

**Independent
Review
Commission
on
Hillsborough
County
Jails**

**Final Report
September 10, 2008**

**Prepared by the
Independent
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Table of Contents

Topic	Page
Introduction	1
Commission Membership	1
Commission Charge	2
Commission Activities	2
Commission Acknowledgements	4
Commission Findings	5
Charge 1: Patterns, customs, and practices of conduct in the jail	6
Commentary	6
Recommendations	16
Charge 2: Policies and procedures that are or should be in place	19
Commentary	19
Recommendations	24
Charge 3: Management and supervisory oversight	25
Commentary	25
Recommendations	29
Charge 4: Training and employee development	30
Commentary	30
Recommendations	33

Appendix A

Independent Review Commission on Jails - Meeting Agendas

March 10
March 21
April 4
April 15
April 25
May 5
June 2
June 20
July 11
August 1
August 15
August 22

Appendix B

Preliminary Report of the Independent Review Commission on Jails

Appendix C

Tasks to be Completed Following the Preliminary Report

Appendix D

Grievance Work Group Report

Appendix E

Internal Affairs Work Group Report

Appendix F

Use of Force Work Group Report

Final Report

Report of the Independent Review Commission On Hillsborough County Jails

Introduction

On February 28, 2008, Hillsborough County Sheriff David Gee announced the creation of an Independent Review Commission to examine the policies, practices and procedures in the Orient Road and Falkenburg Road jails. The development of this Commission followed several publicized incidents in the jail, including one involving Brian Sterner, an inmate in a wheelchair. As the news release announcing this body indicated:

Recent reports about alleged abuse of inmates have cast a critical light on the Department of Detention Services. Sheriff Gee is keenly aware of the public reaction and questions about what occurred in the jail, and understands that public confidence in the county jail system is an essential element in protecting the citizens. Internal investigations into the allegations are currently under way; however Sheriff Gee believes an independent commission needs to further examine the inmate booking and incarceration procedures, and afford the public a legitimate, unbiased report on the jails.

As established by Sheriff Gee, the Commission includes a diverse group of professional and community leaders and lay citizens who have been given unrestricted access to facilities, staff, inmates and documents in carrying out its assessment of the Hillsborough County jails.

Commission Membership

The Commission is composed of eleven members:

- Dr. James D. Sewell, Assistant Commissioner (Retired), Florida Department of Law Enforcement, Chair
- Dr. Lorie Fridell, Associate Professor, University of South Florida, and Board Member, American Civil Liberties Union of Florida
- Ned Hafner, Director of Corrections (Retired), St. Johns County, FL, Sheriff's Office, and Director of Corrections and Jail Services, Florida Sheriffs Association
- Honorable Al Higginbotham, Hillsborough County Commissioner
- Brian Kensel, Special Agent (Retired), Federal Bureau of Investigation
- Reverend Beverly Lane, Pastor, Bethel African Methodist Episcopal Church
- Clarence McKee, Chief Executive Officer, McKee Communications
- Linda McKinnon, Chief Executive Officer, Central Florida Behavioral Health Network, and President, Florida National Alliance on Mental Illness

Report of the Independent Review Commission On Hillsborough County Jails

- Dr. Delia Aguirre Palermo, Professor, St. Petersburg College
- General Peter J. Schoomaker, U.S. Army (Retired)
- Chief Raymond E. Velboom, Dade City Police Department

Personnel from the Hillsborough County Sheriff's Office have provided staff support for the Commission throughout its tenure.

Commission Charge

As indicated, the Independent Review Commission on Jails was established by Sheriff David Gee to examine the inmate booking and incarceration policies, conditions, and procedures in Hillsborough County jails and to provide the citizens of Hillsborough County a legitimate, unbiased, and public report. Specifically, the Commission has been charged with examining:

- Patterns, customs, and practices of conduct and discipline in the jails;
- Policies and procedures that are or should be in place;
- Management and supervisory oversight;
- Training and employee development.

The Commission was further charged with conducting public workshops as necessary and with providing two reports: a preliminary report by May 9, 2008, and a final report by September 1, 2008. This Final Report is being submitted to Sheriff Gee on September 10, 2008.

Commission Activities

During the course of its work, the Commission held twelve public meetings, all of which provided time for public comment:

- On March 10, 2008, at Orient Road Jail
- On March 21, 2008, at Jefferson High School
- On April 4, 2008, at University Area Community Center
- On April 15, 2008, at Hillsborough County Sheriff's Office Training Division, Pinebrooke Building Auditorium
- On April 25, 2008, at Tampa Port Authority
- On May 5, 2008, at Tampa Port Authority
- On June 2, 2008, at the Falkenburg Jail and at the Hillsborough County Sheriff's Office Training Division, Pinebrooke Building Auditorium
- On June 20, 2008, at the Florida Department of Law Enforcement, Tampa Bay Regional Operations Center
- On July 11, 2008, at the 13th Judicial Circuit Main Courthouse, Judicial Conference Room

Report of the Independent Review Commission On Hillsborough County Jails

- On August 1, 2008, at the Hillsborough County Planning Commission Board Room
- On August 15, 2008, at the Hillsborough County Sheriff's Office Training Division, Pinebrooke Building Auditorium
- On August 22, 2008, in the Hillsborough County Center 26th Floor Conference Room

During the course of its 180 day work period, the Commission heard presentations and testimony from 30 individuals who were invited to speak, a number of whom, because of their responsibilities and expertise, appeared at several meetings. Among those invited were representatives from a number of groups, including the National Association for the Advancement of Colored People, American Civil Liberties Union, Equality Florida, Florida's Children First, Hillsborough County Criminal Defense Lawyers Association, and the Advocacy Center for Persons with Disabilities. Fourteen (14) other individuals offered comments during the Public Comments section of the meeting agendas.

Appendix A reflects the formal agenda and invited speakers for each of the Commission sessions. Additionally, as part of the Commission's efforts to ensure the transparency of its actions, transcriptions of each meeting and copies of all handout material provided to the Commission are available on the Hillsborough County Sheriff's Office website (www.hcso.tampa.fl.us). All Commission meetings have been videotaped, and copies of these are maintained by the Hillsborough County Sheriff's Office.

Individual members of the Commission have conducted on-site visits of booking, confinement, housing, and other functions at the Orient Road and Falkenburg Road Jails, and, for comparison purposes, at the Pinellas, Polk, Broward, and Citrus County jails. Commission members conducted numerous staff and inmate interviews during these on-site visits. Several members observed detention trainees participating in the Final Practical Exercises for new Detention personnel on March 26 and on June 8. Members of the Commission also attended several of the monthly inmate representative meetings and other sessions involving Detention personnel. Commission members had, and took advantage of, unhindered 24/7 access to jail facilities and employees.

As part of its formal information gathering process, Commission members conducted 12 focus group interviews with Detention personnel, broken into the following groups: captains and lieutenants (one session); sergeants and corporals (one session of day shift personnel; one of night shift); Detention deputies assigned to Central Booking (one session of day shift personnel; one of night shift); Detention deputies assigned to confinement units (one session of day shift personnel; one of night shift); Detention deputies assigned to housing units (one session of day shift personnel; one of night shift); Detention deputies assigned to transportation duties (one session); and medical personnel (two sessions). A total of 148 individuals participated in these focus group sessions.

Report of the Independent Review Commission On Hillsborough County Jails

Informally, members of the Commission have been approached by and received information from citizens, former inmates and their families, and current and former Detention staff about issues pertaining to the operation of the Hillsborough County Jail.

Working groups of Commission members conducted in-depth reviews of three critical areas: (1) use of force, (2) formal investigations of misconduct, and (3) inmate grievances. The results of these reviews are included as appendices to this report, and key findings and recommendations are contained in the body of this report.

Commission members have also reviewed a variety of documents pertaining to jail and prison practices, including numerous Hillsborough County Sheriff's Office policies and procedures and selected policies from Armor Health Services. Individually, members have interviewed a number of subject matter experts, including personnel from the National Institute of Corrections, the Jail Operations Section of the National Sheriffs Association, the Florida Justice Institute, and the Los Angeles County Jail, to add to their knowledge and understanding of jail operations.

Commission members were provided with the full investigative and disciplinary files for the incident involving Brian Sterner. Sergeant Danny Tewmey, the Sheriff's Office Internal Affairs supervisor, provided the Commission with a detailed case briefing on the incident at its August 15 meeting.

Finally, the Commission's Preliminary Report, submitted on May 9, laid the foundation for our direction and activities over the past four months. It provided a preliminary assessment within each of our areas of examination, identified specific action steps that should be taken during our comprehensive review, and made a number of initial recommendations. The Preliminary Report is included as Appendix B of this Final Report. One component of that Report was a list of tasks identified as necessary for the purposes of completing the Final Report; Appendix C reflects those tasks that were identified and completed.

Commission Acknowledgements

The Commission acknowledges and commends Sheriff David Gee for his decisive action in establishing this body. It is difficult to open up one's agency to an outside, independent group for the review of internal actions and procedures. His leadership in aggressively responding to the situation is outstanding, and his willingness to allow the Commission to operate freely and without constraint for these 180 days is commendable.

Second, the Command Staff and a number of other personnel of the Hillsborough County Sheriff's Office have provided the Commission with a significant amount

Report of the Independent Review Commission On Hillsborough County Jails

of testimony, written material, and personal assistance to facilitate our efforts to understand the operations of the Hillsborough County Jail system. The Commission appreciates their availability, openness, and willingness to work with us. The candor of all the detention personnel who were either individually interviewed or involved in the focus groups was refreshing, and we appreciate their professionalism, concern, and commitment to the Hillsborough County Sheriff's Office and the clientele it serves.

Third, the Commission wishes to recognize and commend the great degree of cooperation between the Sheriff's Office, Public Defender, State Attorney, and Chief Judge which is so essential to the smooth and professional functioning of the criminal justice system in Hillsborough County. As we learned, such cooperation is long-standing and on-going, and the Commission believes that it is a model for the components of the criminal justice system in each of Florida's counties.

Fourth, aside from those invited to appear or those who requested to present to the Commission, few citizens and little media regularly attended these publicly announced Commission meetings. The Commission would like to thank Suzanne Guillet, Shirley Johnson, and Al McCray for their interest and regular attendance at these sessions.

Finally, the Commission commends the performance of the Hillsborough County Sheriff's Office staff assigned to assist throughout our tenure: Corporal Theresa Sweat and Detective Clint Gomes. Their professional approach to this difficult assignment, their positive attitude, and their responsiveness to the many requests by Commission members were an outstanding reflection on the Sheriff's Office. Without their support and assistance, the Commission would not have been able to discharge its tasks completely or in a timely fashion. We sincerely appreciate their hard work and dedication.

Findings of the Independent Review Commission

Introduction

The members of the Commission—like the residents of Hillsborough County and the personnel of the Hillsborough County Sheriff's Office—were shocked and dismayed by the incident on January 29, 2008, that gave rise to this body. We were greatly disturbed by the actions of the deputy as well as by the inaction of supervisory and other Detention personnel at the scene. This incident resulted in the independent and thorough review by this Commission that is documented in this report.

This specific incident notwithstanding, the Commission has documented many more strengths than weaknesses in the Hillsborough County jails. This finding is confirmed by local groups who represent various "constituencies" of the jail and

Report of the Independent Review Commission On Hillsborough County Jails

by officials representing the other components of the criminal justice system in the jurisdiction. It is confirmed by a number of national experts who report to us that the Hillsborough County jails enjoy a stellar reputation nationwide. This reputation is further confirmed by the extent to which Colonel David Parrish is called upon to advise his peers nationwide and his longstanding leadership in national organizations.

We recognize that bad incidents occur in even the best-run institutions. The key is how an institution responds to such events. The response of the Hillsborough County Sheriff's Office has been very strong—conveying clearly and publicly its accountability to its constituency and its commitment to preventing future incidents. The Sheriff's Office thoroughly investigated the incident that occurred on January 29 and provided appropriate consequences to personnel who were involved. Following the incident, the Sheriff's Office immediately initiated changes in its policies, practices, and training that were directly linked to the deficiencies producing it. These include enhancements to supervisory practices in booking, expanded use of video review as an accountability/review mechanism, and more hands-on attention by upper level managers. The Sheriff's Office initiated work on a training program for staff on how to effectively deal with people with disabilities and enhanced their scenario-based training, focusing on what was expected of personnel in the detention setting. Finally, the Sheriff created this Commission to help the Sheriff's Office identify other areas of its important work that could be strengthened.

Charge 1: Patterns, customs, and practices of conduct in the jail

Commission Commentary

As we discuss the policies, procedures, and practices of the Hillsborough County Jail System, the Commission first recognizes that Hillsborough County jails have been voluntarily accredited by three professional bodies for a significant period of time: the Commission on Accreditation for Corrections (since 1989), the National Commission on Correctional Health Care (since 1983), and the Florida Corrections Accreditation Commission (since 1999). The requirements of these accreditations and their on-going compliance reviews indicate that the formal policies, procedures, and basic operations meet national and state standards, and the Hillsborough County Jail fully complies with Florida's Model Jail Standards. National accreditation has been achieved by only approximately 120 of the country's 3300 jails, and the staff of the Sheriff's Office is to be commended for its proactive efforts to attain and subsequently maintain these professional recognitions.

This Commission also finds that, complementing these professional standards, Colonel David Parrish is considered accessible to and responsive to the concerns of other major actors in the criminal justice system. Chief Judge Manuel Menendez, Jr., State Attorney Mark Ober, Public Defender Julianne Holt,

Report of the Independent Review Commission On Hillsborough County Jails

and Judge James Dominguez, Chairperson of the Public Safety Coordinating Council, emphasized this relationship during their appearance before the Commission on July 11, 2008. In a follow-up appearance, Public Defender Julianne Holt testified that, during her 16 years in this elected office and 11 previous years as a defense attorney, only an estimated 10 incidents of “jail abuse” have been reported to her. In each instance, she contacted Colonel Parrish, who, she reported to the Commission, acted upon the information immediately. Ms. Holt reports that many of her peers in other jurisdictions do not enjoy such cooperative relationships with detention leadership.

In any organization, it is the corporate culture—the patterns, customs, and practices of accepted conduct—that defines the parameters of accepted behavior. Especially in a law enforcement agency, it is imperative that such patterns of behavior, customs, and accepted practices meet the highest professional standards. The Commission’s review indicates that the written policies and stated practices of the Hillsborough County Sheriff’s Office set a high bar for professional conduct. In addition, in individual meetings and during a number of the Cell Representative meetings attended by Commission members, even inmates made favorable comments about the Detention personnel supervising them in facility housing.

Hiring Practices

It is significant that just one in 10 applicants for positions within the Hillsborough County Jail is hired. The minimum requirements, background assessment and psychological screening components appear to reflect industry standards and would seem to facilitate and ensure the hiring of quality personnel. During his testimony, Dr. Vincent Skotko recommended that the battery of pre-employment psychological tests be expanded to include the Wonderlic Personnel Test, a cognitive ability test with standardized norms for numerous occupations, including correctional and law enforcement officers.

Staffing

While inmate overcrowding is not an issue in the Hillsborough County jails, Detention personnel are concerned about understaffing. During several focus group sessions, a number of Detention personnel emphasized that the on-going staffing shortage negatively impacts their safety by reducing the number of deputies available to respond when a violent incident does occur. Because of the extended distances between some housing units, Falkenburg Road Jail personnel most commonly voiced this concern; however, Central Booking personnel also expressed their concern that, when the number of Booking staff fell below a certain level, it was difficult for them to effectively perform their functions. The Commission also acknowledges the further impact of stress on detention personnel who must work with such staffing shortages, particularly when excessive overtime results; such stress can lead to inappropriate behavior on the part of those personnel.

Report of the Independent Review Commission On Hillsborough County Jails

The Commission heard from Detention leadership about the difficulty of maintaining a full complement of Detention personnel. While the number of vacancies have remained around 88 for the last year, the addition of 36 personnel recently released from the Pinellas County Sheriff's Office during a budget cutback, will have a meaningful effect once they complete their initial and Field training programs. This will not, however, completely solve the problem of understaffing.

Because of these personnel vacancies, Detention management has established a minimum number of detention personnel necessary to staff each shift and authorized the use of overtime to meet these minimum staffing levels. Personnel are authorized to work up to 48 overtime hours a month (24 hours per pay period); until recently, that maximum level had been set at 72 hours per month. Line staff mentioned a number of issues pertaining to these overtime requirements/policies. Some deputies do not want to work overtime and yet are required to do so; others want to work more than the allotted 48 hours and believe they can do so without an adverse impact on their performance. Several deputies expressed concern that they have been called in to work required overtime on their days off and then sent home after only two hours; the disruption for two hours of pay, they report, is not worthwhile.

Inmate Services/Treatment

Direct Supervision appears to be a strong model for jail operations that promotes the dignity of the inmate while ensuring the safety of staff and inmates. According to the philosophy underlying the model, the inmate is *expected* to exhibit appropriate behavior and is treated based on that assumption until inappropriate behavior is exhibited.

The Sheriff's Office uses various media to inform inmates about the jails. A video describing the booking process plays non-stop in the intake area. Upon transition to housing, each inmate receives an Inmate Handbook that is available in English, Spanish and Braille. Topics include arraignment, canteen, contraband/searches, grievances, per diem fee, inmate disciplinary hearings, law library, mail, money, outside recreation, educational and vocational services, smoking, telephones, visitation, and frequently asked questions. Another video, shown to inmates that are new to housing areas, apparently reviews key information in the handbook; however, Commission members were not able to view this video.

