaffing,
 - c. Decreased access to inmate programs,
 - d. Poor labor management relations and poor staff morale,
 - e. Failures in the inmate disciplinary process,
 - f. Housing large numbers of maximum-security inmates in a facility that was at best appropriate for medium- and minimum-security inmates,
 - g. Lack of interaction and communication between the administration and front line staff and between the administration and the inmate population.
2. Against these general conditions, the actual provocation for the riot appears to have been two policy changes imposed on the population:
 - a. Family members could no longer bring food into the institution on family day.
 - b. Inmate sick call was reduced to every other day rather than daily
3. Management did not respond to some of the classic signs of impending disturbance or attempt to deal with inmate leaders appropriately.
4. Like many prison disturbances, the first day of rioting was spontaneous, but the entire prison was nevertheless lost because staff failed to mount an appropriate response to the initial disturbance.

5. Leadership was problematic throughout the two days of rioting, and the lack of strong, decisive leadership was an integral part of many of the other problems at Camp Hill.
6. Emergency plans were inconsistent from institution to institution in Pennsylvania prior to the riot, and it was impossible to effectively coordinate resources such as SERT teams from other institutions when the riot occurred.
7. Coordination between the institution and external agencies such as the Pennsylvania Emergency Management Agency and the Pennsylvania State Police was similarly ineffectual, primarily as a result of lack of prior planning.
8. In spite of the extent and seriousness of the second day's rioting, the institution was re-taken in a few minutes by state police as soon as it was clear to the rioters that they would face lethal force.
9. Individual officers were not prepared through training or supervision to follow the Department's use of force policies. They also lacked appropriate weaponry. Some staff were taken hostage and/or beaten who might not have been if they used force appropriately.
10. If the aftermath of an emergency is not handled competently and step-down plans are not realistic with regard to issues like security, then an institution may face a second emergency that can be more destructive than the original situation.
11. Institutional managers and administrators must recognize that media coverage and the course of the event are interactive, and the coverage can dramatically affect the course of the event.
12. After an emotional situation has been resolved, some staff may think about retaliation against the inmate population. It is a management responsibility to prevent such retaliation, and the primary issue will be leadership.
13. Poor day-to-day security procedures such as lack of key control, leaving motor vehicles unattended within a prison compound, poor control of heavy tools, etc., are likely to haunt an institution if serious trouble occurs.
14. A prison control center or main control room located inside the security perimeter of a hard institution must itself be as secure as is practically possible.
15. Communication failures and failures of an intelligence operation during a disturbance can lead to security lapses that increase the chance that the disturbance will re-escalate or spread.
16. An institutional emergency plan will likely prove close to useless during an actual emergency if it is :
 - a. Impractical,
 - b. Written to reflect resources that no longer exist, or never existed,
 - c. Unfamiliar to most institution staff,
 - d. Unavailable during an emergency,
 - e. Written to reflect procedures that the Department does not use,
 - f. Not reinforced with training simulation and exercises.
17. Even when almost everything goes wrong in a disturbance at an institution that has not been running well, a large measure of good luck combined with the good work and experience of some of the staff and of external agencies may result in avoiding loss of life and increased risks to the community.

**Case Study:
The 1993 Midwest Floods:
Missouri Loses Renz Correctional Center**

In 1993, early spring flooding was very serious along much of the Missouri and Mississippi Rivers' watersheds. Eight counties in eastern Missouri were designated disaster areas by Presidential declaration. Renz Correctional Center is a medium-sized (average population of about 550 inmates), high-security prison for female offenders, situated within the flood plain of the Missouri River. The prison was opened in 1961 as Renz Farm and is affected when the Missouri flood stage reaches 29 feet.

The early spring floods of 1993 were followed by continual rainy weather and some flooding in the late spring and early summer. Renz fine-tuned its evacuation plans and prepared for evacuation several times during the spring and early summer.

By late June, the facility had moved property and equipment off the floor and had begun to move some critical property out of the institution. The river continued to rise and, on July 2, the Department began to evacuate inmates to the Chillicothe Correctional Center and the Central Missouri Correctional Center. Evacuation of all inmates took two days and was accomplished without violence, injuries, or escapes.

The Central Missouri Correctional Center was under a federal court order that imposed a population cap of 1,000 inmates. The Department of Corrections was able to obtain quick verbal permission from the court to exceed this cap because of the emergency evacuation and subsequently received a formal order granting the emergency exemption from the cap.

After the inmates were evacuated, corrections staff used boats to re-enter the facility and remove as much equipment as possible. They moved other property and equipment to the second floor of the three-story main prison building.

When the Missouri River reached a crest of approximately 35 feet in mid-July, staff was initially optimistic that the institution would be cleaned up, repaired, and eventually re-occupied in spite of the substantial damage. That was not to be the case. Heavy rains continued unabated in the northern part of the state, and the Missouri River began to rise again towards a new crest.

At the end of July, the river finally crested at 38.6 feet. Even after the crest, the river waters took a long time to recede. A 32-foot-high levy that protected the Renz complex was flattened, and, after the waters receded, a new 15-acre, 15-foot lake was left on the property.

Inspections revealed that the Renz facility was completely incapacitated and that restoration would not be practical or cost-effective. Most of the property and equipment that had been moved to the second floor was lost to the flood waters. The river had raged through the Renz complex with such force that the entire 9-foot security fence, including 4,000 feet of razor ribbon, was lost to some unknown location down river. The flood waters had remained so long that locks and other security devices throughout the facility had rusted and were beyond repair. Storage tanks had disappeared, and the compressor room had collapsed. The food service and medical units sustained serious damage.

The emergency evacuation and re-housing of inmates from Renz was not the only emergency with which the Department of Corrections had to contend. The floods cut off all road access to the Algoa Correctional Center, and employees had to be ferried by boat to work and back. The rising flood waters in downtown Jefferson City threatened the Jefferson City Correctional Center (the old Missouri State Penitentiary) and inmates at that facility worked at sandbagging efforts within and around the prison as well as at other public buildings within Jefferson City.