Hillsborough County Jails offer a number of educational, vocational and self-improvement programs for inmates, including Adult Basic Education classes and General Education Diploma (GED) preparatory classes. Vocational training classes include computer skills, carpentry/building trades, hotel and tourism, culinary arts, sewing and alterations, and horticulture/nursery operation. Through the Horticulture Department, inmates make and bottle the Jail House Fire Hot Sauce. Life skills classes address a number of topics, including employment searches, anger management, decision-making, budgeting, food and nutrition,

and parenting. Domestic Violence and Substance Abuse programs and meetings are held on site for members of Alcoholics Anonymous and Narcotics Anonymous. "Seeking Safety" is a model program to help female inmates deal with some of their traumatic life experiences. While available spots within the programs do not match level of interest/need, the Commission notes that the level and quality of available programs (and spots) at the Hillsborough County Jails seem to significantly exceed national norms. The substance abuse course is reportedly one of the best in the country. In 2007, the Sheriff's Office received the American Correctional Association Program of the Year Award for their Discharge Planning Program. It should be noted, however, that, of the inmates interviewed, a number were unaware of the programs (e.g., drug treatment) available to them while in confinement or expressed their concern that they were not readily available for their attendance.

The Commission examined the disciplinary process for inmates. Attention was paid to the quality of the investigation and the due process associated with this function. The Commission learned about the nature of the punishments imposed on inmates who were adjudicated as guilty. The maximum punishment for a particular incident is 30 days in confinement, a loss of privileges, or both loss of privileges and confinement. In 2007, 5400 disciplinary hearings were held.

For a number of years, the jail system has been holding monthly Cell Representative Meetings in each jail facility (Falkenburg and Orient). At these meetings, one inmate represents each of the housing units (pods) and can report concerns/issues to jail staff. Certain staff members, representing the major areas about which there may be questions, are required to attend. Concerns raised by inmates at the forums that were observed pertained to many topics including canteen items, medical response, laundry services, food, program availability, temperature of the housing units, phone service, and visitation; the priority concerns seem to center around issues relating to medical treatment and to the quality of food services, as well as the consistent quantity of food provided. Inmates who were interviewed at these forums had mixed reviews of the process. While a number indicated that they volunteered for this assignment, others reported that a pod deputy may, instead, select the individual who will attend; such a staff-selected group may not provide the most representative input at these meetings.

Inmate Grievances

The Inmate Grievance process is a key method by which inmates can communicate concerns to jail staff. It is a critical accountability mechanism and management tool that can promote quality behavior in all detention operations; its counterpart is the citizen complaint system associated with the law enforcement (versus detention) side of the Sheriff's Office. A Work Group of the Commission conducted a review necessary of this system. Its full report is included as Appendix D; key observations and the recommendations resulting from their review are provided herein.

Report of the Independent Review Commission On Hillsborough County Jails

First, it is important to note that one expert with whom we conferred reported that many jails in this country have no inmate grievance process whatsoever. The Hillsborough County Sheriff's Office changed its methods for processing grievances on November 21, 2006. Pursuant to the new policy and consistent with the philosophy of direct supervision, pod deputies are directed to try to resolve issues raised by inmates immediately without filing any paperwork. If the deputy cannot resolve the inmate's concern, the inmate will next meet with a supervisor. If the issue is not resolved during that meeting, an Inmate Grievance Form (IGF) is completed. The inmate's grievance is investigated and a disposition produced and reported back to the inmate. The inmate can appeal.

Both Public Defender Julianne Holt and Colonel Parrish highlighted the importance of inmates understanding how the grievance process works. This topic in the Inmate Handbook, however, is addressed with just two sentences: "Inmates are afforded the opportunity to register complaints about the conditions of confinement, policy, or incidents. Grievance forms are available upon request from the pod deputy." This very brief description does not convey sufficient information or fully reflect the new procedures that were adopted by the Sheriff's Office in 2006. Both Holt and Parrish similarly highlighted the importance of the inmate Orientation Video for purposes of transmitting this information to illiterate inmates. As previously noted, Commission Members were not able to view the Orientation Video.

Staff who were interviewed or participated in focus groups, for the most part, reported that the grievance system is sufficiently "accessible" to inmates. Other staff members and some inmates, however, expressed concerns about the ability of inmates to utilize/access the grievance system. Some inmates were reticent to approach a pod deputy with their concerns, particularly if that deputy was the source/object of the concerns (e.g., the inmate's concern was with force used by that deputy). Some inmates expressed frustration that they did not understand what types of concerns were officially "grievable" and "not grievable."

Some interviewed inmates reported successful and fair processing of their concerns and, in this context, reported that certain staff members were particularly approachable and otherwise quite clearly dedicated to serving inmates in a respectful manner. Some supervisors, they noted, went "above and beyond" what was required to listen and respond to inmate concerns. Other pod deputies and supervisors were not similarly regarded.

Commission members reviewed all grievances filed in 2007 and requested and received disposition information for grievances filed in both 2006 and 2007. One phenomenon identified through these processes was that not one inmate followed up on his/her stated intention to appeal the disposition of the grievance. While we might expect a low level of inmate follow up, the 100% failure rate raises the question of whether the inmates understand what they must do—beyond checking the box on the form—to proceed. The grievance form indicates

Report of the Independent Review Commission On Hillsborough County Jails

that, “Appeals must be submitted within 15 days and must include a copy of this grievance.” It does not indicate how the appeal is initiated (using the Inmate Request Form).

In the context of discussing the relatively new procedures, Colonel Parrish told the Commission that he wants to “get it automated so I can track it like we do all the other things.” Subsequent interviews with command staff indicated that a new tracking system is, in fact, forthcoming. This will include computerized tracking of requests for and dispositions resulting from supervisor meetings with inmates.

Much of the information about strengths and weaknesses of the system came from interviews with inmates and staff. The committee members understand fully that some individuals in either of these groups might be motivated to put the system in the “best” or “worst” light. These interviews were important for highlighting aspects of the system that *one might expect* would need strengthening if it were implemented in any jail, if only because human beings are being asked to implement it. Because we have come to believe that most of the staff in the Hillsborough County Sheriff’s Office detention system are highly professional and well intentioned, we do not recommend a return to the earlier system nor a switch to some of the other systems we identified through our research on other jails. Instead, we have produced some recommendations to strengthen the current system.

Formal Investigations of Misconduct

During the course of its deliberations, the Commission, through another of its work groups, reviewed the formal investigation of misconduct function, which is in place to conduct administrative and criminal investigations into alleged misconduct on the part of Sheriff’s Office employees. The report of the Work Group on Formal Investigations of Misconduct is included as Appendix E.

Under current policies of the Hillsborough County Sheriff’s Office, formal investigations of misconduct are concluded in one of the following categories of findings:

- Sustained: finding or conclusion that an allegation is supported by a preponderance of evidence.
- Unfounded: A finding or conclusion that an allegation is demonstrably false.
- Unsubstantiated: A finding or conclusion that sufficient credible evidence was lacking to prove or disprove the allegation.
- Exonerated: A finding or conclusion that the incident occurred but the individual's actions were lawful and proper.
- Exonerated Due to Policy Failure: A finding or conclusion that a present policy, procedure, rule or regulation covering the situation was nonexistent or inadequate. In all cases involving a finding of

Report of the Independent Review Commission On Hillsborough County Jails

Exonerated Due to Policy Failure, the person making the finding must initiate a review of the policy in question and draft a recommendation to resolve the failure.

As part of its review, the Work Group examined all incidents requiring formal investigations of misconduct between January 2005 and December 2007. During 2005, 71 incidents required a formal investigation of misconduct. These incidents, which involved 90 detention personnel, included 148 different criminal or administrative charges (findings). As a result of these investigations, 114 charges were sustained and disciplinary or criminal action initiated; 14 were unfounded; and 20 were found to be unsubstantiated.

During 2006, 71 incidents required a formal investigation of misconduct. These incidents, which involved 82 detention personnel, included 161 different criminal or administrative charges. As a result of these investigations, 121 charges were sustained and disciplinary or criminal action initiated; 9 were unfounded; 23 were found to be unsubstantiated; and 8 were exonerated.

During 2007, 56 incidents required a formal investigation of misconduct. These incidents, which involved 62 detention deputies, included 150 different criminal or administrative charges. As a result of these investigations, 132 charges were sustained and disciplinary or criminal action initiated; 9 were unfounded; 7 were found to be unsubstantiated; 1 was exonerated; and 1 was exonerated due to policy failure.

As part of its analysis, the Work Group reviewed 25 randomly selected formal investigations of misconduct from this 3-year period and found them to be substantive and quality investigations. This review confirmed that allegations of excessive use of force were in fact being followed up as internal investigations.

During the course of its assessment, this Work Group identified a number of issues that were later reinforced by staff interviews:

- There is some confusion about what constitutes a Use of Force and what must be reported. The atmosphere within Detention following the Sterner incident has resulted in uncertainty and lack of consistency in definition and reporting across shifts and personnel. Even the Sterner case itself presented some confusion over “where to put it and whether to report it” within current parameters of incident reporting. Supervisors appear to be divided about what to report and what form to use, and this uncertainty for deputies may lead to over or underreporting.
- Formal investigations of misconduct rely on the use of Assailant Control Reports and Assailant Control Investigator Reports generated by deputies and supervisors at the jails. The Work Group identified several cases in which the use of force was not documented through the filing of an Assailant Control Report form, and no consistent

discipline was imposed on those who failed to submit these required reports. Holding detention personnel accountable for the completion and submission of these forms is critical to an effective program of behavioral control. Further training of supervisors on the Use of Force reports should improve their understanding of reporting requirements. Supervisor training should also improve the usefulness and value of investigations before they reach the level of a formal investigation of misconduct and should improve the consistency across shifts and personnel of Use of Force reporting.

- Taser use is limited and rare. However, some Detention personnel are requesting that these instruments be made more readily available to supervisors. If Tasers are made more accessible than is currently the case, their use, and the necessary investigative follow-up, may increase. The Sheriff's Office reports that its personnel review the data recorded by the Taser itself to assess proper use and to corroborate investigative reports. That this information was used as part of the investigation was not indicated in any of the reports reviewed by the Commission.
- One of most useful investigative tools is the review of images captured from multiple cameras at the jails. The camera system used in the jails, particularly at Orient Road Jail, has been updated since its installation. These cameras do not, however, capture sound as part of the monitoring capability. The existence of an audio record to enhance the existing video would protect both inmates and deputies and allow for a more complete understanding and review of any incident.
- Detention deputies are not regularly assigned to Internal Affairs as part of their professional development or to ensure this critical function is undertaken by personnel who fully understand the unique circumstances of detention operations. Similarly, Detention personnel should be encouraged to take advantage of existing Sheriff's Office career development policy which allows rotation into other elements of the agency.

Medical Issues

Medical services are contractually provided by Armor Health Services. Interviews with Detention and medical personnel indicated similar issues raised by the Department of Detention Services and its medical services provider:

- High turnover in clinical and administrative personnel
- Lack of on-going opportunities for professional development and training
- Lack of adequate medical supplies
- Lack of communication within and between the entities
- Need for management and supervisory development training
- Lack of flexibility in scheduling personnel
- Limited scheduling options which reduce available PRN and regular staff and result in increased need for agency personnel.

Report of the Independent Review Commission On Hillsborough County Jails

- High use of agency personnel to supplement Armor staff
- Inability of evening and night shift to access medical supplies
- The inability of PRN and agency medical staff to access computers impedes their ability to do the job
- Lack of documented oversight

Interviews with medical staff generally reflected a good working relationship and communication with Detention staff. Detention personnel and some medical staff raised concerns about patient care, citing instances when, particularly at the pod level, bandages had not been changed in a timely fashion or prescribed medications were not available. Personnel in Central Booking expressed concerns about the accurate and prompt assessment of inmates. Interviews suggested that supervisory medical personnel do not routinely review medical activities at the pod level. Additionally, limitations attributed to the Health Insurance Portability and Accountability Act (HIPAA) appear to act as a barrier to effective communication between Detention and medical personnel.

The Department of Detention Services provides one on-site fulltime equivalent (FTE) position devoted to contract management and oversight, including the review of a number of monthly and daily reports. This Contract Manager also completes an informal review of medical charts and medical operations on a daily basis and is responsible for identifying and addressing specific issues for resolution between Armor and the Sheriff's Office. In addition to this oversight, Medical Services are reviewed by the National Commission on Correctional Health Care (onsite every three years), Florida Model Jail Standards (annually), Commission on Accreditation for Corrections (every three years), and Florida Corrections Accreditation Commission (every three years). The contract does not identify specific requirements regarding incident reporting, although Armor Health Services completes incident reports within the Sheriff's Office system and through its own company reporting system. There appears to be no formal annual contract monitoring document or benchmarking of performance currently in place. Additionally, while the contract requires a written summary of deficiencies and performance, the contract manager does not currently document this.

Armor has a clear process for inmates to request medical services as well as for handling medical grievances. The latter process, which exceeds the requirements of the contract, requires that the Grievance Coordinator investigate the complaint, ensure actions are taken if the complaint is valid, and inform the inmate in writing of those actions. It further includes reviews up to the Health Services Administrator and Medical Director. Armor maintains individual data on requests for medical review and on medical grievances and addresses major issues through their Continuous Quality Improvement (CQI) process; trends on grievances are reported monthly to Department of Detention Services management.

Report of the Independent Review Commission On Hillsborough County Jails

This CQI program included monthly auditing activities and process studies. This program meets the requirements of the National Commission on Correctional Health Care (NCCHC) and is subject to annual review by that body. The contract also requires an annual per review, which is to be completed each year by outside consultants who review medical care, psychiatric care, and dental care in three separate reviews.

Mental Health Issues

The Hillsborough County Jail system has long recognized the impact of mental health issues on those who are incarcerated there. In 2001, for instance, following a year in which three suicides occurred (after a ten-year period with only one suicide), the Sheriff's Office brought in an expert to review its processes/facilities for dealing with suicidal inmates. The Hillsborough County Jail has subsequently adopted new practices of suicide prevention, including providing a suicide information/risk factors card to each member of the Department of Detention Services staff.

At its August 1 meeting, the Commission heard from Judge Steven Leifman, who currently serves as a Special Advisor on Criminal Justice and Mental Health to the Florida Supreme Court. As he noted, on any given day, there are approximately 15,000 people with mental illnesses in Florida's local jails, and our jails and prisons have become warehouses for inmates with mental illnesses. While the correctional and mental health communities in Hillsborough County have been recognized for their innovative ways of dealing with such populations, this continues to be a statewide issue affecting the entire criminal justice system. Legislation being introduced in the 2009 session of the Florida Legislature would promote the diversion of such persons to appropriate services prior to and instead of processing them through the criminal justice system.

Language Capabilities

The Commission heard testimony from Public Defender Julie Holt at its August 22 meeting about the significant increase in inmates for whom English is, at best, a second language; her information was reaffirmed by Colonel Parrish. By the nature of the Hillsborough County community, the majority of such individuals are Spanish-speakers. While the Hillsborough County Jails have made great strides in assuring that all publications, including inmate handbooks and legal forms, and signage are produced in English and Spanish, the administration must continue this effort and identify any areas where gaps exist. The Sheriff's Office is to be commended for providing a monetary incentive for its personnel to become fluent, and maintain their fluency, in Spanish; this effort, supplemented by the use of "street survival Spanish" courses for law enforcement and detention deputies, should also be continued. Similarly, programs offered through the Department of Detention Services, particularly General Education Diploma preparation, substance abuse, and anger management, should also be offered in Spanish as resources permit and are available. As the population and diversity

of Hillsborough County continue to grow, so should the Sheriff's Office program and information capabilities in other languages.

Other Detention Staff Issues

Detention staff was extremely forthcoming during their presentations before the Commission and during our focus group sessions, and their input is reflected throughout this Report. Several other issues were raised during the focus group sessions and are worthy of consideration by the administration of the Sheriff's Office.

First, Detention staff throughout the various ranks spoke with pride about their membership in the Hillsborough County Sheriff's Office and offered that they feel part of a family, especially within the Department of Detention Services. They did note, however, that they felt as "second class citizens" in the hierarchy of the organization and expressed concerns about their mobility within the agency, particularly their ability to move into law enforcement positions, and their opportunities for professional development. They acknowledged the significant gains in salary that have occurred under Sheriff Gee's administration, but recognize that true pay parity with law enforcement does not yet exist.

Second, all shifts expressed a desire to see and hear from ranking officers aside from those who directly supervise them. Personnel in the housing units, especially on night shift, would like to be visited for more than just a walkthrough by the Sheriff, Chief Deputy, Detention Services Colonel, and other agency command officers. As is done in many law enforcement departments, Detention personnel would like to have their own command occasionally work a full shift in Booking or in the housing units to retain their proficiency and awareness of current issues in detention.

Third, Detention personnel expressed a need for greater communication with and information from agency command staff. They were frustrated about the lack of communication about the issues, investigation, and discipline which arose as a direct result of the incident involving Brian Sterner.

Recommendations

The Commission recommends that:

- The Sheriff's Office should consider the inclusion of the Wonderlic Personnel Test among the battery of tests given to applicants being screened for hiring.
- The administration of the Department of Detention Services should ensure that inmates selected to attend Inmate Representative meetings do so voluntarily and are representative of their housing unit.

Report of the Independent Review Commission On Hillsborough County Jails

- The administration of the Department of Detention Services should ensure that inmates understand how to initiate a grievance and what to expect from the system once it has been filed. This should include accurate and expanded coverage in the Inmate Handbook that reflects the procedures adopted in 2006 and corresponding coverage in the “Orientation Video.”
- The administration of the Department of Detention Services should make it clear to both inmates and staff that a grievance can be filed on a shift other than the one during which the grievance occurred. This information should be included in the written and video material provided to inmates and, if necessary, Department policy.
- The administration of the Department of Detention Services should ensure that Detention staff members understand the importance of both the grievance system and their own role in it.
- The administration of the Department of Detention Services should incorporate into policy (e.g., DTN 914.06) a provision indicating that a jail staff member is subject to discipline if he or she intentionally or due to ignorance of policy thwarts an inmate’s efforts to use the grievance procedures for what appears to be a viable grievance.
- The administration of the Department of Detention should ensure through policy and/or training that supervisors who are charged with investigating/resolving grievances conduct sufficiently comprehensive reviews and document them in their reports.
- The Department of Detention Services should supplement procedures and forms, as necessary, to ensure that inmates who check “I would like to request an appeal,” are uniformly provided with information regarding the tasks they must complete.
- To ensure grievances are used as both a monitoring and a management tool, reports on the number, nature and disposition of grievances should be reviewed by supervisory staff up to and including, at regular intervals, Facility Commanders.
- Grievance disposition statistics should be compared on a regular basis across similarly situated supervisors who are conducting the investigations. A finding that a particular supervisor has disposition statistics that are very different from

Report of the Independent Review Commission On Hillsborough County Jails

his/her peers should result in a further review of his/her processes.

- The definition of Use of Force should be clarified and disseminated to ensure that all deputies understand what Use of Force is and what must be reported.
- Once this above noted consistency has been accomplished, the discipline for failing to document use of force through an Assailant Control Report should be clearly defined and consistently applied.
- Training of supervisory personnel in the documentation and investigation of use of force incidents, including the Early Warning System, should be continued and enhanced.
- The Sheriff's Office should ensure its Use of Force investigative reports reflect the review of any data recorded by the Taser data port.
- The Sheriff's Office should explore the addition of sound recording devices at designated areas of the jail, particularly in certain areas of Central Booking, to supplement the existing video recording equipment.
- The Sheriff's Office Legal Counsel should work with appropriate staff from Armor Health Services to explore better information sharing between Detention and medical personnel within the constraints of the Health Insurance Portability and Accountability Act.
- Department of Detention Services management should ensure that medical requirements not met through the various credentialing bodies are regularly reviewed and documented according to a clearly defined process understood by both the Sheriff's Office and Armor Health Services.
- Detention management should ensure that, per contract, an annual external peer review of medical services is conducted and that the results are made available to appropriate management within the Sheriff's Office.
- The Department of Detention Services Medical Services Contract Manager should ensure the creation of appropriate medical trend reports, including requests for interviews and on grievances, deficiencies, and performance, for review by Detention management.

Report of the Independent Review Commission On Hillsborough County Jails

- Sheriff Gee should assume a leadership position within the Florida Sheriff's Association in supporting the passage of the Supreme Court's mental health/criminal justice legislation.
- The Department of Detention Services should identify needs and gaps in the translation of all forms, publications, and signs into Spanish and make appropriate translations.
- The Sheriff's Office should institute an aggressive program of recruitment of interpreters in a variety of languages in addition to Spanish and assure their access by Detention personnel.

Charge 2: Policies and procedures that are or should be in place

Commission Commentary

Especially in a detention setting, it is critical that policies, procedures, and practices achieve their desired result. It is equally important that the reasons behind a particular practice not be misconstrued or, particularly during this time at the Hillsborough County Jail, generate an appearance of impropriety. Consequently, all policies and procedures must be scrutinized to assure compliance with these two goals.

A particular example of a practice that can be misunderstood is the use of well-being checklists in the booking area. Detention deputies tape these checklists to the glass walls of the Orient Road Jail holding cells to document the 15- and 30-minute checks of inmates. In one instance, the paper was placed in such a manner that the view of the inmate by the surveillance camera was impeded; we note, however, the view by detention personnel was not restricted. The inmate involved later claimed that he had been mistreated and that the paper was intentionally placed to prevent surveillance filming of the incident. It is the Commission's understanding that this practice has been eliminated; additionally, we understand that the Detention administration is reviewing other electronic or computerized means of documenting such checks.

Development and Dissemination of Policies

Participants in the focus groups recognize the importance of effective policies in the governance of the Hillsborough County Jail system. Many, however, felt the need for increased involvement of line Detention personnel in the development of these policies and procedures.

New or revised policies are frequently first disseminated as a Departmental order. Subsequently, such orders produce new or revised policies that are electronically provided to employees. Although an asterisk in the margin indicates provisions of policy that have been changed, staff in focus groups

report that it is sometimes difficult to discern what is “new” about a policy that is emailed to them.

The computer-based On-Service training is used to promote knowledge of policies and standard operating procedures by Detention personnel. Although the tests used in the program are not difficult, many of those participating in the focus groups found this to be an effective method of assuring that they have read the policies.

Use of Force

The Use of Force policy, including the response-to-resistance matrix, which is undergoing further refinement, reflects current professional standards. It is positive that, within the Department of Detention Services, use of force reports for all physical contact above escort are required to be reviewed up the chain of command through Colonel Parrish.

As part of its examination of use of force within the Jail, the Commission reviewed a frame-by-frame analysis of several use of force incidents that were brought to its attention by the media and the American Civil Liberties Union. In each case, we reviewed activity before and after the application of force upon an inmate. The Commission members—several of whom are practitioner and/or academic experts on the use of force—concluded that the Detention staff investigations and analyses were comprehensive and that, in light of the totality of each set of circumstances, their conclusions were reasonable.

The Commission Work Group on Use of Force examined use of force policy, procedures, documentation, and oversight in the Hillsborough County jail system. As part of this analysis, Work group members reviewed data on all force incidents that occurred between January 2005 and the end of May 2008, conducted interviews with inmates, conducted interviews and focus groups with staff, heard presentations from staff in public meetings, and reviewed documentation on selected use of force incidents. The Group also examined video recordings of ten use of force incidents for compliance with standard operating procedures. Only uses of force above Level 2 of the Use of Force matrix were examined during this review.

Our research uncovered no systemic problems regarding the use of force in Hillsborough County Jails. Statistically, an arrestee entering the jail system faces less than a one percent chance of being involved in a use of force incident at any time during his/her time in jail. In 99.8% of those incidents in which force is used, an investigation found it necessary and appropriate to the circumstances.

The detailed report from this Work Group is included as Appendix F. Among its key findings:

- Examination of various Sheriff's Office data systems for the 41-month period reflected 3078 uses of force during 1720 incidents; this reflects

Report of the Independent Review Commission On Hillsborough County Jails

an average of 42 incidents and 75 uses of force per month. As most incidents involve multiple deputies (on average, 1.8 deputies per incident), each of whom is required to independently report his/her use of force via the completion of an Assailant Control Report; the number of Use of Force Reports will always exceed the number of incidents.

- During this same period, 247,999 persons were booked into Hillsborough County Jails. Force at a Level 2 or above was used 3078 times, indicating 1.2% of the population was the subject of force *if each Use of Force Report was directed at a separate person*. However, as noted above, an average of 1.8 Use of Force Reports are submitted with each incident, thus the actual percentage of individuals booked who are the subject of a use of force incident is .7 of 1%.
- Since 2005, 28.6% of all incidents involving force, represented by 35% of all Use of Force Reports, took place in Central Booking at the Orient Road Jail. Another 2.6% of the incidents occurred in the booking area of the Juvenile Assessment Center, which performs the same duties for juveniles as Central Booking does for adult inmates.
- The greatest rate of Use of Force Reports occurs as part of the booking process, with 56% taking place during the night shift.
- A small group of inmates was involved in an inordinately high number of use of force incidents. A group of 230 inmates, less than one per cent of all persons booked, was responsible for 18.2% of the reported uses of force.
- The annual rate of bookings and Use of Force Reports was consistent throughout the period, showing a minor peak in 2006 with a slight downward trend since.
- The “average” deputy used force 3.28 times during the 41 months. A group of 20 deputies, representing 2.1% of all deputies in the study, were involved in 599 Use of Force Reports, or 19.5% of the total. All but two of these 20 deputies were assigned to Central Booking.
- HCSO defines 19 types of incident by which it classifies Use of Force Reports. The most common incident types are “Disruptive Inmate”, “Assaults on Staff”, and “Inmate Altercations”. During the 41-month period under study, a total of 1629 Use of Force Reports involving a disruptive inmate were filed, of which 1129 (67%) occurred in the Orient Road Jail. A total of 440 Use of Force Reports involving inmate altercations were filed, of which 271 (62%) occurred in the Falkenburg Road Jail. There were 377 reports documenting assaults on staff, of which 215 (57%) occurred in the Orient Road Jail.

Report of the Independent Review Commission On Hillsborough County Jails

- Documentation contained in the Use of Force Reports indicated that 40 inmates received injuries ranging from minor scrapes (31) to known visible injuries (8) to hospitalization (1). During the same time, detention personnel received injuries ranging from minor scrapes during altercations (30) to known visible injuries (7) to hospitalization (1).
- There were 238 incidents, involving 383 deputies, in which Oleoresin Capsicum (OC) foam was used. Most OC incidents (68%) occurred at Falkenburg Road Jail; 31% took place at Orient Road Jail; the remaining 1% occurred at the Juvenile Assessment Center, Work Release Center, or Transportation. OC use represents 14% of the total Use of Force incidents.
- A Taser was used six times during the study period: five times at Falkenburg Road Jail and once at Orient Road Jail.
- The Pro-Strait Chair was used 1195 times during the 41 months, with a peak of 400 in 2006 and a declining trend matching drops in booking and Use of Force rates in subsequent years. It is noted that use of the restraint chair is generally not reported on an Assailant Control Report, unless Level 3 or higher force was used getting the inmate into the chair. All chair use does, however, require submission of an Incident Report.
- There were no instances of Deadly Force (Level 6) used in HCSO detention facilities during this 41-month period of study, nor were less than lethal munitions used.
- Under current reporting policies, the use of force at Levels 1 (presence and dialogue) and 2 (escort, touch, restraint devices) on the Continuum of Force does not require an Assailant Control Report and is not considered Use of Force for the purposes of this report. For all Jail facilities, force characterized as Level 3 was used 881 times; force characterized as Level 4 force was used 1189 times, of which 78% were physical takedowns, and 20% involved the use of OC foam. Level 5 force was used 92 times, 86% of which were characterized as “defensive strikes.”
- Overall, there were 17 investigations into allegations of the use of unnecessary or excessive force against Detention personnel during the study period. Four of those allegations were sustained and disciplinary action taken; the others were unfounded.
- As noted in the earlier discussion concerning formal investigations of misconduct, the Work Group’s review of files and personnel interviews indicates that some confusion exists over what out-of-the-ordinary circumstances must be reported on an Assailant Control Report.

Report of the Independent Review Commission On Hillsborough County Jails

Some instances that fall outside of the standardized categories, including the Sterner incident, are not seen as Use of Force by some deputies, and thus are not recorded via an Assailant Control Report. Some deputies said their supervisors now require Assailant Control Reports for even escort force or handcuffing, because of what they described as an environment where “everyone is walking on egg shells.” Other supervisors apparently tell deputies to avoid using force at all, so the supervisor will not have to “waste time entering it in Blue Team.” Enhanced training should clarify the definition of force to ensure more consistent reporting and thus a more accurate record of jail activities. This would avert a sudden spike in Use of Force statistics that is likely to occur if current practices continue.

Further Analysis of Oleoresin Capsicum (OC) Incident Reports

Most of the incidents involving OC spray in 2007 were precipitated by inmate altercations. Deputies reported they ordered inmates to stop fighting and, when they did not, used OC spray against one or more of the involved inmates. This use of OC spray is consistent with the policy allowing for OC spray to defend against physical force/resistance (against a jail employee or against other inmates).

The Work Group found that, generally, the incident descriptions in these reports are satisfactory and that these reports present facts as well as conclusions. The investigators usually indicated the specific individuals whom they interviewed as part of the investigation. Generally, this included all involved inmates and deputies; sometimes there were specific notations indicating why a particular inmate was not interviewed or that the inmate was uncooperative. In one exception, a supervisor did not explain why he did not interview an inmate. Only a few of the investigators reported interviewing inmates who had witnessed the incident but were not involved in it, even though a number of the Use of Force incidents (e.g., precipitated by inmate altercations in housing) were likely in view of many. In one exception, the investigator reported that he interviewed “the inmates in the pod that witnessed the incident.”

In just one of the examined incidents did the investigator note reviewing the applicable video. Focus groups with supervisory personnel indicate they now routinely review video on Use of Force investigations. That review was confirmed by examining recent Assailant Control Investigator Reports.

Analysis of Taser Incident Reports

It is notable and important that the Taser incident reports included detailed narratives. Generally, these narratives provided detail on the circumstances that led to the request to use a Taser, the preparations for its use (e.g., bringing a video to the scene), the actual use and the follow-up (e.g., probe removal and nurse check on subject). The reports appeared to include all information required per policy.

Report of the Independent Review Commission On Hillsborough County Jails

In all but one incident, the jail staff reported a single 5-second activation of the Taser. The other incident involved one activation using the probes and two more with direct contact. The reports of five of the six incidents mentioned that a video was brought to the scene prior to weapon activation. Some reports mentioned that a nurse was called to the scene prior to weapon activation; all reported that a nurse was present at the scene after the activation to check on the subject. Deputies are trained to apply handcuffs during the activation phase to take greatest advantage of the inmate's temporary incapacitation.

In several incidents the narrative did not indicate why immediate action was necessary. There may have been reasons that were not documented. While the Sheriff Office leadership report that information from the Taser data port and stationary or handheld video are consistently reviewed as part of the investigation, this generally was not documented in the investigative reports.

Currently, Lieutenants are responsible for controlling access to and use of Tasers. Mid-level supervisors support continuing the current practice; Corporals and Sergeants urge increasing Taser availability by extending the authority and carriage of Tasers to their level.

Confinement

The Commission found that "confinement" (designating a more restrictive environment with reduced contact with staff and other inmates) is used for death row inmates, other "notorious or high profile" inmates, those in need of protective custody, those who are a danger to self or others, and those receiving discipline. The Commission reviewed closely (1) conditions of confinement; (2) the process and frequency of staff review of classification to this high-security unit; (3) the selection and training of personnel assigned to this unit; and (4) the rationale for (and national practice regarding) the "notorious or high profile" category. We found the policies and practices within the Hillsborough County Jail to be reasonable and in accord with nationally accepted policies and practices.

Confinement staff in focus groups suggested that inmates who are in disciplinary confinement should not receive all the same privileges, e.g., access to canteen, visitation, and daily showers, that other inmates in confinement receive. They report that there is no disincentive for being moved to Disciplinary Confinement and that some inmates prefer disciplinary confinement over general housing because they get "private cells" along with all the benefits they enjoy in general housing. This issue is worth further review by the administration of the Sheriff's Office and the Department of Detention Services.

Recommendations

The Commission recommends that:

- Data down to the individual deputy level should be added to the quarterly command staff reviews of the Use of Force, including multiple Uses of Force. This should permit a comprehensive

Report of the Independent Review Commission On Hillsborough County Jails

overview of the individuals using force, and would allow for the consideration of contributing (and mitigating) factors such as their location of assignment, shift, etc. that may not otherwise be apparent.

- Additional training should be provided on definitions of the “types of force used” in the Assailant Control Report template in order to increase accuracy of the information and reduce use of the category “other.”
- The Sheriff’s Office should examine the formation of dedicated Use of Force investigation team(s) to review all Use of Force incidents, rather than continuing the current system in which immediate supervisors conduct the review.
- The records of those inmates involved in multiple Use of Force incidents should be flagged so additional caution may be exercised during future bookings and to expedite assignment to appropriate housing during classification. Modifications to current classification procedures should allow at least corporals and sergeants to determine the appropriate type of housing for historically dangerous inmates.
- Consideration should be given to requiring law enforcement officers from all involved jurisdictions to contact Central Booking via a designated radio channel or by telephone when initiating transportation to Orient Road Jail to provide at least the name/date of birth of arrestee(s), and notification of any resistance, medical issues, etc. which would permit booking to appropriately prepare for the inmate’s arrival.
- Incident Reports and Assailant Control Reports in Taser incidents should include the reason that immediate use of the Taser was required. Investigative reports should document that data are downloaded from the Taser data port and that the investigator has reviewed the jail camera videos and/or shot with handheld camera brought to the scene.

Charge 3: Management and supervisory oversight

Commission Commentary

The Use of Force Work Group examined the oversight/review system in place to monitor Use of Force by Detention Deputies and found it to be adequate and effective. Several policies and procedures put into effect in the last seven months, including those noted below and the addition of new software intended to permit supervisors to more easily identify emerging trends in Use of Force, have strengthened that system.

Report of the Independent Review Commission On Hillsborough County Jails

Longstanding Department of Detention Services policy has required Central Command lieutenants to review videos of any reported incidents in Booking involving use of force, officer needs assistance, fights, reported accidents, disturbances, or unusual situations at the end of their shifts. It is commendable that the Sheriff's Office, as one component of their response to the Sterner incident, expanded this review on March 7, requiring lieutenants in Central Booking to spend one hour at the end of each shift reviewing random segments of the video for that shift. After each shift, lieutenants are now required to submit a report indicating that they have conducted this review and indicating what, if anything, was noteworthy. As of July 7, lieutenants at Orient Road Jail are required to conduct and document similar reviews of cameras within Housing units.