During the course of the spring and summer floods, well over a 1,000 inmates helped in community efforts to save flooded areas, sandbag and reinforce threatened levies, and clean up after flood damage. All of Missouri's 16 state prisons were extensively involved in these efforts. Missouri DOC documented over 4,000 hours of staff time supervising inmates in community assistance efforts during and after the floods.

The Department of Corrections' Board of Probation and Parole also contributed significantly to flood relief efforts across the state. Probation and parole staff and offenders from 28 of 29 district offices participated in relief activities. Staff numbered 178 and completed 1,638 hours. They also contributed food, dry goods and cash to relief projects. A total of 661 probationers and parolees contributed 9,875 hours of relief work. Probationers ordered by the courts to perform community service contributed significantly in this effort.

Lessons Learned

1. The Department's pre-existing emergency preparedness system and facility emergency plans provided an appropriate and practical framework for the emergency response to the floods. In particular, the detailed evacuation plans at the facility level proved to be invaluable.
2. Inmate populations were kept well advised about the status of the floods, and the inmate reaction was one of cooperation and assistance.
3. The lack of a statewide communications system meant that various state agencies could not monitor each other's radio traffic or transmit to each other throughout the emergency.
4. Communications were taxed throughout the emergency, and access to phone lines was often a determining factor in responding to the emergency.
5. As has been the case during earthquakes, one of the most valuable items during the floods were cellular telephones.
6. Staff needed to be kept informed about many issues outside the affected facility, including road closings, emergency assistance if their homes were affected, availability of counseling and support, etc.
7. It was necessary to keep staff involved in the planning regularly briefed. Maintaining staff meetings was difficult but important. As extra help became available, staff from the affected facility assumed supervisory and management roles and outside staff were used in support roles and for logistical help.
8. Coordination between the Department of Corrections, county jails, and community correctional facilities needs to include planning for large-scale natural disasters. In particular, county and local facilities must have plans for temporary holding facilities and temporary transportation if the local facilities cannot use Department of Correction facilities or transportation for an extended period of time.
9. The planning for moving inmates, staff, and equipment from the facility that was being evacuated proved far better than the planning for handling the inmates at the receiving institutions.
10. Access to inmate files and other information, as well as the roster system for scheduling staff, was compromised by the emergency. Backup systems would have been invaluable, and planning in these areas proved inadequate.

11. Comprehensive maps indicating emergency routes and primary choices for evacuation routes would have been most helpful during the floods, as would some sort of ID card system for the major players in the emergency.
12. It is important for the Department to be able to track its requests for assistance, the external agency asked for help, and the progress of the task.
13. Supplies of emergency food and water were inadequate for staff remaining to work within Renz after the inmates were evacuated.
14. Emergency supplies were inadequate for the length and severity of the emergency. Security and accountability for the supplies were both poor.
15. The Department needed more heavy equipment than it could locate during the emergency (forklifts, dump trucks, flat trailers, etc.).
16. Clear leadership of the DOC Director was evident as departmental resources were made available for community assistance wherever possible.
17. Staff efforts to assist with local community problems were extraordinary. Most of these efforts were on a volunteer basis.

**Case Study:
Helicopter Intrusion/Escape
Colorado Department of Corrections**

On Friday morning, August 18, 1989, a helicopter entered the main compound of the Arkansas Valley Correctional Facility near Ordway, Colorado, and landed on the ball field of the prison's main recreation yard. Within seconds, two inmates entered the helicopter and it rose, turned, and flew out of sight. At approximately 6:00 p.m. that day, the two escapees and their two female accomplices were located driving in a rental truck towards Holdrege, Nebraska. A shoot-out with police ensued, after which both inmates and both women were taken into custody in Holdrege.

The Arkansas Valley Correctional Facility (AVCF) is a modern, medium-security state prison that opened in 1987. At the time of the escape, AVCF staff had become used to seeing helicopters from two television station news operations flying near the facility, and both of those helicopters were similar in appearance to the jet helicopter that made the intrusion on August 18.

The helicopter appeared to have circled the facility prior to crossing the perimeter and entering the compound. Officers on the perimeter reported the helicopter as it crossed the perimeter of the facility, but not before that. At the time the helicopter entered the compound, there were 15 to 20 inmates on the main recreation yard and five staff members outside the buildings supervising inmates. When the helicopter landed on the ball field, two inmates immediately entered the helicopter and two staff members ran towards it, getting quite close before it took off. The staff members who approached the helicopter were able to give descriptions of the male pilot and two female passengers.

The Prison Superintendent was in his office overlooking the recreation yard when the initial radio report indicated the helicopter entry to the facility. The Superintendent gave immediate orders that if the helicopter lifted off, the perimeter officers were to stop or disable it with lethal force. He repeated this order two more times during the next minute, but no shots were fired. There are no armed posts at AVCF that have sight lines or fields of fire to the ball field. Given the helicopter's path of ascent and departure from the area, one of the two towers had, at best, a partially obstructed view. The armed perimeter vehicle was also in a position where it was not possible to fire at the helicopter, partially because of obstruction from the fence fabric. The other tower officer should have had a clear view of the helicopter once it rose over the ball field. That officer should have been able to fire several shots, but he did not. He was suspended pending investigation.

Staff estimates of the total time the helicopter took from initially crossing the perimeter of the facility to taking off from the ball field and beginning to leave the institution ranged from 15 to 30 seconds. Estimates were that the helicopter took off from the ball field at 40 to 50 mph while climbing, and then turned to leave the compound, accelerating to 90 to 100 mph during this turn. It was also clear from staff witnesses that the two inmates were waiting for the helicopter when it arrived, perhaps within ten feet of the spot where it touched down. There were reports that the inmates wore distinctive bright clothing, probably as a signal or beacon for the helicopter.

The facility called an emergency count within five minutes of the escape, at 9:20 a.m. The emergency count was completed at 9:32 a.m., and the identities of the two escapees were confirmed. Department headquarters and the Colorado State Patrol were both notified of the escape at approximately 9:30 a.m. The prison remained locked down (except inmate kitchen help) until lunch hour. NCIC and state warrants were issued quickly, and wanted flyers with pictures were also disseminated.

The facility Duty Officer left the facility to participate in the search, although the facility procedures call for the Duty Officer to remain at the prison and complete a checklist of responsibilities in the event of an escape. Most of these responsibilities were handled by the Shift Commander.

Both prison investigators also left the facility to participate in the search, which hampered the development of intelligence about the escapees. For example, the escapees' cell was secured immediately after the emergency count, but the cell was not searched until the investigators returned.

The search itself quickly became problematic. AVCF procedures call for the use of structured search teams for any escape. In this instance, the structured search teams were not used, perhaps because of the unanticipated nature of the escape. Six vehicles and 14 staff left the institution on the search, and only half of those staff were designated as search team members. The primary Search Commander, and all three designated relief Commanders joined this initial search response. If the search had continued hours longer, no relief Commander would have been available. Once the search vehicles were more than 30 miles north of Ordway, they lost all radio communication with the facility control center. Car-to-car communication was also difficult to impossible. Outside law enforcement agencies were able to provide some information to the institution about the status of the search vehicles, but the search Commander had no information about vehicle positions or directions. Two search vehicles were participating without the knowledge of the search Commander.

The AVCF armory officer was not in the facility at the time of the escape, so the shift Commander assigned an alternate. It was discovered subsequently that several weapons were taken from the armory without an armory officer present for proper weapons assignment and documentation.

Within 45 minutes of the escape, the facility discussed the situation with the Air National Guard Commander, who immediately made helicopter training flights available to help with the search. The airborne surveillance from the Air National Guard and the Colorado State Patrol was extremely helpful with the search effort and with the coordination of communications.

At 9:46 that morning (31 minutes after the escape), a small local airport aviation company reported that a blue and white helicopter had landed at 8:40 a.m. and refueled, with two women and a male pilot aboard. At 10:09 a.m., a county sheriff's office radioed that the helicopter was spotted on the ground some 35 miles north of the prison and that suspects had been seen running to a yellow rental truck. A press release was authorized at 10:24 a.m. At 10:40 a.m., the helicopter and pilot were located near an abandoned farmhouse. A National Guard helicopter was dispatched and, 10 minutes later the prison received information that the pilot had been tied up but was unharmed and that the two women and two inmates were armed. The prison determined that one of the inmates' wives had an older Volkswagen registered to her and, at 11:40 a.m., the Superintendent issued an APB for this car and its license plate. Speculation at the prison was that the Volkswagen might be inside the rental van.

By mid-afternoon, the escape response at the prison was focusing on the planning of the escape and attempting to confirm the identities of the two women involved. At 2:30 p.m., the Superintendent interviewed the two officers who had gotten within a few feet of the helicopter before it lifted off. One of them confirmed the identity of one of the female passengers as the wife of one of the two inmates. He recognized her from prior visits to the prison.

As is often the case in these kinds of situations, there were a number of rumors, false starts, and misunderstandings. The Sheriff of Arapahoe County, Colorado, had suggested at 10:30 a.m. that a female former Deputy Sheriff who had been fired from Arapahoe County for becoming involved with a jail inmate there might have been involved in the escape. The intelligence operation had been focusing on whether this former deputy sheriff might be the wife of one of the two inmates, or might be involved in the escape using an alias. At 4:30 p.m. the Sheriff's Office advised the prison that the female ex-deputy sheriff and her attorney had appeared there to verify she was not involved in the escape.

When the police found the helicopter pilot, he was untied and claimed he had been able to cut the ropes using a pocket knife. The initial police reaction was very skeptical, and the pilot was taken to jail as a suspect. The initial indications to the prison were that the pilot was likely a collaborator in the escape, and it was not until mid to late afternoon that it became clear that he was an innocent victim.

By late afternoon, information about the chartering of the helicopter had become more clear. The helicopter had been chartered out of the Centennial Airport, but the two women who chartered it were actually picked up at the nearby La Junta Airport. They got on the helicopter carrying large bags and presumably took weapons from the bags once the helicopter was in flight. Because Centennial and La Junta are not commercial airports, there are no metal detectors or other commercial aviation security precautions in place. Information was also developed that the charter had originally been arranged for two days earlier, but was canceled by the helicopter company because of bad weather. The charter company operator remembered that one of the women had become irate when the earlier charter was canceled and that both were upset when the Friday morning charter was running 10 to 15 minutes late.

At 6:15 p.m., one of the department administrators was advised that the evening television news had just reported a shoot-out in Holdrege, Nebraska. Calls to the Holdrege Police Department were initially frustrating as the Department of Corrections was advised that the Nebraska State Patrol was handling all information about the incident. The Department was unable to get an immediate status report. By 7:30 that evening, the Department had detailed information from the Nebraska State Patrol and had verified that both inmates and their female accomplices were in police custody.

The day after the escape, the prison confirmed information that one of the two women involved had been a criminal justice student at a Colorado college and had done volunteer work at another Colorado prison the prior year as part of an internship. As an assistant to a case manager, she conducted tutoring and case management testing of inmates behind closed doors. She was terminated by that prison in November 1988, and in March 1989 she appeared at AVCF with papers indicating she had married an inmate (one of the two escapees) "by proxy." The other female accomplice was the wife of the second inmate.