A member of the Commission reviewed all of the reports submitted since the policy was adopted and found them to be generally informative, including notes of any unusual occurrences as well as descriptions of the scenes on the videos. As time has progressed, however, some of the reports have become more brief, reflecting, in some instances, only that the lieutenant conducted the review; earlier reports not only reflected any incidents uncovered, but also identified the specific camera which had been viewed.

The Booking Video Review requirement now has been incorporated into the Department of Detention Services' Departmental Standard Operating Procedures Manual as has the requirement for supervisory random review of shift videos and the daily summarization of those observations. Daily summary information is submitted to a Detention Division Commander (Major). This Standard Operating Procedure could be enhanced by more clearly articulating the information to be captured in each shift report.

Also in immediate response to the Sterner incident, a new policy was adopted requiring the on-duty booking sergeant to conduct his/her work at a location nearer the first station at Booking. This increases the sergeant's ability to provide appropriate oversight of his/her staff. In focus groups, staff generally reported increased visits to their work locations of supervisors up through and including Captains. This increased presence enhances oversight capabilities and also, as the staff pointed out, gives supervisory/command staff a greater understanding of what is happening at the line level.

As previously noted in this Report, interviews indicate that there are inconsistencies between supervisory personnel in the application of policies and procedures and in the degree to which oversight is provided.

Promotion to Supervisory Positions

As mentioned above, lack of supervisory intervention and follow-up were key issues in the incident that led to this Commission. It is significant that line

personnel do not seek promotions in numbers that would allow for selectivity; such expanded selectivity could increase the quality of supervision in the jails. With many more applicants than spots, detention leadership could identify and promote the people who have the most potential for supervising in a manner that promotes/facilitates high quality, professional conduct. The lack of supervisor candidates has been due in part to unsatisfactory rewards for promotion, most significantly that new supervisors will have reduced seniority to bid on desirable schedules. This means that, more often than not, new supervisors must work the night shift for a considerable period before returning to the day shift, which is, for many, the more desirable shift. The new pay plan for detention sergeants, effective May 5, 2008, increases the pay differential between line deputies and sergeants and has the potential to reduce the problem of insufficient applicants for supervisory positions. This change, which is a very positive for advancement to higher position, may help in the long run to reduce the size and scope of this problem.

Additional actions are needed to increase the pool of applicants to supervisory positions. In this context, staff in focus groups suggested that “years in rank” should not be the only basis for one’s placement in the hierarchy used for assignment bidding. A system could be developed that further considers the number of years a person has been employed by the HCSO. The combined factors---years of service and years in rank---would determine hierarchy placement and might increase the likelihood that qualified, experienced jail staff would apply for a supervisory position.

In many law enforcement agencies across the nation, insufficient attention is given in the promotional process to a person’s ability to manage personnel to promote professional, in-policy behavior. This can lead to the promotion of individuals who have successfully memorized the standard operating procedures (SOPs), but who cannot manage and lead the personnel under their command. The current promotion test of the Sheriff’s Office emphasizes knowledge of policies and procedures. The Sheriff’s Office new Employee Performance Management System (EPMS), when fully implemented, should enhance the opportunity for managerial skills to be considered for purposes of promotion.

Miscellaneous Accountability Mechanisms

The new Employee Performance Management System has the potential to significantly promote personnel accountability and even the quality of supervision. The adoption of this system by the Sheriff’s Office is commendable and reflects significant foresight.

The fact that the Sheriff’s Office has had an Early Warning System (EWS) in place since 2002 is also of significance. Such systems have great potential to promote high quality work/behavior on the part of personnel. These systems maintain information on individual employees and generate “alerts” to initiate division commander review/intervention (three uses of force in a six-month period

Report of the Independent Review Commission On Hillsborough County Jails

generate an “alert” calling for supervisory review). Currently, data elements in the system used for both detention and law enforcement personnel are citizen complaints, administrative investigations, use of force and vehicle pursuits. At present, division commanders are expected to conduct the required review and note their action on the Detention department log; there is no immediate notification of or review of the commander’s actions by Professional Standards. Instead, Professional Standards personnel verify this accomplishment during their annual staff inspection. Supervisors are not currently trained in how to maximize the accountability/management potential of the early warning system.

We acknowledge that the Sheriff’s Office will continue to develop this system by incorporating other data elements. We strongly support the continued development of this important accountability/management system.

Blue Team, a web-based paperless reporting system utilized by detention and law enforcement supervisors, complements this Early Warning System. Staff interviewed indicated, however, that the system requires duplicative entry of information and does not fully integrate the Department’s reporting systems. When fully implemented in Detention, Professional Standards personnel will be able to electronically monitor compliance with Early Warning System supervisory reviews by Detention management.

During our review, the Commission noted several issues resulting from the system in place prior to the advent of Blue Team in February 2008. The Assailant Control Report template, for instance, did not include the name and/or personal identification (PID) of the supervisor of the deputy submitting the Report. Such information allows for monitoring of Use of Force activity under individual supervisors and offers early notice of an unusual pattern of Use of Force by deputies working for a particular supervisor. Additionally, data was not kept in a manner to permit easy identification of the number of incidents, regardless of the number of employees involved or Assailant Control Reports filed. Both of these deficiencies, identified originally as areas of needed improvement by the Use of Force Work Group, are corrected in the Blue Team data system.

Sheriff’s Office policy includes Sheriff’s Order 0705.17, which establishes Rule 6.1.06 (Failure to Act) and requires employees to report inappropriate behavior on the part of colleagues. One source indicated that recruits are trained to intervene with peers who are acting inappropriately. Significantly, a number of the charges against Detention personnel during the Sterner incident stemmed from violations of this particular Order.

Community Involvement in the Jail System

During the Commission’s tenure, several citizens have recommended a formal process of civilian oversight of Sheriff Office operations. While the efforts of this Commission have centered on an examination of issues pertaining to the Jail,

these citizens suggested civilian oversight over law enforcement operations as well.

The Commission recognizes that the Sheriff is accountable to the citizens of Hillsborough County through the electoral process and to the judicial system for misconduct, misfeasance, or malfeasance in public office. The Hillsborough County Sheriff's Office has in place adequate policies, procedures, and guidelines to define acceptable conduct by its personnel and to deal with citizen complaints, grievances, and use of force issues. Our review finds that the existing formal investigations of misconduct process for both administrative and criminal violations is professional, responsive, and effective, and we have seen no significant patterns of misconduct or abuse in our review of formal investigations of misconduct, use of force, or grievance reports.

The current administration of this agency is equally concerned with assuring the highest levels of professional conduct and has defined its expectations through myriad policies, procedures, and approved practices. When leaders and managers do their job, adequate internal oversight safeguards are in place to ensure the protection of the citizens of Hillsborough County and the safety of its law enforcement and detention personnel. This Commission, therefore, does not support the establishment of a standing civilian oversight body.

Recommendations

The Commission recommends that:

- The Sheriff's Office should consider, if feasible, incorporating information on grievances filed by inmates against particular Detention personnel in its Early Warning System. This inclusion would be consistent with the current inclusion of citizen complaints in the system.
- The Early Warning System should allow for more frequent tracking of whether division commanders do, in fact, conduct the required reviews following "flags/triggers" and monitor these tracking data.
- The Department of Detention Services should explore a system for developing the shift bidding hierarchy of supervisors that considers both years of service and years in rank.
- The newly adopted Employee Performance Management System (EPMS) should be used to consider more fully at promotion the managerial skills of applicants and otherwise attend more closely to managerial skills when screening applicants for supervisory positions.

- The periodic presence of command staff in all areas of the jail and at all hours of operation should be maintained and, if possible, increased to enhance oversight and ensure command staff knowledge of the day-to-day activities of the jail.

Charge 4: Training and employee development

Commission Commentary

The Commission reviewed the Sheriff's Office training activities through (1) presentations by training staff, (2) review of curriculum outlines, (3) demonstration of On-service training and review of On-service topics, (4) attendance at several training sessions, and (5) discussions during focus groups with staff regarding academy, on-service and in-service training.

Most of the employees participating in focus groups perceived that the training they received was appropriate and has become increasingly effective. Indeed, the Commission has documented a number of strengths associated with the training provided to Sheriff's Office employees:

- The number of hours provided to academy trainees exceeds the requirements of the Florida Criminal Justice Standards and Training Commission (CJSTC), and trainees receive an additional 200 hours of post-academy training prior to their assignment to a Field Training Officer.
- Hours provided to in-service employees exceed CJSTC requirements for mandatory retraining.
- In recent years, the Sheriff's Office has reduced in-service class sizes. Additionally, employees can volunteer to take advanced, outside training courses.
- To set direction for the agency, the Sheriff required in-service training for all captains, lieutenants, sergeants and corporals shortly after he took office.
- An emphasis in training is on the use of verbal skills to achieve inmate cooperation and to defuse potentially tense or even violent situations.
- The "On-service" (computerized) training is an innovative way to provide training in a time of reduced resources.
- Academy training and the five-week training provided to recruits before their assignment to the Field Training Program include practical training scenarios, in which the recruit trainee practices his/her skills and judgment in role-play exercises. The scenario content is developed as a result of actual incidents that have occurred in the jail.
- Outside expert training resources are utilized to supplement Sheriff's Office resources.

Report of the Independent Review Commission On Hillsborough County Jails

- The Field Training Officer (FTO) program, which is eight weeks in length, appears to be state of the art. Selection and training of FTOs appear to be strong. It is important that the jail has twice as many applicants for FTO positions as spots available; this allows for selectivity. While the periodic meeting of FTOs as a group to discuss training issues is commendable, these meetings may not occur frequently enough.
- Sheriff's Office support for employee education through tuition reimbursement is positive.
- The Sheriff's Office uses a variety of mechanisms, including courses presented by nationally recognized providers, to develop the skills and abilities of current and future leaders. Over a number of years, personnel have attended the FBI National Academy, the Senior Management Institute for Police (provided by the Police Executive Research Forum), the University of Louisville's Southern Police Institute, and all three levels of leadership courses presented by the Florida Criminal Justice Executive Institute.

In our preliminary report, the Commission recommended that, "where practical, in-service training be expanded to include the use of scenario based training." Training staff report that this has been implemented particularly in the training of new personnel; current academy classes have more scenario-based training. Several Commission members observed "practical training scenarios" as part of the post-academy training that we judged to be very realistic and effective learning experiences. Scenarios are also being incorporated into new supervisory training. As additional in-service training for detention deputies is developed and implemented, it, too, should focus on the use of realistic scenario-based training dealing with contemporary issues, such as use of force and cell entry and extraction techniques, experienced by Detention personnel.

During its research, the Commission learned that academy training on managing the stress associated with detention responsibilities is limited to discussions of stress in general and the need for exercise and other healthy habits. Again, the development of an "applied" stress management curriculum can better prepare new and experienced Detention personnel to deal with the psychological, physiological, and emotional rigors of their job.

As a direct result of concerns arising out of the Sterner incident, staff of the Sheriff's Office Training Division and Department of Detention Services have been working with personnel from the Florida Center for Inclusive Communities and the Advocacy Center for Persons with Disabilities since February 20, 2008, to develop training for detention staff on effectively interacting with persons with mental and physical disabilities. Using a needs assessment survey completed by 292 Detention deputies, the assigned staff have examined the techniques used by other agencies in providing similar training and explored the best avenues for delivery of training and informational materials within the Hillsborough County Sheriff's Office. As a result, the Sheriff's Office will be

Report of the Independent Review Commission On Hillsborough County Jails

implementing a three part training program in the immediate future: Phase 1 will provide 8 hours of “Disability Awareness” training and 2 hours of control tactics for dealing with the disabled during the academy for new personnel; Phase 2 will provide 8 hours of web-based “Disability Awareness” in-service training for existing personnel; and Phase 3 will provide 40 hours of Crisis Intervention Training (CIT) for designated Detention personnel. Additionally, future training efforts will increase the availability of in-house and contracted supervisory training; will introduce scenario based training for supervisors; and, in conjunction with the implementation of the Sheriff Office’s new Use of Force matrix for law enforcement and detention, will ensure specialized training for all supervisors on evaluation of the Use of Force.

Supervisor training is critically important to any law enforcement function. Nationally, this training has been deficient; too frequently, attention to liability issues and policy knowledge is at the expense of training on how to manage supervisees in order to ensure quality performance and effectively deal with personnel issues. According to testimony received by the Commission and reinforced during the focus group sessions, there appear to have been similar deficiencies in the training of Detention supervisors.

Even before the incident occurred that led to this Commission, the Sheriff’s Office had planned new training for supervisors that does, in fact, highlight quality management/oversight of employees. “Excelling as a First Line Supervisor” will be given to newly appointed supervisors beginning in Fall 2008. According to the provider, the Institute for Police Technology and Management, “This interactive course will teach [supervisors] the fundamentals of coaching and how to effectively coach employees to obtain maximum performance. [Supervisors] will also learn how to tactfully counsel poor performers and set clear expectations for improvement while maintaining their self-confidence.” This new training will cover “stress awareness” to help supervisors deal with their own stress; it does not, however, help supervisors detect and respond to the stress of those for whom they are responsible. Effective training of first-line supervisors should help them better recognize, respond to, and more effectively deal with personnel stress prior to severe incidents of misconduct.

Following the Sterner incident, the Sheriff’s Office provided supervisors with “review” training on how and when to document Use of Force and other incidents and new training will provide enhanced coverage of how to evaluate Use of Force incidents. As previously indicated, staff report inconsistencies in and confusion regarding the definition of and documentation for such incidents; additional training should be immediately forthcoming.

Upon promotion, supervisors are usually transitioning to both a new function and a new location in the Jail system. The use of a structured mentor or Field Training Officer program, such as that provided to new deputies, would be an important supplement to classroom training. Existing Standard Operating

Procedure 202.01, "Supervisor Field Training and Evaluation Program," establishes a field training program for new supervisors and should be fully and completely implemented within the Department of Detention Services. An additional "peer support" option could bring groups of same or similarly ranked supervisors together periodically (e.g., quarterly) to discuss issues, successes, and challenges.

Recommendations

The Commission recommends:

- Where practical, in-service training should be enhanced by the use of scenario based training, and an increased emphasis should be placed on detention specific in-service training.
- Training provided to detention deputies and medical personnel assigned to intake/booking should be enhanced to include required training unique to that environment; to provide a better ability to anticipate and resolve problems, particularly relating to substance abuse and mental health; and to include elements of stress and anger management and crisis intervention training. Personnel skilled in these unique areas of human behavior should provide such training.
- More formalized training should be provided to medical staff on the signs and symptoms of substance abuse and mental health, as well as on co-occurring disorders; on appropriate intervention strategies; on assessment techniques; and on enhanced clinical skills.
- Supervisors should receive increased training in the identification and management of stress among their employees.
- The Department of Detention Services should offer enhanced interpersonal skills training for detention deputies, including "street survival Spanish" and techniques for de-escalation and dealing with angry people
- The Hillsborough County Sheriff's Office should utilize the Field Training Officer concept in the development, training, and evaluation of new Detention supervisors.
- Detention personnel should be encouraged to seek rotational assignment to other areas of the agency as part of career development efforts.

Appendix A

Appendices

**INDEPENDENT REVIEW COMMISSION ON JAILS
ORIENT ROAD JAIL
1201 ORIENT ROAD, TAMPA, FL 33619**

MARCH 10, 2008 - 10:00 a.m. to 3:00 p.m.

AGENDA

Charge to the Commission **Sheriff David Gee**

Introduction to Hillsborough County Jail System **Colonel David Parrish**
➤ **Organizational Chart**
➤ **Policies and Procedures**

Jail Accreditation **Aimee Elliott, Accreditation Manager**

Medical Accreditation **Joan Carver, Accreditation Manager**

Training of Detention Personnel **Major James Previterra**

Tour of Orient Road Jail **Colonel David Parrish & Staff**

Development of Commission Work Plan **Dr. James Sewell**

Schedule of Commission Meetings **Dr. James Sewell**

Public Comments

Adjournment

**INDEPENDENT REVIEW COMMISSION ON JAILS
4401 CYPRESS STREET, TAMPA FL
(JEFFERSON HIGH SCHOOL AUDITORIUM)
MARCH 21, 2008 - 10:00 a.m. to 3:00 p.m.**

AGENDA

Beyond the Myths: the Jail in Your Community (U.S. Department of Justice National Institute of Corrections video)	Colonel David Parrish
Training	
<ul style="list-style-type: none">• Recruit/Cadet and In-service training<ul style="list-style-type: none">- Human Diversity- Interpersonal Communication• Supervisory management development	Major James Previtiera Colonel David Parrish/ Major James Previtiera Major James Previtiera
Use of Force - Detention	
<ul style="list-style-type: none">• Use of Force Continuum• Training • Documentation	Major James Previtiera Major James Previtiera/ Colonel David Parrish Colonel David Parrish
Handling of Complaints of Employee Misconduct and Inmate Grievances	
<ul style="list-style-type: none">• Early Warning System• Complaints of Employee Misconduct<ul style="list-style-type: none">- Procedure- Tracking and monitoring- Annual statistics (CY 2003 – CY 2007)• Grievances<ul style="list-style-type: none">- Procedure- Tracking and monitoring- Annual statistics (CY 2003 – CY 2007)<ul style="list-style-type: none">- Filed / Sustained	Sergeant Danny Tewmey Sergeant Danny Tewmey Colonel David Parrish
Assaults	
<ul style="list-style-type: none">• Number of Inmate on Inmate per year<ul style="list-style-type: none">- Assaults- Altercations (Fights)• Number of Inmate on Deputy per year	Colonel David Parrish Colonel David Parrish
Psychological Evaluations (time certain 2:00 PM)	Dr. Vincent Skotko
Commission Work Plan	Dr. James Sewell
Schedule of Commission Meetings	Dr. James Sewell
Public Comments	
Adjournment	

INDEPENDENT REVIEW COMMISSION ON JAILS

April 4, 2008 - 10:00 a.m. to 3:00 p.m.