Lessons Learned

1. Most of the problems encountered had to do with failures to follow the prison's established plans, policies, and procedures for escapes, rather than with inadequacies in the procedures themselves. The initial response of AVCF after the escape, including the lockdown, emergency count, and identification of the escapees was fast, orderly, and effective.
2. Even with detailed planning, any major emergency will give rise to some unanticipated problems. An extraordinary situation such as the one presented here, will demand quick and creative flexibility. (The search vehicles might have been effective if the inmates left the prison premises by car, but because of the speed and point-to-point nature of the helicopter's flight, the prison search effort was hours behind the escapees.)
3. The problem with the duty officer, the investigators, and the relief search Commanders all inappropriately joining the search underscores the importance of a well-trained, well-practiced, and disciplined response to a major emergency. The long prison tradition of every available staff member responding to an alarm and trying to get to the scene as quickly as possible works against the kind of disciplined response necessary for managing a major emergency.
4. Prison security is designed from the inside out, rather than from the outside in. Prisons that may be extremely secure against the typical inmate escape attempt may be highly vulnerable to an assault from the outside. It is important, and it may be enlightening, for every prison to conduct an informal survey of its security against assaults from the outside. (Which security systems would be ineffectual from the outside moving in? What areas of the prison might civilian accomplices breach or disable? How easily could someone throw a weapon in to a waiting inmate? Could a heavy vehicle simply drive over perimeter fences? How might an aircraft-assisted escape be planned?)

5. Procedure should require perimeter posts to notify the shift Commander whenever an aircraft is flying unusually low or appears to be approaching the facility. (A number of prisons and jails in this country are adjacent to airports and very close to established flight paths. For those institutions, notification should be limited to aircraft that appear to be out of established flight paths and flight patterns.)
6. The prison had not seriously contemplated a helicopter escape, although more than 20 such escape attempts from American jails and prisons occurred during the preceding ten years. Helicopter escape attempts remain somewhat exotic because of the planning requirements, but not necessarily because of resources. In 1989, this five-passenger jet helicopter was chartered for \$475 an hour, well within the realm of possibility for many inmate friends and family members.
7. Policy questions about use of lethal force to prevent helicopter escapes remain difficult and somewhat controversial. There is some consensus that lethal force should not be directed at a helicopter that is apparently trying to land within a prison compound, in part because the pilot in an escape attempt will almost always turn out to be a civilian hostage or the helicopter might be having mechanical problems and simply trying to find a safe place to land. There is also some consensus that the best way to deal with a potential helicopter escape is to prevent inmates from approaching and boarding a helicopter that is hovering or has landed. Many states specify that lethal force may be used against inmates who ignore verbal orders and/or warnings and attempt to move towards or get on board such a helicopter. There is less policy agreement about what to do if a helicopter is taking off with inmates on board. The competing priorities of protecting the community against inmate escapes versus the risk that lethal force will kill the civilian hostage piloting the helicopter and the risk that the helicopter might crash into occupied buildings and cause a large-scale loss of life have led different agencies to different policies on this question.
8. This situation was extraordinary in that the Superintendent actually saw the escape in progress and was able to issue orders to use lethal force. Most escape attempts that can be stopped with lethal force will not allow time for orders from a superior officer. An officer on a perimeter post will typically have to make a very quick decision about lethal force based on the agency's use-of-force policy and the officer's prior training, experiences and expectations.
9. The situation described here, where an officer is properly ordered to use lethal force but does not shoot, is more common than might be predicted. Some officers will "freeze up" and not fire, and it is not possible to predict who will and who will not fire until the situation occurs.
10. The prison should have at least five staff (preferably more) who are intimately familiar with the armory, its contents, its organization, and its procedures. Otherwise, the institution may have an emergency when the designated armory officer is unavailable, and critically important weapons or other equipment may not be available for staff or may not be adequately accounted for once the incident is over. In addition, staff at and above the shift command level should have more than a passing familiarity with the contents and organization of the armory.
11. An intelligence operation may be as important to solving an escape as the escape posts and search procedures.
12. Communications systems are seldom adequately tested for emergencies. Interagency compatibility problems with communications systems are often unaddressed until after a serious incident in which communications proved to be a major barrier.

**Case Study:
Fire in a New Institution
Taney County, Missouri**

Taney County, Missouri is located in a relatively isolated area of the Ozark Mountains. Forsyth, the county seat, is a town of approximately 1,200. The new Taney County Jail in Forsyth was completed in 1982. It is designed to hold approximately 32 prisoners, primarily in double cells. The jail building also houses the County Sheriffs Dispatch Center and all of the Sheriffs Department offices.

The jail is constructed of steel and concrete and was equipped with numerous fire extinguishers but no self-contained breathing apparatus, fire hoses, or sprinkler system. Located behind the administrative areas and the dispatch room, the housing areas are entered through a sliding steel door which then gives access to three separate sub-housing areas: the women's unit, the men's minimum unit, and a high-security men's housing unit. Each of these areas is accessed by another sliding, electrically operated steel door. The cells are of open-front construction, with sliding barred doors. All of the doors in the jail can be manually operated with a key in the absence of electric power, but there is no gang unlock and each cell door must be individually keyed open.

At approximately 3:45 a.m., September 14, 1991, some of the minimum-custody prisoners in cells along the back wall of the jail became aware of a fire just outside the jail walls and visible through translucent windows in the housing area. They began yelling and woke the trustee inmates housed in the cells closest to the doors to the dispatch room, where the night staff member is usually stationed. At night, the Taney County Jail is staffed by one person, a "dispatcher/jailer" who runs the county dispatch center and also handles duties inside the jail. Inmates were unable to contact this staff member for a substantial period of time. By the time contact was made, smoke was coming into the jail from the roof.

A wooden shed-like structure had been constructed just outside the east wall of the jail building to house a large emergency generator for use in the event of a main power failure. The emergency generator was powered by propane, and a large propane tank was mounted outside the wooden shed between one and two feet from the northern wall of the shed. By state code, the propane tank should have been at least ten feet from any flammable structure. The shed housing the emergency generator also housed two large batteries and a battery charger, which was powered with electric lines run from inside the jail.

While a number of issues surrounding this fire remain unclear or in dispute, it appears that a short circuit in the battery charger or its wires produced a fire that involved the wooden shed. The roof of the jail is constructed of prestressed concrete, but above that a wooden soffit, or eaves and false roof, had been constructed in apparent violation of state codes. The fire in the shed spread to the wooden structure above the concrete roof of the jail, and it was this wooden roofing that apparently produced most of the smoke that entered the jail.

When the dispatcher/jailer responded to the outer door of the jail housing areas, he had an immediate problem. If that door, the inner doors, and the cell doors were opened to evacuate the inmates, they would be in a corridor leading to an unsecured outside door to the jail, and might escape. At some point early in this series of events, the shed fire burned the wiring on both the emergency generator and the main power lines, and the jail lost all power. The time at which the power and emergency power were lost has never been established with any degree of precision. There were allegations the jailer/dispatcher had a window of opportunity after he was aware of the fire, and before the power was lost, and that he could have electrically operated all of the doors and evacuated all of the inmates, and that he failed to do so, perhaps out of fears about escapes or perhaps simply because he did not know an evacuation procedure. It was also suggested that the power went out almost immediately after the fire was first noticed and well before the dispatcher/jailer was even notified.

The jail had not conducted fire drills or any sort of practice evacuations. State code required an annual fire safety inspection of the jail, with a written report of the results of the inspections. No such inspections had been conducted and the Fire Marshal did not have jurisdiction over the jail. The smoke detectors installed in the jail did not have battery backup and were ineffective.

At some point after the power was lost, the jailer/dispatcher tried to manually key the main housing area door, but was unable to operate the door.

Conditions within the cell areas had become extremely bad. Thick smoke was reaching all of the cell areas. The built-in smoke ejector system did not work because it was dependent upon power. Although timelines are not clear, reconstruction of events suggested that it may have been more than 30 minutes after the dispatcher/jailer was alerted before help arrived. Two or three jail staff, including the head jailer, and Fire Department assistance all arrived in close proximity to each other. After the head jailer tried unsuccessfully to operate the main housing area door manually, a firefighter wearing self-contained breathing apparatus was able to finally open the door. The doors of the units also had to be manually opened, and then cell doors had to be opened individually. The jail staff and firefighters were able to enter the women's area and the minimum-security men's area and open cell doors. The maximum-security unit door could not be operated manually and eventually was opened with an acetylene torch, causing even lengthier delays in reaching the cells there.

Three male inmates and one female inmate died of smoke inhalation. Another female inmate suffered very serious permanent lung damage and will require oxygen assistance for the rest of her life. The other 21 inmates housed in the jail suffered smoke-related injuries described as mild to medium. No serious injuries occurred to jail staff or firefighters.

In the aftermath of the fire, no comprehensive analysis of what happened, and why, was attempted. With the exception of a short investigation report by the Division of Fire Safety of the State Department of Public Safety (consisting primarily of a description of what was found burned, partially burned, and intact), most of the available documentary information on the fire is found in deposition testimony resulting from a large number of lawsuits filed by surviving inmates and families of deceased inmates. The lengthiest of the civil cases was concluded in 1995. Taney County was insured, and the carrier settled relatively quickly at policy limits. Out of court settlements were also reached with the company that manufactured the security doors and the company that installed the propane tank that fed the emergency generator.

In repairing the jail, the eaves and false roof were redesigned using nonflammable materials. The dispatcher/jailer who had been on duty had a severe post-traumatic incident stress reaction and eventually resigned from the Sheriffs Office.

Lessons Learned

1. No building is fireproof,
2. Even in a modern facility constructed of steel and concrete, many items are capable of producing life-threatening smoke, including mattresses, inmate personal property, carpeting, paint on walls, cleaning supplies, and insulation.
3. Unless procedures are tested with fire drills that include full-scale evacuation, some problems may not be identified until they occur during a real fire, perhaps with disastrous consequences.
4. Local fire departments should participate in simulated fire emergencies with local correctional institutions.

5. Every correctional institution should have self-contained breathing apparatus and staff trained to properly use it. The primary purpose of this equipment is not fire suppression, but search and rescue.
6. Fire exit signs and smoke and fire detectors should always have battery backup systems.
7. Inmate housing areas that are isolated from staff during some portions of the day must have a method or mechanism for alerting staff to an emergency.
8. Where possible, emergency generators should not be in the same location as the main power for the institution.
9. At least annually, every correctional institution should have a thorough fire inspection conducted by someone not on the institution's staff.
10. After a serious emergency situation, a comprehensive critical incident review should be required to ensure that problems encountered do not reoccur and to avoid other problems.

Section 4

MODEL INSTITUTIONAL EMERGENCY PLAN ORGANIZATION AND REPRESENTATIVE SAMPLE SECTIONS

(The documents and portions of emergency plans in this section are taken from actual emergency plans in the Oregon Department of Corrections and are reprinted here with permission.)

MODEL ORGANIZATION OF INSTITUTIONAL EMERGENCY PLANS

1. Table of Contents
2. General Emergency Procedure Summary
3. Command Notifications
4. Chain of Command
5. External Notifications
6. List of Emergency Equipment
7. List of Emergency Locations
8. Staff Recall Procedures
9. Emergency Organizational Structure Diagrams
10. Emergency Family Notifications (Procedure and Locations of Information)
11. Declaring (and Canceling) a State of Emergency
12. Deactivation Procedure
13. Appendices: Plans for Specific Emergencies
 - (a) Riot/Disturbance/Sit-Down
 - (b) Hostage Incident
 - (c) Escape
 - (d) Employee Job Action
 - (e) Outside Assault/Civil Disorder
 - (f) Fire
 - (g) Natural Disaster: Hurricane
 - (h) Natural Disaster: Tornado
 - (i) Natural Disaster: Flood
 - (j) Natural Disaster: Earthquake
 - (k) Man-Made Disaster: Chemical Spill
 - (l) Man-Made Disaster: Nuclear Accident
 - (m) Epidemic
14. Record of Changes to Emergency Manual
15. Care of Manual and Authorization for Changes
16. Distribution of Emergency Manual
17. Institutional Risk Analysis
18. Emergency Policies

19. Departmental Phone Listings
 - (a) Central Office (including FAX)
 - (b) Other Institutions (including FAX, Superintendent's Pager)
20. External Agency Agreements
 - (a) Fire Department
 - (b) Local Police
 - (c) State Police
 - (d) State Emergency Management Agency
 - (e) Hospital(s)
 - (f) Ambulance Companies
 - (g) Phone Company
 - (h) Utilities
 - (i) Other
21. Vehicle Inventory
22. Evacuation Plans
23. Medical Services Emergency Plans
24. Food Service Emergency Plans
25. Procedures for Volunteers and Non-Inmate-Contact Staff
26. Staff Recall Lists and Phone Numbers
27. Floor Plan, Maps of Institution, Utility Locations, and Architectural Plans
28. Fire Evacuation Routes

Model Emergency Plan: Representative Sections
COMMAND NOTIFICATIONS

CHAIN-OF-COMMAND NOTIFICATION

All Command Staff will be notified for recall for any declared emergency.
 Notify with Command. type. and extent of the emergency.