University Area Community Center

14013 N. 22nd Street

Tampa, FL 33613

AGENDA

**Recruitment and Screening
of Detention (DTN) Deputy Applicants** **Lt. Alan Hill
Training Division**

Selection of Detention Deputy Candidates **Colonel David Parrish
Department of Detention Services**

Training (DTN)
• **Field Training Program** **Lt. James Downie
Field Training Program Coordinator**
• **Selection of Field Training Officers** **Lt. James Downie**

Stress Management
• **Training** **Lt. Alan Hill**
• **Employee Assistance Program** **Michele Hamilton**
• **Critical Incident Stress Management** **John Garbreana
HCSO Chaplain**
• **Peer Support Team** **John Garbreana**

Personnel Evaluations **Captain Clyde Eisenberg
Child Protective Investigations Division**

Promotion
• **Process** **Captain Clyde Eisenberg**
• **Candidate Selection** **Colonel David Parrish**

Fitness for Duty **Jim Livingston
Director, Support Services Division**
• **Psychological** **Colonel David Parrish**
• **Medical** **Rick Swann
Director, Risk Management Bureau**
• **Drug Screening** **Corporal Jeff Schiro
Professional Standards Section**

Commission Work Plan **Dr. James Sewell**

Public Comments

Adjournment

INDEPENDENT REVIEW COMMISSION ON JAILS

**April 15, 2008 - 6:00 p.m. to 9:00 p.m.
Hillsborough County Sheriff's Office
Training Division - Pinebrooke Building
1409 Falkenburg Road
Tampa, FL 33619**

AGENDA

Dealing with arrestees with physical disabilities

**Colonel David Parrish
Department of Detention Services**

- **Policies***
- **Procedures***
- **Practices***

**Dealing with arrestees under the influence
(of alcohol/illegal substance/medication)**

Colonel David Parrish

- **Policies***
- **Procedures***
- **Practices***

Dealing with arrestees with mental health issues

Colonel David Parrish

- **Policies***
- **Procedures***
- **Practices***

Commission Work Plan

Dr. James Sewell

Public Comments

Adjournment

***Policies, procedures and practices that were in effect on 01/29/08 and any revisions that have occurred since that date.**

INDEPENDENT REVIEW COMMISSION ON JAILS

April 25, 2008 - 10:00 a.m. to 3:00 p.m.

Tampa Port Authority Board Room

1101 Channelside Drive

Tampa, FL 33602

AGENDA

Administrative Confinement

**Colonel David Parrish
Department of Detention Services**

- **Disciplinary**
- **Administrative**
- **Psychological**
- **Protective Custody**

Commission Work - Drafting Preliminary Report

Dr. James Sewell

Commission Work Plan

Dr. James Sewell

Public Comments

Adjournment

INDEPENDENT REVIEW COMMISSION ON JAILS

May 5, 2008 - 10:00 a.m. to 1:00 p.m.

Tampa Port Authority Board Room

1101 Channelside Drive

Tampa, FL 33602

AGENDA

Commission Work - Drafting Preliminary Report

Dr. James Sewell

Commission Work Plan

Dr. James Sewell

Public Comments

Adjournment

INDEPENDENT REVIEW COMMISSION ON JAILS

June 2, 2008

**10:00 a.m. to 12:00 p.m.
Hillsborough County Sheriff's Office
Falkenburg Road Jail
520 Falkenburg Road
Tampa, FL 33619**

**12:00 p.m. to 3:00 p.m.
Training Division - Pinebrooke Building
1409 Falkenburg Road
Tampa, FL 33619**

AGENDA

Tour of Falkenburg Road Jail	Falkenburg Road Jail Staff Department of Detention Services
Inmate disciplinary due process	Sergeant Thomas Luckey Department of Detention Services
Administrative Confinement -Decision making process for assignments -Periodic review of circumstances	Lieutenant Steven Wallace Department of Detention Services
“On-service” training -How knowledge of agency policy is promoted -Course review	Lieutenant James Downie Department of Detention Services
Florida Center for Inclusive Communities (Advocacy Center for Persons with Disabilities) -Training development update	Major Jim Previterra Training Division
Stress Management training (detailed review) for: -All Detention personnel -Supervisory/managerial personnel - General stress management training - Training in recognition and response to job-related and personal stress	Major Jim Previterra Training Division
Commission Work Plan	Dr. James Sewell
Public Comments	
Adjournment	

INDEPENDENT REVIEW COMMISSION ON JAILS

June 20, 2008

10:00 a.m. to 3:00 p.m.

4211 N. Lois Avenue

Tampa FL 33614

AGENDA

Leadership and Management Training

**Colonel Carl W. Hawkins, Jr.
Department of Administrative Services**

“American Jail” video footage

Early Warning System

- **Statistics**
- **Responses**

**Sergeant Danny Tewmey
Professional Standards Section**

“American Jail” video footage

Inmate Programs

**Joel Pietsch
Senior Treatment Counselor**

“American Jail” video footage

Work Group Plans

Work Group members

Commission Work Plan

Dr. James Sewell

Public Comments

Adjournment

INDEPENDENT REVIEW COMMISSION ON JAILS

July 11, 2008

**10:00 a.m. to 3:00 p.m.
13th Judicial Circuit Main Courthouse
Judicial Conference Room – 6th Floor
800 E. Twiggs St.
Tampa FL 33602**

AGENDA

Hillsborough County Detention Facilities

- **Management**
- **Control**
- **Issues**

**Chief Judge Manuel Menendez, Jr.
Chief Judge - 13th Judicial Circuit
Judge James V. Dominguez
Judge - 13th Judicial Circuit
Chairperson – Public Safety
Coordinating Council
Mark A. Ober
State Attorney – 13th Judicial Circuit
Julianne M. Holt
Public Defender – 13th Judicial Circuit**

Juveniles in the Criminal Justice System

**Robin Rosenberg
Deputy Director, Children First
(Florida)
Marlene Sallo
Attorney Advocate, Florida Advocacy
Center for Persons with Disabilities**

Work Group Status Reports

Work Group members

Commission Work Plan

Dr. James Sewell

Public Comments

Adjournment

INDEPENDENT REVIEW COMMISSION ON JAILS

August 1, 2008

**10:00 a.m. to 3:00 p.m.
Hillsborough County Center
Planning Commission Board Room 18th Floor
601 E. Kennedy Boulevard
Tampa FL 33602**

AGENDA

Criminal Justice and Mental Health

**Judge Steve Leifman
Special Advisor
Criminal Justice and Mental Health
Supreme Court of Florida**

Equality Florida

**Brian Winfield
Communications Director**

American Civil Liberties Union (ACLU)

**Michael E. Pheneger
ACLU Chairperson –
Greater Tampa Chapter**

**Vacancies in Detention (Sworn Positions)
2005-2007**

**Colonel David Parrish
Department of Detention Services**

Work Group Plans

Work Group members

Commission Work Plan

Dr. James Sewell

Public Comments

Adjournment

INDEPENDENT REVIEW COMMISSION ON JAILS

August 15, 2008

10:00 am to 3:00 pm

**Hillsborough County Sheriff's Office
Training Division - Pinebrooke Building
1409 Falkenburg Road
Tampa, FL 33619**

AGENDA

**Administrative Investigations
Related to Brian Sterner**

**Sgt. Danny Tewmey
Professional Standards**

**Florida Center for Inclusive Communities
(Advocacy Center for Persons with Disabilities)**

**Major Jim Previtera
Training Division**

Review of Use of Force

**Major Jim Previtera
Training Division**

Work Group Reports

Work Group members

Commission Work Plan

Dr. James Sewell

Public Comments

Adjournment

INDEPENDENT REVIEW COMMISSION ON JAILS

August 22, 2008

**10:00 a.m. to 3:00 p.m.
Hillsborough County Center
26th Floor
Conference Room A
601 E. Kennedy Boulevard
Tampa FL 33602**

AGENDA

Presentation

**Julianne M. Holt
Public Defender – 13th Judicial Circuit**

**Local Corrections:
A Historical Perspective**

Commissioner Ned Hafner

Work Group Reports

Work Group members

Focus Group Reports

Focus Group members

Work on Final Report

Dr. James Sewell

Public Comments

Adjournment

Appendix B

**Preliminary
Report**

Preliminary Report of the Independent Review Commission on Jails

Introduction

On February 28, 2008, Hillsborough County Sheriff David Gee announced the creation of an Independent Review Commission to examine the policies, practices and procedures in the Orient Road and Falkenburg Road jails. The development of this Commission followed several publicized incidents in the jail, including one involving Brian Sterner, an inmate in a wheelchair. As the news release announcing this body indicated:

Recent reports about alleged abuse of inmates have cast a critical light on the Detention Department. Sheriff Gee is keenly aware of the public reaction and questions about what occurred in the jail, and understands that public confidence in the county jail system is an essential element in protecting the citizens. Internal investigations into the allegations are currently under way; however Sheriff Gee believes an independent commission needs to further examine the inmate booking and incarceration procedures, and afford the public a legitimate, unbiased report on the jails.

As established by Sheriff Gee, the Commission includes a diverse group of professional and community leaders and lay citizens who have been given unrestricted access to documents related to inmate booking and incarceration procedures. In carrying out its duties, this Commission has been given the freedom to interview Sheriff's Office personnel to gather additional information regarding these procedures and the policies and practices supporting them.

Commission Membership

The Commission is composed of eleven members:

- Dr. James D. Sewell, Assistant Commissioner (Retired), Florida Department of Law Enforcement, Chair
- Dr. Lorie Fridell, Associate Professor, University of South Florida
- Ned Hafner, Director of Corrections (Retired), St. Johns County, FL, Sheriff's Office, and Director of Corrections and Jail Services, Florida Sheriffs Association
- Honorable Al Higginbotham, Hillsborough County Commissioner
- Brian Kensel, Special Agent (Retired), Federal Bureau of Investigation
- Reverend Beverly Lane, Pastor, First Mount Carmel AME Church
- Clarence McKee, CEO, McKee Communications
- Linda McKinnon, Chief Executive Officer, Central Florida Behavioral Health Network
- Dr. Delia Aguirre Palermo, Professor, St. Petersburg College

- General Peter J. Schoomaker, U.S. Army (Retired)
- Chief Raymond E. Velboom, Dade City Police Department

Personnel from the Hillsborough County Sheriff's Office have provided staff support for the Commission throughout its tenure.

Commission Charge

As indicated, the Independent Review Commission on Jails was established by Sheriff David Gee to examine the inmate booking and incarceration procedures in Hillsborough County jails and to afford the public a legitimate, unbiased, and public report. Specifically, the Commission has been charged with examining:

- Patterns, customs, and practices of conduct and discipline in the jails;
- Policies and procedures that are or should be in place;
- Management and supervisory oversight;
- Training and employee development.

The Commission was further charged with conducting public workshops as necessary and with providing two reports: a preliminary report by May 9, 2008, and a final report by September 1, 2008.

Commission Meetings

During the course of its work in preparing this Preliminary Report, the Commission held six public meetings, all of which provided time for public comment:

- On March 10, 2008, at Orient Road Jail
- On March 21, 2008, at Jefferson High School
- On April 4, 2008, at University Area Community Center
- On April 15, 2008, at Hillsborough County Sheriff's Office Training Division, Pinebrooke Building Auditorium
- On April 25, 2008, at Tampa Port Authority
- On May 5, 2008, at Tampa Port Authority

The Commission heard presentations and testimony from 20 individuals who were invited to speak, a number of whom, because of their responsibilities and expertise, appeared at several meetings. Seven citizens offered comments during the Public Comments section of the meeting agendas. Appendix A reflects the formal agenda and invited speakers for each of the Commission sessions. Additionally, transcriptions of each meeting and copies of all handout material provided to the Commission are available on the Hillsborough County Sheriff's Office website (www.hcso.tampa.fl.us). All Commission meetings were also videotaped, and copies of these are maintained by the Hillsborough County Sheriff's Office.

Individual members of the Commission have also conducted on-site visits of booking and other functions at the Orient Road Jail and, for comparison purposes, of the Pinellas and Polk County Jails. Commissioner members conducted selected staff and inmate interviews during these on-site visits.

Additionally, several members observed detention trainees participating in the Final Practical Exercise for Class 198, conducted on March 24-26, 2006.

Commission members have reviewed numerous documents pertaining to jail and prison practices and individually have interviewed a number of subject matter experts, including personnel from the National Institute of Corrections, the National Sheriffs Association, and the Los Angeles County Jail, to add to their knowledge and understanding of jail operations.

Commission Observations

The Commission has several observations and acknowledgements related to the first segment of its work. First, the Commission acknowledges and commends Sheriff David Gee for his decisive action in establishing this body. It is difficult to open up one's agency to an outside, independent group for the review of internal actions and procedures. His leadership in aggressively responding to the situation is outstanding.

Second, the Command Staff and a number of other personnel of the Hillsborough County Sheriff's Office have provided the Commission with a significant amount of both testimony and written material to facilitate our efforts to become educated about the jail system. The Commission appreciates their availability, openness, and willingness to work with us.

Third, the Commission recognizes that the Hillsborough County jails are accredited by three bodies: the Commission on Accreditation for Corrections, the National Commission on Correctional Health Care, and the Florida Corrections Accreditation Commission. These accreditations and their on-going compliance reviews indicate that the formal policies, procedures, and basic operations meet national and state standards, and the Hillsborough County Jail fully complies with Florida Model Jail Standards. The staff of the Sheriff's Office is to be commended for its proactive efforts to attain and subsequently maintain these professional recognitions.

Fourth, the Commission has focused its attention during these first 60 days on gaining a better understanding of the organization, facilities, policies, procedures, and training at the jail, particularly those implemented after the incidents reported in mid-February. As a result, most of our meetings have consisted of presentations by staff from the Sheriff's Office. An adequate review of the actual implementation of and compliance with such policies, procedures, and training, however, will require interviews and discussion with jail personnel lower in the chain-of-command and other individuals as discussed later in this report.

Fifth, several of the reported incidents of alleged misconduct, including the incident involving Brian Sterner, are still undergoing Internal Affairs investigation or disciplinary review. As a result, this Commission has not yet delved into these allegations. However, upon the completion of these investigations and the subsequent disciplinary review and prior to completing its Final Report, the Commission fully intends to conduct a review of a number of critical issues, especially relating to management and supervisory oversight and training, identified during these incidents.

Sixth, a number of issues relating to the Hillsborough County Sheriff's Office and the Hillsborough County Jail have been raised by concerned citizens. While many of these will be addressed in the Preliminary and Final Reports of this Commission, others are beyond the scope of this Commission's work. These latter issues include:

- Contract awarding procedures in the jail
- The need for future jail expansion
- Services for persons outside the jail system

Such issues are worth examination by appropriate staff of the Hillsborough County Sheriff's Office to assure the most effective use of taxpayer dollars and the most appropriate and responsive treatment of individuals in custody.

Finally, it is significant that the survey of Sheriff's Office employees conducted in 2005 indicates high employee satisfaction with their jobs. Retention rates have improved significantly in recent years; this can have positive ramifications for budgets and the retention of qualified personnel.

Commission Preliminary Assessment

In this section of the report, the Commission provides a preliminary assessment for each of our four charges. Within each section, we reflect a preliminary review of the issue, outline the next steps for our inquiry, and set forth any preliminary recommendations.

Charge 1: Patterns, customs, and practices of conduct in the jail

Preliminary Review

General

In any organization, it is the corporate culture—the patterns, customs, and practices of accepted conduct—that defines the parameters of accepted behavior. Especially in a law enforcement agency, it is imperative that such patterns of behavior, customs, and accepted practices meet the highest professional standards. The Commission’s preliminary work indicates that the written policies and stated practices of the Hillsborough County Sheriff’s Office set a high bar for professional conduct. Further work by the Commission is necessary to assess the extent to which the behaviors of personnel at all levels are consistent with these written policies and practices.

Several organizations have approached this Commission with a request to provide additional information on the treatment of individuals in the jail system. During its initial efforts at developing a baseline of knowledge about jail operations and organization, the formal involvement of such groups has not yet been possible. During its next stage of work, in preparation for our Final Report, the Commission will formally solicit information from these groups.

Hiring Practices

It is significant that just one in 10 applicants for positions within the Hillsborough County Jail is hired. The minimum requirements, background assessment and psychological screening components appear to reflect industry standards and would seem to facilitate and ensure the hiring of quality personnel. During his testimony, Dr. Vincent Skotko recommended that the battery of pre-employment psychological tests be expanded to include the Wonderlic Personnel Test, a cognitive ability test with standardized norms for numerous occupations, including correctional and law enforcement officers.

Inmate Services/Treatment

Direct Supervision appears to be a strong model for inmate supervision that promotes the dignity of the inmate while ensuring the safety of staff and other inmates. According to the philosophy underlying the model, the inmate is *expected* to exhibit appropriate behavior and is treated based on that assumption until inappropriate behavior is exhibited.

Of the few inmates interviewed to date, a significant proportion was unaware of the programs (e.g., drug treatment) available to them while in confinement.

It is commendable that the jail holds Cell Representative Meetings once per month in each jail facility (Falkenburg and Orient). At these meetings, inmates can report concerns/issues to jail staff. Certain staff members are required to attend.