TIME CONTACTED	PERSON	POSITION	PAGER NUMBER	HOME PHONE NUMBER
	Sonia	Superintendent	373-xxxx	393-xxxx
	Sonia	Assistant Superintendent	373-xxxx	393-xxxx
	Jeff	Security Manager	373-xxxx	393-xxxx
		Officer-of-the-Day		

SPECIALIST NOTIFICATION

Specialist will be notified as designated by the Commander.
 Notify with Commander, type, and extent-of the emergency.

T I M E CONTACTED	PERSON	POSITION	PAGER NUMBER	HOME PHONE NUMBER
	Margaret	TERT Squad Leader	375-xxxx	363-xxxx
		*OSP TERT	--	378-xxxx
		*OSCI TERT	--	373-xxxx
	Rich	Emergency Coordinator	375-xxxx	362-xxxx
	Sonia	Public Info. Officer (PIO)	373-xxxx	393-xxxx
	Keith	Intelligence Officer	--	538-xxxx
	Jim	Negotiator	370-xxxx	362-xxxx
	Ron	Negotiator	370-xxxx	364-xxxx
	Terrence	Physical Plan Manager	373-xxxx	363-xxxx
	IMO	Chaplain	370-xxxx	588-xxxx
	Dave	Safety Off/Key & Tool Control	--	371-xxxx
	Paula	Gang Coordinator	375-xxxx	364-xxxx
	Mike	Computer Security Officer	--	390-xxxx

 Notification Officer Signature

 Date

 Time

*See TERT Alert

Model Emergency Plan: Representative Sections

DATE: _____

Dear Employee:

EMERGENCY RECALL ROSTER

The phone numbers listed on the reverse side of this letter are **CONFIDENTIAL**. Please do not release this information to anyone.

If your phone number changes, or is listed incorrectly on the reverse side of this letter, please provide the Superintendent's Office with the new phone number as soon as possible (within seven (7) days). You should place this roster in a safe location near your telephone.

When you receive official notification to report for emergency duty, it is your responsibility to contact the next person listed under your name on the recall roster. **Continue down the roster until contact has been made.** You must make contact with an individual before reporting to the facility. Do not rely on spouses or children to relay the message.

Remember, it is each person's responsibility to report for duty properly clothed (in uniform, if possible). In case of inclement weather, overdress rather than underdress.

When reporting to the facility, give the following written information to the Personnel Officer:

1. Who contacted me: _____
Time: _____
2. Who I contacted: _____
Time: _____
3. Time I arrived at the facility: _____

Sincerely,

Superintendent, OWCC

FAMILY NOTIFICATIONS

(Emergency)

EMERGENCY INFORMATION

All employees will be requested to submit a completed Emergency Preparedness Personal Information form. This information will be **CONFIDENTIAL** and will be maintained in a secure location (Superintendent's Office).

All employee names on-duty in response to the emergency will be compiled on a list by the Personnel Officer and submitted to the Emergency Staff Services Coordinator (ESS).

"Family" (for purpose of clarity) will indicate those persons listed by the employee and inmate for emergency notification.

Affected families will be notified of the emergency and offered the listed services for employees and inmates.

HOSTAGE OR SERIOUSLY INJURED SERVICES

Employees and Inmates

- Separate briefing areas at facility (OPTIONAL).
- Separate telephone information lines at facility.

Employees Only

- Assign DOC Employee Liaison at family home to answer door, accurately convey the latest information from the facility, and act as an intermediary with the media.
- Lodge family at a motel close to the facility at DOC expense.
- Provide counseling for family members during and after emergency.
- Give information on nature of injury from a qualified medical services employee.
- Offer to transport employee or family member to hospital.
- Assign Employee Liaison to answer questions and communicate family needs to DOC Personnel Section.
- Give information on medical benefits for employee.
- Provide child care services

FAMILY NOTIFICATIONS

(Emergency)

LONG DURATION SERVICES

Employees and Inmates

- Provide separate telephone information line at facility.
- Provide separate briefing areas near facility.
 - * After 12 hours if emergency involves multiple serious injuries and/or deaths.
 - * After 24 hours if emergency is unresolved.
 - * Activated by order of the Commander

Employees Only

- Provide counseling for employee family members after emergency.

DECEASED SERVICES

Employees and Inmates

- Inform family of death by Chaplain or designee (use State Police or Sheriffs Office for personal contact if telephone notification cannot be made within three hours of death for staff and within eight hours of death for inmates).
- Provide location of Funeral Home
- Give telephone number and name of contact person for more detailed information.
- Send telegram as backup, (See Vol. II, Sect. 7. B.).

Employees Only

- Provide notification of death through personal contact.
- Grant Chaplain service of their choice.
- Explain Employee Assistance Program resources.
- Provide child care services.
- Explain health insurance and death benefits.
- Assist in funeral planning services.
- Give federal death benefits information for law enforcement officials.
- Provide employee Liaison to answer questions and communicate family needs to DOC Personnel Section and the Commander.

EMERGENCY PREPAREDNESS PERSONAL INFORMATION

C O N F I D E N T I A L

The following **VOLUNTARY** information will be confidential and maintained in a secure location to be accessed only by the Commander/Director in an emergency situation. This information will be used to ensure proper medical treatment and actions used to respond to a lockdown, hostage, or serious emergency incident:

COMPLETION OF SECTION A IS REQUIRED

I choose not to complete sections B and C.

A. IDENTIFICATION INFORMATION	
<input type="checkbox"/> Employee <input type="checkbox"/> Contractor <input type="checkbox"/> Volunteer	Print Name: <hr/> Signature: <hr/> SS# <hr/> Date: _____ Functional Unit: _____ <hr/> Section: <hr/> Supervisor: <hr/>

B. MEDICAL INFORMATION	
Blood Type:	Physician(s)
Allergies:	Name: Address: Phone#:
Medical Conditions:	Name: Address: Phone#:

C. EMERGENCY NOTIFICATIONS			
Name:	Name:	Name:	Name:
Address:	Address:	Address:	Address:
Phone# Day: _____	Night: _____	Phone# Day: _____	Night: _____

TO BE COMPLETED AND KEPT CURRENT BY EVERY EMPLOYEE, CONTRACTOR, AND VOLUNTEER

STATE OF EMERGENCY

Declaration and Cancellation

STATE OF EMERGENCY
Declaration of a State of Emergency requires the signature of the Governor.
Cancellation of a State of Emergency requires the signature of the Governor.
DECLARATION OF A STATE OF EMERGENCY
The State of Oregon Emergency Management Division will work with the DOC Director to prepare the documentation and the written proclamation.
The proclamation will authorize specific use of other state agency resources.
A specific request for the activation of the Oregon National Guard will require the mutual agreement between the DOC Director and the Superintendent of the Oregon State Police.
The Commander will provide the Director with the necessary information for a Declaration of Emergency.
CANCELLATION OF A STATE OF EMERGENCY
The Commander will provide the Director with the necessary information for the Cancellation of Emergency.
The DOC Director and Superintendent for the Oregon State Police will reach mutual agreement that the emergency has subsided to a level no longer requiring the assistance from external state agencies and/or the Oregon National Guard.
The State of Oregon Emergency Management Division will assist in communications with the Governor's office to cancel the State of Emergency.

Attachment: State of Emergency (Example)

STATE OF EMERGENCY

(Example)

EXECUTIVE ORDER NO. EO - XX - XX

DETERMINATION OF A STATE OF EMERGENCY AT *(Name of Facility)* **IN** *(Name of County)* **COUNTY DUE TO** *(Type of Emergency)* **CAUSED BY** *(Reason for Emergency)*.

Pursuant to ORS 401.055, I find that a *(Type of Emergency)* **within the** *(Name of Facility)* **located in** *(County)* **has caused** *(Result of Emergency)*. **This has led to** *(Summary of Emergency conditions. i.e.. damage. number involved, injuries. dollar value. etc.)*.

The Director of the Department of Corrections and the Superintendent of the Oregon State Police have requested that a "State of Emergency" be declared on *(Month) (Date), (Year)*, and have requested assistance to resolve the *(Type of Emergency)*. I find that appropriate response is beyond the capability of the Department of Corrections, the Oregon State Police, and *(County)*.

The **Declaration of a State of Emergency** was made orally on *(Month) (Date), (Year)*, and is confirmed by this Executive Order.

IT IS ORDERED AND DIRECTED

1. The Oregon Emergency Management Division will coordinate all agencies of the State of Oregon to use appropriate state personnel and equipment and supplies to assess, alleviate, or mitigate damage caused by the emergency.
2. The Oregon State Police of the Oregon Department of Public Safety is directed to coordinate any such assistance and to seek available resources to regain control of the facility.
3. The Oregon National Guard is directed to provide all equipment and personnel necessary to regain control of the *(Name of Facility)* and continue with support services until security and operations of the facility have been adequately restored.
4. The Oregon Emergency Management Division is directed to assist with the assessment and mitigation of activities as required by conditions that have resulted from this *(Type of Emergency)*.

Done at Salem, Oregon, this *(Date)* day of *(Month)*, *(Year)*.

GOVERNOR

ATTEST:

SECRETARY OF STATE

EMERGENCY LOCATIONS

COMMAND CENTER

Primary - Superintendent's Office

Backup - OSP Residence #1

OPERATIONS CENTER

Primary - Control Center

Backup - Communications Center

RESOURCE CENTER

Primary - DOC Warehouse on OSP Grounds

Backup - None Required

MEDICAL TREATMENT

Employees

Primary - At location of injury or Clinic Dental Area	
Backup - Recreation Room (Program Unit)	
Inmates	
Primary - Clinic Exam Area	
Backup - GED Education Room (Program Unit)	
PUBLIC RELATIONS (INCLUDES ACCESS REQUIREMENTS)	
Media Center	
Primary - OSP Residence #5 - Parking - OSP Visitor parking lot	
Backup - None required	
Offsite Family Briefing Areas - (long duration)	
Employee - National Guard Headquarters on Airport Road	
Inmate - Armory on 17th Street. NE	
Onsite Family Briefing Areas - (OPTIONAL)	
Employee (hostage/injured only) - OSP Residence #2 - Parking - OSP Visitor parking lot	
Inmate (hostage/injured only) - OSP Curio Store - Parking - OSP Curio Store parking lot with overflow at Forestry	
STAGING AREAS	
TERT - OSP Conference Room	
Employees - OSP Warehouse (unless otherwise ordered)	
State Police - OWCC front parking lot (Backup - OSP Motor Pool)	
Ambulance - Area adjacent OWCC Vehicle Gate	
National Guard - National Guard Headquarters on Airport Road	
PARKING AREAS	
Employees - OSP Visitor parking lot (unless otherwise ordered)	
TERT - OSP Employee parking lot	
Other Support - Highway Building parking lot	

Inmates

PUBLIC RELATIONS (INCLUDES ACCESS REQUIREMENTS)

Media Center

Offsite Family Briefing Areas - (long duration)

Onsite Family Briefing Areas - (OPTIONAL)

STAGING AREAS

PARKING AREAS

RECORD OF CHANGES

MANUAL CHANGES

Operational and policy changes for manuals will be reduced in writing to ensure standardization, proper distribution, and adequate training.