It is commendable that in 2001, following a year in which three suicides occurred (after a ten year period with only one suicide), the Sheriff's Office brought in an expert to review its processes/facilities for dealing with suicidal inmates. The Hillsborough County Jail has subsequently adopted new practices of suicide prevention, including providing a suicide information/risk factors card to each member of the Department of Detention Services staff.

Next Steps

In preparation for its Final Report, the Commission will:

- Invite the Circuit's Chief Judge, State Attorney, Public Defender, and Chair of the Public Safety Coordinating Council to address jail operations at a future Commission meeting
- Conduct appropriate interviews with and/or surveys of line staff of the jail
- Conduct a thorough review of grievances and completed Internal Affairs investigations to determine any patterns of inappropriate conduct on the part of personnel
- Develop and utilize appropriate mechanism(s) to receive information from inmates regarding their experiences and treatment
- Further explore the inclusion of the Wonderlic Personnel Test during the agency's psychological screening process
- Attend and observe Cell Representative Meetings
- Further review the programs available to inmates that might promote their positive transition back to society
- Identify and invite to speak at Commission meetings individuals (e.g., former inmates) or associations/groups in the community (e.g., ACLU, NAACP, Human Rights Commission, CAIR, defense attorneys) that have additional information to share regarding inmate treatment and jail policies and practices
- Assess the on-going communication between medical and detention staff.

Initial Recommendations

The Independent Review Commission has no recommendations regarding patterns, customs, and practices of conduct at the jail at this time.

Charge 2: Policies and procedures that are or should be in place

Preliminary Review

General

Especially in a detention setting, it is critical that policies, procedures, and practices achieve their desired result. It is equally important that the reasons behind a particular practice not be misconstrued or, particularly during this time at the Hillsborough County Jail, generate an appearance of impropriety. Consequently, all policies and procedures must be scrutinized to assure compliance with these two goals. A particular example of a practice which can be misunderstood is the use of well-being checklists in the booking area. Detention deputies tape these checklists to the glass walls of the Orient Road Jail holding cells to document the 15- and 30- minute checks of inmates. In one instance, the paper was placed in such a manner that the view of the inmate by the surveillance camera was impeded; the view by detention personnel, however, was not obstructed. The inmate involved later claimed that he had been mistreated and that the paper was intentionally placed to prevent surveillance filming of the incident.

Use of Force

The use of force policy, including the response-to-resistance matrix, reflects current professional standards. It is also positive that use of force reports are required for all physical contact above escort and are reviewed up the chain of command. Detention's current practice, implemented by an internal memorandum, is for these reports to be reviewed up the chain through Colonel David Parrish.

It is commendable that policy regarding the use of chemical spray designates its use only as a defensive weapon and not to coerce behavior.

Confinement

The Commission learned that "confinement" (designating a more restrictive environment with reduced contact with staff and other inmates) is used for death row inmates, other "notorious or high profile" inmates, those in need of protective custody, those who are a danger to self or others, and those receiving discipline.

Next Steps

In preparation for its Final Report, the Commission will:

- Complete a review of the policies and procedures of the jail
- Review specific post orders relating to booking and other key areas
- Interview and/or survey appropriate personnel as a means of assessing compliance with policies and procedures

- Review selected/“random” use-of-force reports to assess whether these reports are sufficiently descriptive, are given meaningful review through the appropriate/designated chain of command, and reflect policy
- Research industry standards regarding the administrative confinement of “notorious or high profile inmates” and regarding the care and treatment of inmates who are considered suicidal. This research will help guide the Commission’s assessment of these practices/policies at the Hillsborough County jails
- Conduct on-site visits to assess and observe the treatment of inmates in administrative confinement, protective custody, disciplinary detention and high security housing
- Review the decision-making process for assigning inmates to confinement and periodically reviewing such assignments
- Request a presentation from jail staff on the due process accorded inmates during the disciplinary process and review selected closed inmate-disciplinary-action files to assess due process, quality of review, and appropriateness of outcomes
- Observe disciplinary hearings
- Re-visit the Booking and Housing areas
- Conduct a tour of the Falkenburg Jail

Initial Recommendations

The Commission recommends that:

- Well-being checklists and any other items used in holding cells be placed in such a manner that their location does not block the view of the interior of the cell by either officers or cameras
- In its response-to-resistance matrix, the Sheriff’s Office reflect that the use of Tasers in the Jail are allowed at Level 4

Charge 3: Management and supervisory oversight

Preliminary Review

General

It must be observed that, even with the best prepared plans and policies and the most comprehensive training programs, effective management and supervisory oversight is necessary to ensure compliance and prevent misconduct. Jail administration had already required the Central Command Lieutenant to review videotapes of any incidents involving use of force, officer needs assistance, fights, reported accidents, disturbances, or unusual situations. Since the incident involving Mr. Sterner, the Hillsborough County Sheriff's Office has taken a number of steps to enhance such oversight at the Jail, particularly in the Booking area, including:

- Requiring that the on-duty booking sergeant conduct his/her work at a location nearer the first station at Booking.
- Requiring the Central Command Lieutenant to spend an hour each shift reviewing videos taken from different vantages within Booking.

Promotion to Supervisory Positions:

It is significant that line personnel do not seek promotions in numbers that would allow for selectivity; such expanded selectivity could promote the identification/promotion of people who could manage those they supervise in a manner that would promote/facilitate high quality, professional conduct. Preliminary information indicates that the lack of supervisor candidates is due in part to unsatisfactory rewards that do not offset the fact that new supervisors will have reduced seniority to bid on desirable schedules. The new pay plan for detention sergeants, effective May 5, 2008, increases the pay differential between line deputies and sergeants and has the potential to reduce the problem of insufficient applicants for supervisory positions.

Information received by the Commission to date indicates that a person's ability to manage personnel to promote professional, in-policy behavior is not given significant weight in the current promotion process. The Sheriff's Office's new Employee Performance Management System (EPMS), when fully implemented, should alleviate this problem.

Miscellaneous Accountability Mechanisms:

The new Employee Performance Management System has the potential to significantly promote personnel accountability and even the quality of supervision. The adoption of this system by the Sheriff's Office is commendable.

The fact that the Sheriff's Office has had in place an Early Warning System since 2002 is also of significance. Blue Team, a web-based paperless reporting system utilized by detention and law enforcement supervisors, complements this

system. Such systems have great potential to promote high quality work/behavior on the part of personnel. Because of the unique nature of jail work, this system should also reflect grievances filed against detention personnel.

The manner in which policies and operating procedures are disseminated to employees appears not to ensure knowledge of agency policy.

Importantly, Sheriff's Office policy includes Sheriff's Order 0705.17, which establishes Rule 6.1.06 (Failure to Act) and requires employees to report inappropriate behavior on the part of colleagues. One source indicated that recruits are trained to intervene with peers who are acting inappropriately.

Longstanding policy has required lieutenants to review the video from on-site cameras of incidents (e.g., use of force) at the end of their shifts. It is commendable that the Sheriff's Office has recently expanded this review, now requiring lieutenants to spend one hour at the end of each shift reviewing "random" segments of the video for that shift. Lieutenants are further required to submit a report each shift indicating that they have conducted this review and indicating what, if anything, was noteworthy.

A strong grievance receipt and review system is a critically important accountability mechanism that can promote quality behavior in all detention operations. In November, 2006, the Sheriff's Office Department of Detention Services changed the manner in which grievances are received and handled. Prior to this change, all grievances, regardless of topic, were recorded; under the new system, a supervisor has the discretion to intervene when a concern is initially expressed and attempt to achieve informal resolution; if the concern is not resolved during this process it becomes a formal grievance. The Sheriff's Office reported that this system facilitates the quality review of significant grievances that were, under the prior policy, at risk of being given insufficient attention due to the volume of grievances.

Next Steps

In preparation for its Final Report, the Commission will:

- Review Internal Affairs cases dealing with management and supervisory oversight issues in the Jail
- Review disciplinary processes and procedures
- Conduct interviews and/or surveys with supervisors and managers in the Jail
- Further explore the mechanisms that might ensure that employees who would be quality supervisors apply and are selected for promotions
- Explore how the promotion process might give more attention to the candidate's ability to promote high quality work on the part of his/her subordinates
- Conduct a "random" review of grievances/complaints to assess the quality of the investigation and the appropriateness of the disposition

- Review selected reports submitted by lieutenants regarding their “random” video review
- Consider and provide recommendations concerning a more effective mechanism for the dissemination of policies and procedures
- Assess the extent to which “on-service training” promotes knowledge of agency policy
- Give additional attention to the new grievances receipt system to assure that sufficient safeguards are in place to ensure appropriate use of supervisor discretion in their “informal” resolution
- Provide input to the Sheriff’s Office on how to maximize the potential of the Early Warning System.

Initial Recommendations

The Commission recommends that:

- The Early Warning System include grievances filed against individual detention personnel
- The Detention Department formalize its Department Order on Booking Video Review into its Policy and Procedure Manual

Charge 4: Training and employee development

Preliminary Review

There are a number of strengths associated with the training provided to Sheriff's Office employees. For instance:

- The number of hours provided to academy trainees exceeds the requirements of the Florida Criminal Justice Standards and Training Commission (CJSTC), and trainees receive an additional 200 hours of post-academy training prior to their assignment to a Field Training Officer
- Hours provided to in-service employees exceed CJSTC requirements for mandatory retraining
- In recent years, the Sheriff's Office has reduced in-service class sizes. Additionally, employees can volunteer to take advanced, outside training courses.
- To set direction for the agency, the Sheriff required in-service training for all sergeants and corporals shortly after he took office
- An emphasis in training is on the use of verbal skills to achieve inmate cooperation and to defuse potentially tense or even violent situations
- The "on-service" (computerized) training is an innovative way to provide training in a time of reduced resources
- Academy training and the five-week training provided to recruits before their assignment to the Field Training Program include practical training scenarios, in which the recruit trainee practices his/her skills and judgment in role-play exercises. The scenario content is developed as a result of actual incidents that have occurred in the jail
- Outside expert training resources are utilized to supplement Sheriff's Office resources
- The Field Training Officer (FTO) program, which is eight weeks in length, appears to be state of the art. Selection and training of FTOs appear to be strong. It is important that the jail has twice as many applicants for FTO positions than spots available; this allows for selectivity. While FTOs periodically meeting as a group to discuss training issues is commendable, these meetings may not occur frequently enough
- Sheriff's Office support for employee education through tuition reimbursement is positive.

According to testimony received by the Commission, staff of the Sheriff's Office Training Division met with personnel from the Florida Center for Inclusive Communities on February 20, 2008, to begin discussions about improved training for Sheriff's Office staff who deal with persons with disabilities. It is the understanding of the Commission that a needs assessment and focus groups are currently underway. The implementation of this training should be a priority of the Training Division and the staff of the Jail and the Commission is anticipating a review of its results.

According to testimony received by the Commission, there appear to be several deficiencies in the training of mid-level supervisors. They apparently receive little training in recognizing or addressing personnel issues. This is particularly critical in identifying warning signs of stress-related problems. Effective training of first-line supervisors on these topics allows the agency to better respond to and more effectively deal with personnel stress prior to severe incidents of misconduct. It should be noted that a supervisory class, "Excelling as a First Line Supervisor," will be given to newly appointed supervisors beginning in Fall 2008; its curriculum meets many of these identified needs.

Next Steps

In preparation for its Final Report, the Commission will:

- Examine more closely the in-service training provided to Jail personnel
- Review the curriculum and training developed in conjunction with the Florida Center for Inclusive Communities
- Interview and/or survey jail personnel regarding training needs
- Review the list of "on-service" training courses and conduct more in-depth review of selected courses
- Review in more depth the training provided to supervisors and research comparable training provided by other sheriffs' agencies and commercial providers. A key focus will be on training to manage personnel to promote professional, in-policy behavior
- Further review leadership development opportunities provided by the Sheriff's Office to in-service staff (e.g., courses available from national associations or commercial providers)
- Further review the stress management training provided to all jail employees and, in particular, the training provided to managerial and supervisory personnel on the recognition of and response to job-related and personal stress
- Further review training issues which may come to light following the conclusion of pending internal affairs investigations.

Initial Recommendations

The Commission recommends:

- Where practical, in-service training be expanded to include the use of scenario based training
- Training provided to detention deputies assigned to intake/booking be enhanced to include required training unique to that environment, to provide a better ability to anticipate and resolve problems, particularly relating to substance abuse and mental health, and to include elements of stress and anger management and crisis intervention training. Such training should be provided by personnel skilled in these unique areas of human behavior
- Ensure that more formalized training is provided to medical staff on substance abuse and mental health issues, as well as training on co-occurring disorders.

Appendix C

Tasks to be Completed Following the Preliminary Report

Tasks to be Completed Following the Preliminary Report

Charge 1: Patterns, customs, and practices of conduct in the jail

Follow-up on Action Steps Identified in the Preliminary Review

In its Preliminary Report, the Commission identified a number of action steps necessary in preparing for its Final Report. The following reflect the Commission's efforts since its May 9 Report:

- Invite the Circuit's Chief Judge, State Attorney, Public Defender, and Chair of the Public Safety Coordinating Council to address jail operations at a future Commission meeting
 - Chief Judge Manuel Menendez, Jr., State Attorney Mark Ober, Public Defender Julianne Holt, and Judge James Dominguez, Chairperson of the Public Safety Coordinating Council, appeared before the Commission on July 11, 2008.
- Conduct appropriate interviews with and/or surveys of line staff of the jail
 - Members of the Commission conducted 12 focus group interviews with Detention Department staff.
- Conduct a thorough review of grievances and completed Internal Affairs investigations to determine any patterns of inappropriate conduct on the part of personnel
 - A working group of the Commission reviewed a random sample of the grievances filed by inmates from 2005-2007 and completed Internal Affairs investigations.
- Develop and utilize appropriate mechanism(s) to receive information from inmates regarding their experiences and treatment
 - Commission members received information during the Cell Representative meetings, during contact with individual inmates, and from former inmates and their families.
- Further explore the inclusion of the Wonderlic Personnel Test during the agency's psychological screening process
 - The Commission will provide recommendations later in this Final Report.
- Attend and observe Cell Representative Meetings
 - Members of the Commission have attended and observed several Cell Representative meetings.
- Further review the programs available to inmates that might promote their positive transition back to society
 - At its session on June 2, 2008, the Commission reviewed many of these programs available for inmates.
- Identify and invite to speak at Commission meetings individuals (e.g., former inmates) or associations/groups in the community

(e.g., ACLU, NAACP, Human Rights Commission, CAIR, defense attorneys) that have additional information to share regarding inmate treatment and jail policies and practices

- The Commission invited representatives from a number of groups, including the National Association for the Advancement of Colored People, American Civil Liberties Union, Equality Florida, Florida's Children First, Advocacy Center for Persons with Disabilities, and the Hillsborough County Criminal Defense Lawyers Association.
- Assess the on-going communication between medical and detention staff.
 - As part of its focus groups conducted, the Commission assessed the communication between medical and detention staff.

Charge 2: Policies and procedures that are or should be in place

Follow-up on Action Steps Identified in the Preliminary Review

In its Preliminary Report, the Commission identified a number of action steps necessary in preparing for its Final Report. The following reflect the Commission's efforts since its May 9 Report:

- Complete a review of the policies and procedures of the jail
 - The Commission has reviewed the policies and procedures of the Jail.
- Review specific post orders relating to booking and other key areas
 - The Commission has reviewed a number of specific post orders.
- Interview and/or survey appropriate personnel as a means of assessing compliance with policies and procedures
 - The Commission interviewed Detention personnel concerning policy compliance as part of its focus group sessions.
- Review selected/"random" use-of-force reports to assess whether these reports are sufficiently descriptive, are given meaningful review through the appropriate/designated chain of command, and reflect policy
 - A work group of the Commission conducted a random review of Use of Force reports.
- Research industry standards regarding the administrative confinement of "notorious or high profile inmates" and regarding the care and treatment of inmates who are considered suicidal. This research will help guide the Commission's assessment of these practices/policies at the Hillsborough County jails

- The Commission will provide recommendations later in this Final Report.
- Conduct on-site visits to assess and observe the treatment of inmates in administrative confinement, protective custody, disciplinary detention and high security housing
 - The Commission has conducted a number of on-site visits to observe inmates in confinement, detention, and high security.
- Review the decision-making process for assigning inmates to confinement and periodically reviewing such assignments
 - The decision-making process for assignment to administrative confinement was reviewed with the Commission at its meeting on June 2, 2008.
- Request a presentation from jail staff on the due process accorded inmates during the disciplinary process and review selected closed inmate-disciplinary-action files to assess due process, quality of review, and appropriateness of outcomes
 - Jail staff provided a presentation on due process during the disciplinary process on June 2, 2008.
- Observe disciplinary hearings
 - Due to legal considerations, the Commission was unable to observe any disciplinary hearings.
- Re-visit the Booking and Housing areas
 - Individual members of the Commission have re-visited both the Booking and Housing areas.
- Conduct a tour of the Falkenburg Jail.
 - The Commission toured the Falkenburg Jail on June 2, 2008.

Charge 3: Management and supervisory oversight

Follow-up on Action Steps Identified in the Preliminary Review

In its Preliminary Report, the Commission identified a number of action steps to take in preparing for its Final Report. The following reflect the Commission's efforts since its May 9 Report:

- Review Internal Affairs cases dealing with management and supervisory oversight issues in the Jail
 - A work group of the Commission conducted a random review of Internal Affairs cases within the jail.
- Review disciplinary processes and procedures
 - Disciplinary processes were discussed during several Commission meetings, including during the presentation of the Internal Affairs investigation resulting from the Brian Sterner Case.

- Conduct interviews and/or surveys with supervisors and managers in the Jail
 - Supervisors and managers in the Jail were interviewed as part of the focus group interview process.
- Further explore the mechanisms that might ensure that employees who would be quality supervisors apply and are selected for promotions
 - The Commission will provide recommendations later in this Final Report.
- Explore how the promotion process might give more attention to the candidate's ability to promote high quality work on the part of his/her subordinates
 - The Commission will provide recommendations later in this Final Report.
- Conduct a "random" review of grievances/complaints to assess the quality of the investigation and the appropriateness of the disposition
 - A work group of the Commission conducted a random review of inmate grievances and complaints.
- Review selected reports submitted by lieutenants regarding their "random" video review
 - Commission members have reviewed the reports submitted by Booking lieutenants as part of the Jail's random review process.
- Consider and provide recommendations concerning a more effective mechanism for the dissemination of policies and procedures
 - Commission input is provided later in this Final Report.
- Assess the extent to which "on-service training" promotes knowledge of agency policy
 - Commission members discussed "on-service training" with Detention personnel during the focus group process.
- Give additional attention to the new grievances receipt system to assure that sufficient safeguards are in place to ensure appropriate use of supervisor discretion in their "informal" resolution
 - Commission members received input concerning the grievance system during their focus group sessions.
- Provide input to the Sheriff's Office on how to maximize the potential of the Early Warning System
 - Commission input is provided later in this Final Report.

Charge 4: Training and employee development

Follow-up on Action Steps Identified in the Preliminary Review

In its Preliminary Report, the Commission identified a number of action steps to take in preparing for its Final Report. The following reflect the Commission's efforts since its May 9 Report:

- Examine more closely the in-service training provided to Jail personnel
 - The Commission has received a number of briefings on the in-service training provided to Detention personnel and has discussed such training during the focus group interviews.
- Review the curriculum and training developed in conjunction with the Florida Center for Inclusive Communities
 - The Commission was updated on the progress of this training at its June 2, 2008 and August 15, 2008 meetings.
- Interview and/or survey jail personnel regarding training needs
 - Commission members explored training needs of Detention personnel during the focus group sessions.
- Review the list of "on-service" training courses and conduct more in-depth review of selected courses
 - Commission members were provided further review of the "on-service" courses at their meeting on June 2, 2008 and discussed their effectiveness during the focus group sessions.
- Review in more depth the training provided to supervisors and research comparable training provided by other sheriffs' agencies and commercial providers. A key focus will be on training to manage personnel to promote professional, in-policy behavior
 - The Commission has been provided additional material concerning training for supervisors.
- Further review leadership development opportunities provided by the Sheriff's Office to in-service staff (e.g., courses available from national associations or commercial providers)
 - The Commission heard testimony on leadership development opportunities and efforts at its June 20, 2008 meeting.
- Further review the stress management training provided to all jail employees and, in particular, the training provided to managerial and supervisory personnel on the recognition of and response to job-related and personal stress
 - The Commission heard further testimony about stress management training at its June 2, 2008 meeting.

- Further review training issues which may come to light following the conclusion of pending internal affairs investigations.
 - Further recommendations concerning training will be provided in this Final Report.

Appendix D

Grievance Work Group Report

Independent Review Commission On Jails

Grievance Work Group Report

The Inmate Grievance process is a key method by which inmates can communicate concerns to jail staff. It is a critical accountability mechanism and management tool; its counterpart is the citizen complaint system associated with the law enforcement (versus detention) side of the Sheriffs Office. Commission members Lorie Fridell (Chair), Linda McKinnon, and Reverend Beverly Lane comprised the work group to assess this system. The key objectives of the work group were to assess the accessibility and integrity of the grievance process and make any necessary recommendations to ensure/promote same. We assessed the system as pertains to both non-medical and medical grievances. We expanded our attention to medical issues by reviewing, not just the grievance process, but also the contract with Armor Correctional Health Services.

The work group members completed a number of tasks as part of their investigation. For purposes of assessing the process for handling non-medical grievances, we:

- 1) Reviewed DTN 914.06, which is the HCSO policy on inmate grievances.
- 2) Reviewed other documents and statistics provided by the HCSO in a bound document disseminated at the 3/21 meeting of the Commission entitled, "Procedures and Statistics for: Use of Force, Grievances, Assaults and Altercations" (see 18 – 29).
- 3) Obtained copies of policies regarding grievances from other jails in the region (e.g., those in Jacksonville, Polk, Pasco).
- 4) Reviewed coverage of grievances in the Inmate Handbook and attempted, without success, to view the Orientation Video that supposedly covers the same content.
- 5) Received information/commentary from speakers at Commission meetings. See for instance Commission meeting transcript for 3/21, pp. 95 through 101; and transcript for 7/11, p. 45).
- 6) Communicated by phone and email with Lt. Phillips of HCSO to understand fully how the process is designed to work. Interviewed Captain Herman to determine how concerns were conveyed by inmates in booking.
- 7) Conducted interviews with inmates in the housing pods—asking about their knowledge of and faith in the system, if they have used it, and their experience with it.
- 8) Conducted interviews with staff regarding the strengths and weaknesses of the current procedures. Included questions related to grievances in the protocols used with the focus groups held with HCSO staff.

- 9) Reviewed all grievances filed/resolved during 2007 to assess comprehensiveness of staff review and fairness/soundness of disposition.
- 10) Received and reviewed statistics on inmate grievances filed during the period 2003 through 2007, including a breakdown by type of grievance.
- 11) Requested and reviewed dispositions of grievances for 2006 and 2007.
- 12) Reviewed relevant accreditation standards.
- 13) Interviewed several national experts including Susan W. McCampbell, President of the Center for Innovative Public Policies and Randy Berg at the Florida Justice Institute.

To assess the process for handling medical grievances and the contract to provide medical services, we:

- 1) Reviewed the medical services contract and relevant HCSO policies.
- 2) Interviewed the Medical Services Contract Manager, Contract Administrator, and Medical Grievance Coordinator.
- 3) Reviewed the period statistics produced by the contractor for the Contract Manager.
- 4) Conferred with national experts on jails.
- 5) Interviewed inmates in medical and non-medical housing pods.
- 6) Conducted two focus groups with medical staff.
- 7) Reviewed relevant accreditation standards.

Observations: Non-Medical Grievances

In this section, we begin by describing how the (non-medical) inmate grievance procedure is designed to work; we continue in this section with our observations that inform our recommendations contained at the end of this report.

Description of Inmate Grievance Procedure per Policy

One expert with whom we conferred reported that many jails in this country have no inmate grievance process whatsoever. The HCSO changed its methods for processing grievances in November 21, 2006. Prior to that date, once an inmate communicated a concern/grievance, s/he was given a Grievance Form by the pod deputy and investigation/disposition commenced. This produced as many as 4800 Grievance Forms per year. According to jail staff, the change was made to the system because it was clear that many inmate concerns could, in fact, be quickly and easily resolved and because, with the large numbers, there was a risk that important concerns would be "lost" in the mass of minor ones. The number of grievance forms filed in 2004 represented the peak of the five-year summary provided to the Commission. This number plummeted to 212 in 2007, the first full-year of the new system. This change of policy and the corresponding reduced numbers led the Commission and this work group to look closely at these new processes.

Pursuant to the new policy and consistent with the philosophy of direct supervision, pod deputies are directed to try to resolve the issue immediately without paperwork being filed. If the deputy cannot resolve the inmate's concern, the inmate can fill out an Inmate Request Form (IRF)¹ to either (1) request to meet with a supervisor, or (2) obtain a Grievance Form (GF).² Either of these requests are to result in a meeting between the inmate and a supervisor. The supervisor will first determine if the concern is "grievable." If it is not "grievable" the supervisor will explain the procedure and why it is not "grievable" and annotate his/her response on the IRF.³ If the concern is "grievable" the supervisor can attempt to achieve resolution on the spot or furnish the inmate with a GF. The inmate will fill out the GF and return it to a deputy who will enter it into JAMS and record the computer generated number on it.

Per DTN 914.06, the GF goes to a supervisor/manager who will "determine if s/he is responsible and/or able to respond to the grievance." If the supervisor/manager is not able to handle the grievance, s/he is to assign the grievance to the appropriate supervisor and update the Inmate Grievance Log. If s/he is able to respond, s/he will investigate/review the inmate's complaint, "ensure that corrective action is taken" if the inmate's complaint is founded, and inform the inmate in writing within 10 days of any action that is to be taken. If the grievance is unfounded or unsubstantiated, s/he is to similarly report this to the inmate, with explanation, within 10 days.⁴

DTN 914.06 provides for shift commander and facility commander review of the GFs including action/disposition. (See 914.06 IV D and E.) Each signs off on the GF.⁵ The Facility Commander reviews all appeals to previously completed grievances and provides the requisite response to the inmate who has appealed within five days.

¹IRF's are three part forms that are numbered at printing. The "Original" top copy is ultimately placed in the inmate's file after it has been completed. The second copy (Yellow) is returned to the inmate after it, too, has been completed and is a carbon copy of the original. The third copy (Pink) is retained by the inmate at the time s/he submits it so that s/he has proof of submission.

²GF's are four-part forms that are assigned numbers when entered into the Jail Administration Management System (JAMS) using (INMGRV); this number is transposed to the "hard" copy of the grievance. The number indicates where the grievance originated and keeps a tally of the total number of grievances for that area (2008N0008 = Year: 2008, N = North Command, 0008 = Number issued in that command for that year.) The "Original" top copy is ultimately placed in the inmate's file after it has been completed. The second copy (Canary) is forwarded to the Facility Operations Manager for filing after completion. The third copy (Pink) is returned to the inmate after completion. The bottom (Goldenrod) copy is kept by the inmate at the time s/he submits it so that there is documentation of the submission.

³ The supervisor will give the inmate the yellow copy with his/her response and the white copy will be forwarded to Inmate Records at the Orient Road Jail for placement in the inmate's file.

⁴ The inmate receives the goldenrod copy showing resolution and all signatures. The disposition is entered into the INMGRV program. "A copy of the JAMS report (is) printed and attached to the original grievance."

⁵ The white copy of the IGF goes to the inmate file.

Communication of Process to Inmates

Public Defender, Julianne Holt, in speaking to the Commission on 7/11 (see transcript p. 18) highlighted the importance of inmates' understanding of the grievance process. According to Holt, "one of the things that we've talked about in the past is to ensure that everyone really does know what the process is." She mentioned the Inmate Handbook in this context. The Inmate Handbook is to be given to all inmates when they are transferred from intake to housing. This document covers topics such as canteen, contraband/searches, initial per diem fee, mail, library, meals, medical services, programs and services, to name a few. The grievance process is addressed on page 6 of the English language version and reads in full: "Inmates are afforded the opportunity to register complaints about the conditions of confinement, policy, or incidents. Grievance forms are available upon request from the pod deputy." This very brief description does not convey sufficient information and, relatedly, does not fully reflect the new procedures that were adopted by the HCSO in 2006.

Ms. Holt also mentioned in this vein the importance of the inmate Orientation Video, noting that "a significant (number) of our clientele cannot read past the third-grade level." At that same Commission Meeting, in response to these comments, Colonel Parrish, too, highlighted the importance of the inmate Orientation Video to supplement the written handbook. Commission Member Fridell visited Orient Jail with notice, to view the Orientation Video, but was told it was not available as it was currently undergoing revision.

Some inmates who were interviewed knew how to initiate a grievance, others did not.

System Accessibility

Staff who were interviewed or participated in focus groups, for the most part, reported that the grievance system is accessible to inmates; one commented that it is "too accessible." Other staff members and some inmates, however, expressed concerns about the ability of inmates to utilize/access the grievance system and, relatedly, concerns about whether all relevant parties understood how the system was supposed to work. As conveyed above, the first step is for the inmate to convey his/her concern to the pod deputy who can try to resolve it immediately. Some inmates were reticent to approach a pod deputy with their concerns, particularly if that deputy was the source/object of the concerns (e.g., the inmate's concern was with force used by that deputy). Some inmates anticipated non response or even retribution. When this issue raised by inmates was shared with staff in interviews and focus groups, we were told that this issue is "easily remedied." If an inmate is reticent to initiate his/her concern with the pod deputy on the job at the time the issue/concern manifested, s/he can raise the issue with another pod deputy on another shift. However, other interviews

indicated that some inmates and deputies were not aware that inmates could lodge the complaint on another shift. (Or said the inmate could only lodge a complaint on another shift *after* s/he attempted to lodge it on the first one.) Several inmates reported that when they approached a deputy “on another shift” to initiate the grievance procedures, they were told that they could not do so.

Several inmates reported that, when they tried to lodge a concern, they were told that their concern was “not grievable.” They did not understand what types of concerns were officially “grievable” and “not grievable.” One inmate reported that when he requested a Grievance Form he was told none were available.

Inmates were asked about their ability to request an interview with a supervisor if the pod deputy could not resolve the issue they raised. Some reported success with this step in the process; others did not. One inmate suggested that “sometimes the deputies will pass the request on to the supervisor, sometimes not.” One inmate reported during an interview that when he asked to see a corporal the pod deputy told him, “No, you can talk to me when I’m a corporal.” Some indicated a lack of faith that a request to speak to a supervisor would result in a meeting at all or result in a *meaningful* meeting. Regarding the latter, they assumed a supervisor would “side” with the pod deputy. Some of these inmates, however, acknowledged that they had yet to test their assumptions. Some staff denied that their supervisors would let them off the hook if they had done something inappropriate. One commented to the effect, “I’m held accountable by my supervisor and would not have it any other way.”

The inmates conveyed frustration that they did not understand fully how the system was supposed to work and therefore did not know when it *was* or *was not* serving them as designed. They suggested that the system might have more integrity and credibility if the staff knew *that the inmates knew* what the process was supposed to be.

Grievance Processing

Some interviewed inmates reported successful and fair processing of their concerns and, in this context, reported that certain staff members were particularly approachable and otherwise quite clearly dedicated to serving inmates in a respectful manner. Some supervisors, they noted, went “above and beyond” what was required to listen and respond to inmate concerns. Other pod deputies and supervisors were not similarly regarded. One deputy whom the inmates regarded very highly reported in an interview that the grievance process needs some additional safeguards to ensure its accessibility and integrity. On the other hand, asked if grievances were taken seriously once lodged, many staff who were interviewed or participated in focus groups, indicated they thought they were.

As noted above, all grievances filed in 2007 at all sites were reviewed. The “depth” of information provided by the staff members investigating/resolving the grievances varied considerably. Some grievances required very little investigation and documentation because of the simplicity of the concern raised (e.g., not being allowed access to the law library). In others, it was difficult to determine from the documentation whether a solid investigation had been conducted and sufficient consideration given to the inmate’s concerns. DTN 914.06 merely says the supervisor/manager will “investigate/review” the inmate’s complaint; it does not indicate what processes are expected, although we acknowledge this might be covered in training.

We requested and received disposition information for grievances filed in 2006 and 2007. The results are reported below.

	2006	2007	Total (%)
Founded	404	14	418 (17.0%)
Non-Grievable	212	24	236 (9.6%)
Open	14	2	16 (0.7%)
Other	18	0	18 (0.7%)
Unfounded	1427	149	1576 (64.2%)
Unsubstantiated	167	23	190 (7.7%)

Disposition information in any realm is not easy to interpret. In the law enforcement realm, for instance, a low rate at which citizen complaints are sustained could mean that the behavior of law enforcement is good or that the investigation of complaints is not. It is similarly difficult to interpret the disposition information above. We merely note with favor that the “founded” rate is not *questionably low*, relative to industry standards. We are interpreting the “founded” rate of 17.0% to mean there is at least some degree (maybe a high degree, we cannot tell) of system integrity.

Following investigation and resolution, the Inmate Grievance Form is returned to the inmate. On that form, the inmate can indicate by checking a box, "I would like to request an appeal." The form (that is returned to the inmate) indicates, "Appeals must be submitted within 15 days and must include a copy of this grievance." In reviewing the files for 2007, we noted that not one inmate who indicated an interest in an appeal ever filed it. For instance, we reviewed over 40 grievances filed at Orient Road Jail in 2007. In 18 of these, the inmate indicated s/he "would like to request an appeal." Stamped on every one of those forms was the statement "No appeal has been filed, Fifteen days have expired." While we might expect a low level of inmate follow up on their desire to appeal, the 100% failure rate raises the question of whether the inmates understand what they must do—beyond checking that box—to proceed. The Grievance Form indicates that "Appeals must be submitted within 15 days and must include a copy of this grievance." It does not indicate how the appeal is initiated (using the Inmate Request Form).

Documentation

In the context of discussing the relatively new procedures, Colonel Parrish told the Commission that he wants to "get it automated so I can track it like we do all the other things." Subsequent interviews with command staff indicated that a new tracking system is, in fact, forthcoming. This will include computerized tracking of requests for and dispositions resulting from supervisor interviews with inmates.

One national expert with whom the work group conferred expressed concern that the grievance form, once the grievance is resolved, is placed into the inmate's file. This person indicated that this information in inmate files had the potential to label the inmate as a "trouble maker." We determined, however, that these "hard copy" inmate files are not available to line staff, but are instead kept in a file room at Orient Jail.

Concluding Comments on Observations

Much of the information about strengths and weaknesses of the system came from interviews with inmates and staff. The work group members understand fully that some individuals in either of these groups might be motivated to put the system in the "best" or "worst" light. These interviews were important for highlighting aspects of the system that one might expect would need strengthening if it were implemented in any jail, if only because human beings are being asked to implement it. Because we have come to believe that most of the staff in the HCSO detention system are highly professional and well intentioned, we do not recommend a return to the earlier system nor a switch to some of the other systems we identified through our research on other jails. Instead, we have produced some recommendations to strengthen the current system.