Manual changes will be identified by the change number, change code, change type, change date, and change person.

Operational and policy changes affecting the Department will be approved and made by the Emergency Planning Committee.

Operational and policy changes affecting the facility will be approved and made by the Facility Emergency Coordinator and recorded on a Manual Change Log

The Manual Change Log will be maintained in each manual (**Record of Changes, Vol. II, Sect. 2**).

The Department Emergency Coordinator will ensure the Audit Checklist is routinely updated to reflect the operational and policy changes previously recorded on the Manual Change Log.

Any revised Audit Checklist will be distributed to the Facility Emergency Coordinators.

DISTRIBUTION OF MANUALS

MANUAL DISTRIBUTION

Distribution (Distribution of Manuals, Vol. II, Sect. 5) of the Emergency Preparedness Manuals shall be limited to those locations and primary users approved by the Functional Unit Manager. Manuals shall be available for emergency use in strategic and secure locations (**see Manual Locations**) with at least one manual in the Control Center inside the facility and at least one manual located outside the facility.

The Emergency Coordinator shall maintain a current list of manuals issued to a location and its primary user (**see Manual Locations**).

The Emergency Coordinator shall audit, every three months, with documented records the contents and physical presence of manuals.

MANUAL SECURITY

Manuals shall be maintained in a secure location not accessible to any inmate or outside intrusion.

All contents of the manual will be considered and treated as confidential.

No material in a manual will be removed, replaced, or copied without the approval of the Emergency Coordinator or Functional Unit Manager/Commander.

No inmates shall be allowed to view the manual contents.

Only the Functional Unit Manager/Commander or Emergency Coordinator may authorize manuals to be removed from the assigned secure locations.

Manuals shall be logged in and out of secure locations by using the Manual Checkout Log.

The employee signing out the manual shall be responsible for the manual's security and must immediately proceed to another secure location.

Manuals shall not be housed in any private residence.

All employees in a location issued manuals shall account for the manuals presence each work day. Loss of a volume or manual shall be immediately reported to the Facility Emergency Coordinator and the Security Manager with subsequent reporting to the Department Emergency Coordinator.

DISTRIBUTION OF MANUALS

MANUAL LOCATIONS		
SET	Secure Area	Primary User
1	OWCC Superintendent's Office	Command Center
2	Control Center, OWCC	Operations Officer
3	Control Center, OWCC	Facility Emergency Coordinator
4	Communications Center, OWCC	Staff Review
5	Communications Center, OSP	Backup Copy
6	DOC Central Office	Department Emergency Coordinator

MANUAL CHECKOUT LOG

MANUAL NO.	AUTHORIZING ADMINISTRATOR	EMPLOYEE	DATE	TIME OUT	TIME IN

CARE OF MANUALS

The Facility Emergency Coordinator through guidance of the Department Emergency Coordinator will maintain current and complete Emergency Preparedness Manuals.

The Facility Emergency Coordinator will maintain current and complete information that is specific to the facility for each listed section (**Care of Manuals, Vol. II, Sect. 4**).

Each section with specific facility information will be displayed in the style and format prescribed by the Department Emergency Coordinator.

VOL.	SECTION	SPECIAL INSTRUCTIONS
I	3. Command Notifications	Keep Current
I	4. Internal Notifications	Keep Current
I	5. External Notifications	Keep Current
I	6. Recall Notifications	Update Quarterly
I	11. Emergency Locations	Keen Current
I	12. Emergency Equipment	Keep Current
I	14. A. 14) Utility Failures	Current Utility Information
I	14. B. 3) Evacuation	Current Evacuation Information
II	2. Record of Changes	Update Manuals & <u>Log as Required</u>
II	3. Audit of Manuals	Current and Completed Checklist
II	5. Distribution of Manuals	Current Locations & Checkout Log
II	6. Risk Assessment	Annually Review for Update
II	7. Emergency Directives	Keep Current with Attachments
II	8. Departmental Phone Listings	Keep Current
II	9. External Agreements	Annually Review with Participants
II	10. Vehicle Inventory	Keep Current
II	11. Evacuation Diagrams	Keep Current
II	12. Medical Services Plan	Attachments Only
II	13. Food Services Plan	Attachments Only
II	14. Maintenance Services Plan	Attachments Only
II	15. Facility Maps	Keep Current
III	2. B. 11) Other	Special Post Orders Only
III	2. C. 3) Other	Special Post Orders Only
III	2. Other	Special Post Orders Only

Section 5

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USER FEEDBACK FORM

Please complete and mail this self-addressed, postage-paid form to assist the National Institute of Corrections in assessing the value and utility of its publications.

1. What is your general reaction to this document?

Excellent Good Average Poor Useless

2. To what extent do you see the document as being useful in terms of:

Very Useful Of Some Use Not Useful

Providing new or important information
Developing or implementing new programs
Modifying existing programs
Administering ongoing programs
Providing appropriate liaisons

3. Do you feel that more should be done in this subject area? If so, please specify what types of assistance are needed.

4. In what ways could the document be improved?

5. How did this document come to your attention?

6. How are you planning to use the information contained in the document?

7. Please check one item that best describes your affiliation with corrections or criminal justice. If a governmental program, please also indicate level of government.

Dept. of corrections or prison
 Jail
 Probation
 Parole
 Community corrections
 Court
 Juvenile justice

Police
 Legislative body
 Professional organization
 College/university
 Citizen group
 Other government agency
 Other (please specify) _____

Federal State County Local Regional

8. **OPTIONAL:**

Name _____ Agency _____

Address _____

Telephone No. () _____

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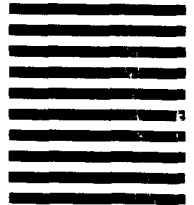
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