Observations: Medical Grievances and Medical Services Contract

The contract for the outsourcing of medical services to Armor Correctional Health Services (hereafter "Armor") was reviewed. The contract specifies that the medical provider is responsible for the following:

- Providing or purchasing all medical, dental and behavioral health (excluding psychiatric hospitalization) services, including comprehensive health evaluations of each inmate following booking, and pharmacy.
- Educating inmates and staff through e.g., an ongoing health education program.
- Maintaining medical records.
- Completing all medical transfer forms for internal and external transfers.
- Meeting the quality standards set forth by the National Commission on Correctional Health Care (NCCHC), the American Correctional Association (ACA), the Florida Model Jail Standards (FMJ), and the Florida Corrections Accreditation Commission (FCAC).

Further the contract specifies that, "A quality assurance program will be ongoing consisting of regularly scheduled audits of inmate health care services with documentation of deficiencies and plans for correction of deficiencies." A quality plan must include an annual external peer review with results made available to HCSO.

The HCSO provides one on-site FTE devoted to contract management and oversight. The Contract Manager reviews the following monthly reports: staffing (tied to payment), grievance by type, copies of grievance forms, and a myriad of information available through data systems. The Contract Manager attends quarterly Quality Improvement Committee (QI) meetings, but does not have copies of QI documents as they contain Personal Health Information (PHI). The manager receives the following daily reports from Armor for the following:

1. Transfers off site
2. Communicable disease
3. Suicide attempts, precautions
4. Number of inmates in local hospitals and infirmary
5. Staffing roster
6. Medical incident reports – copies
7. Medical grievance reports – copies
8. List of filing discrepancies
9. Status report of history and physicals

The Contract Manager also does an informal review of medical charts and medical operations on a daily basis. Issues identified are conveyed verbally to Armor management. If the issue is not resolved satisfactorily, the Contract Manager notifies the appropriate Captain or Major; if necessary, Colonel Parrish

will become involved. Written corrective actions are rare, and when implemented, they require action plans. All other on-site and contract issues related to review appear to be resolved on the verbal level and have not been tracked.

The detention medical services are reviewed annually by Florida Model Jail Standards and every three years by the National Commission on Correctional Health Care (NCCHC), the American Correctional Association (ACA), and by the Florida Corrections Accreditation Commission (FCAC). There is no formal annual contract monitoring document or benchmarking of performance currently in place.

The contract with the medical provider does not identify specific requirements regarding the grievance process; these processes are set forth in the HCSO grievance policy (DTN 914.06). Section H of this policy covers "Submission of Inmate Medical Grievance," and sections I, J, and K cover "Medical Grievance Coordinator's Responsibilities," "Health Services Administrator Responsibilities," and "Medical Director Responsibilities," respectively.

Armor provided Commission Member, McKinnon, with the following documents: Grievance Policy, Inmate Grievance Medical Log, Request for Medical Review Form, and Inmate Grievance Form – Medical Services. Armor has clear processes by which inmates request medical services and file medical grievances. Inmates may request medical services by completing a Sick Call Request Form available in the pod. These requests are given directly to medical staff. LPN's circulate through all pods and make rounds three times daily. Requests for sick call may receive the following responses depending on urgency: urgent care (within 24 hours), clinic (within 36 hours), and general clinic (within 5 to 7 day).

In addition, a Request for a Medical Interview Form may be completed by an inmate at any time; it is given to the medical staff during rounds. Inmates may request medical interviews for any reason, however the primary reason for requesting a medical review is that the inmate is not satisfied that his/her medical needs are being met. By contract, Armor has up to five days to respond to an inmate request for review. Armor has a full time RN Grievance Coordinator to address all inmate requests for medical reviews/interviews and maintains that most are resolved quickly. The form identifies the issue, finding and identified actions necessary. The form is signed by the Grievance Coordinator and the inmate indicating either that the issue was resolved or that a formal grievance will be initiated. A copy of the Medical Review Form is sent to the Health Services Administrator.

Statistics as to number and type of medical requests are reported to and reviewed by the HCSO Contract Manager and an internal committee monthly and on a quarterly basis they are reported to and reviewed by QI Committee. While

the Contract Manager receives information regularly regarding requests for interviews and grievances, there does not appear to be a mechanism whereby jail administrators regularly receive/review this information.

If the inmate is not satisfied with the interview/review and decides to file a grievance, s/he completes a Medical Grievance Form, and gives it to medical staff. The Grievance Coordinator must investigate the complaint, ensure actions are taken if the complaint is valid, and inform the inmate in writing of actions taken. This information is entered into the JAMIS system. The information is then forwarded, reviewed and signed off by both the Contract Administrator and the Medical Director; the form must be returned to the inmate within 5 working days. The inmate has 15 days to appeal.

For the month of June 2008 there were a total of 180 inmate requests for review at Falkenburg Jail; 40 were unfounded, 140 founded. All issues, founded or unfounded, were resolved. At Orient Jail there were a total of 51 requests for medical interviews, 15 were unfounded, 36 founded. All were resolved. There were zero grievances filed. The three categories that received the greatest number of requests for interview were “dissatisfied with medical care” (n=52), problems with medication (n= 69), and request to be seen (n=38). Armor states that the issues are addressed by the Quality Improvement Committee, however due to privacy considerations relevant to Personal Health Information, the minutes or activities of the committee are not divulged. Due to HIPPA regulations the Grievance Work Group of the Jail Commission was not able to review any trending or corrective action reports and activities that have been initiated as a result of the Quality Improvement Committee.

Grievance Work Group Initial Recommendations

We recommend that HCSO:

- 1) Ensure that inmates understand how to initiate a grievance and what to expect from the system once it has been filed. This should include accurate and expanded coverage in the Inmate Handbook that reflects the procedures adopted in 2006 and corresponding coverage in the Orientation Video. While the written and audio portions need not be lengthy, the coverage should indicate what is grievable and not grievable and reference all steps of the process. Importantly, the inmates should learn from these sources that a concern does not need to be raised on the shift during which it occurred/manifested, and that detention staff (per recommendation below) can be disciplined for thwarting an inmate’s legitimate attempts to use the system.
- 2) Make sure staff members understand the importance of the grievance system and their own important role in it. Ensure a common understand among staff regarding what concerns are grievable and not grievable. Ensure that staff understand that they are to accept/process grievances

- even if the concern arose on another shift. If necessary to ensure this latter understanding, incorporate this into policy (DTN 914.06).
- 3) Incorporate into policy (e.g., DTN 914.06) a provision indicating that a jail staff member is subject to discipline if s/he intentionally or due to ignorance of policy thwarts an inmate's efforts to use the procedures for what appears to be a viable grievance. Communicate this changed policy to staff.
 - 4) Ensure through policy and/or training that supervisors who are charged with investigating/resolving grievances conduct sufficiently comprehensive reviews and document same in their reports.
 - 5) Supplement procedures and forms, as necessary, to ensure that inmates who check "I would like to request an appeal," are uniformly provided with information regarding the tasks they must complete. One option is to include in the next iteration/printing of the Grievance Form, a sentence indicating how the inmate initiates the appeal.
 - 6) To ensure grievances are used by command staff as a monitoring and management tool, produce reports on the number, nature and disposition of grievances as frequently as Assailant Control Reports (ACRs) are similarly reviewed. These reports should be reviewed by supervisory staff up to and including, at regular intervals, Facility Commanders.
 - 7) Compare grievance disposition statistics across similarly situated supervisors who are conducting the investigations. A finding that a particular supervisor has disposition statistics that are very different from his/her peers would result in a further review of his/her processes.
 - 8) Consider, if feasible, incorporating information on grievances filed against particular deputies into the developing Early Intervention System (EIS). This inclusion would be consistent with the current practice of including complaints in that system. In evaluating the possible inclusion of grievances into the EIS, policy makers should consider whether this increased accountability might produce a corresponding unfortunate increase in grievance "thwarting" behavior on the part of staff.
 - 9) The Sheriff's Office General Counsel Office should work with appropriate staff from Armor Health Services to explore better information sharing between Detention and medical personnel within the constraints of the Health Insurance Portability and Accountability Act.
 - 10) Detention Department management should ensure that medical requirements not met through the various credentialing bodies are regularly reviewed and documented according to a clearly defined process understood by both the Sheriff's Office and Armor Health Services.
 - 11) Detention management should ensure that, per contract, an annual external peer review of medical services is conducted and that the results are made available to appropriate management within the Sheriff's Office.
 - 12) The Detention Department Medical Services Contract Manager should ensure the creation of grievance trend reports for review by Detention management.

- 13) More formalized training should be provided to medical staff on identification of signs and symptoms of substance abuse and mental health, as well as on co-occurring disorders; on appropriate intervention strategies; on assessment techniques; and on enhanced clinical skills.

Appendix E

Internal Affairs Work Group Report

Independent Review Commission On Jails

Internal Affairs Work Group Report

The Internal Affairs work group was formed to review the formal misconduct investigations of Detention employees. The work group was comprised of Ray Velboom, Delia Palermo and Al Higginbotham.

The work group met twice in conjunction with the Use of Force work group. The Sheriff's Office was requested to provide an analysis of formal investigations of misconduct involving detention employees. The members also reviewed individual report investigations.

A list was provided of closed investigations from January 2005 through December 2007. The list included administrative as well as criminal cases. The information provided included the date, case number, employee name and ID number, charge and finding.

Formal misconduct investigations findings are concluded in one of the following categories as defined in the Hillsborough County Sheriff's Office's *Misconduct; Suspension* Standard Operating Procedure:

- | | |
|-----------------------------------|--|
| Sustained: | A finding or conclusion that an allegation is supported by a preponderance of evidence. |
| Unfounded: | A finding or conclusion that an allegation is demonstrably false. |
| Unsubstantiated: | A finding or conclusion that sufficient credible evidence was lacking to prove or disprove the allegation. |
| Exonerated: | A finding or conclusion that the incident occurred but the individual's actions were lawful and proper. |
| Exonerated Due to Policy Failure: | A finding or conclusion that a present policy, procedure, rule or regulation covering the situation was non-existent or inadequate. In all cases involving a finding of Exonerated Due to Policy Failure, the person making the finding shall initiate a review of the policy in question and draft a recommendation to resolve the failure. |

Other terms useful to analysis of this report:

- UOF Use of force, here described as any force above that of dialogue (Level 1) or simple escort (Level 2). (“UOFs” will designate multiple Uses of Force).
- ACR Assailant Control Report, a document required of each deputy who uses pain compliance, physical controls, or strikes with an inmate.
- ACIR Assailant Control Investigator Report, a document completed by a supervisor on each UOF documented on an ACR evaluating that UOF.
- SOP Standard Operating Procedure

Analysis

An analysis of the completed formal misconduct investigations conducted from January 2005 to December 2007 that involved Detention personnel revealed the following information:

Year	Number of Incidents	Number of Charges	Number of Involved Detention Personnel	Findings
2005	71	148	90	114 sustained 14 unfounded 20 unsubstantiated
2006	71	161	82	121 sustained 9 unfounded 23 unsubstantiated 8 exonerated
2007	56	150	62	132 sustained 9 unfounded 7 unsubstantiated 1 exonerated 1 exonerated due to policy failure

Table: Analysis of Formal Misconduct Investigations – Detention Personnel 2005-2007

The Sheriff’s Office was requested to provide 25 formal investigations of misconduct files that were randomly selected. These files included criminal allegations as well as administrative cases.

The files were reviewed and discussed by work group members. The investigations were found to be substantive and quality investigations. One area of concern was if formal investigations of misconduct occur when allegations of excessive use of force are made. It was determined that this does occur and several of the cases reviewed involved of use of force.

Initial Recommendations

The committee would recommend the following:

1. The use of force (UOF) definition should be clarified and disseminated to ensure that all deputies understand what a use of force is and what must be reported. The current atmosphere following the Sterner incident has resulted in uncertainty and lack of consistency in definition and reporting across shifts and personnel. Even the Sterner case itself presented some confusion over “where to put it and whether to report it” within current use of force parameters. Now supervisors are divided about what to report and this uncertainty for deputies may lead to over or underreporting.
2. Once this consistency has been achieved through definition and dissemination of the definition, the discipline for violations of failing to document use of force through an Assailant Control Report could be increased. We saw several cases involving the failure of filing Use of Force reports. An increase of discipline would give more incentive for filing of reports- once the term UOF was adequately defined.
3. Investigations rely on ACRs and ACIRs from deputies and supervisors at the jails. Therefore, further training of supervisors on the Use of Force reports would improve the basis on which investigations are begun. Supervisor training would improve the usefulness and value of site investigations before they reach the level of IA. Additionally, supervisor training would improve the consistency across shifts and personnel of Use of Force reporting.
4. Taser use is limited and rare. However, if the Taser were made more accessible than is currently the case, that use may increase. HCSO should employ any data recorded by the Taser itself to assess proper use and to corroborate investigative reports.
5. One of most useful investigative tools is the review of images captured from multiple cameras at the jails. However, use of sound with these images would ensure greater accuracy and detail to reports.
6. Detention deputies should be assigned to Internal Affairs to ensure the validity and reliability of investigations involving the unique circumstances of detention personnel.

Appendix F

Use of Force Work Group Report

Independent Review Commission On Jails

Use of Force Work Group Report

This work group examined the use of force in the Hillsborough County jail system from January 2005 through the end of May 2008, the 41 month duration of the administration of Sheriff David Gee. The numeric data were obtained from HCSO computer systems; the subjective from numerous interviews, public hearing testimony, focus group discussions, and the review of randomly selected written narratives which are not captured or searchable by computer programs currently in use. We reviewed pertinent policies, and conducted frame by frame analyses of 10 jail videos provided by HCSO, the American Civil Liberties Union, and the news media. Only uses of force above Level 2 of the Use of Force matrix were examined and reported below.

For clarity, following are explanations of terms used throughout this report:

UOF	Use of Force, here described as any force above that of dialogue (Level 1) or simple escort (Level 2). (“UOFs” will designate multiple Uses of Force).
ACR	Assailant Control Report, a document required of each deputy who uses pain compliance, physical controls, or strikes with an inmate.
ACIR	Assailant Control Investigator Report, a document completed by a supervisor on each UOF documented on an ACR evaluating that UOF.
IR	Incident Report, a document required to record various events, including use of the restraint chair, use of force, or any of numerous other occurrences.
SOP	Standard Operating Procedure
Pain Compliance Level 3	on UOF Matrix, to include pressure points, joint manipulations, pad subduing, redirection.
Physical Controls Level 4	including Oleoresin Capsicum (OC) foam, takedowns.
Strikes Level 5	punches, kicks, baton strikes, Tasers.
ORJ	Orient Road Jail
FRJ	Falkenburg Road Jail

CB Central Booking, a location at ORJ

JAC Juvenile Assessment Center

The record keeping systems primarily maintain statistics by the number of UOFs, by the number of deputies involved, and less frequently, by the number of incidents. Where statistics are used, their nature will be specified.

This report will follow the 10 areas designated by outline in the work group's original report to the Commission, and will describe the processes used, the findings and then the work group's recommendations. The Use of Force work group members are Brian Kensel (Chair), Dr. Lorie Fridell, Dr. Delia Palermo and General Peter Schoomaker.

The Use of Force work group's outline listed the following items for examination:

1. The number of use of force incidents.
2. The number of times force was used by each deputy, to identify those using force most frequently.
3. The types of incidents in which force is being used (assaults on staff, inmate fights, etc.)
4. The frequency of use of the various levels/types of force used (chair, OC, strikes, etc.)
5. The location(s) where force is most commonly used.
6. The frequency of injuries to inmates and staff.
7. Any correlations between the types of incidents (#3 above) and location(s) (#5).
8. Any correlation between the type of force used (#4 above) and location(s) (#5).
9. Prevalence of use of force by squad assignment.
10. The validity of the review system used to evaluate use of force events.

Each section of the report will be marked with **ITEM 1-10** to indicate the issue it addresses. They are not necessarily addressed in the order above.

ITEM 1

Any examination of the use of force must begin by quantifying its occurrence. Examination of various HCSO data systems for the 41 month period previously described revealed 3078 Uses of Force during 1720 incidents, an average of 42 incidents and 75 UOF per month. As most incidents involve multiple deputies (on average, 1.8 deputies per incident), each of whom is required to independently report his/her UOF via the completion of an ACR, the number of UOFs will always exceed the number of incidents.

During this same period, a total of 247,999 people were booked into Hillsborough County Jails. Force at a Level 2 or above was used 3078 times, for a rate of 1.2% of the population *if each UOF was directed at a separate person*. However, as determined above, an average of 1.8 UOFs are involved with each incident, thus the actual percentage of people booked being involved in a UOF incident is .7 of 1%.

Further examination of the records revealed a small group of inmates was involved in an inordinately high number of UOF incidents. Five inmates were involved with 92 UOF, or 3% of the total, a rate 1500 times higher than the statistical average. The impact of a relatively small group of inmates will be explored in more detail below in the section marked "ITEMS 3, 7".

The annual rate of bookings and UOFs paralleled one another throughout the period, showing a minor peak in 2006 with a slight downward trend since.

ITEM 2

The work group conducted an examination of the deputies involved in multiple UOFs. Employment records indicate an average of 938 deputies of the rank sergeant and below were employed in the jails each year of the period. Our examination chose that group of employees to reflect those who have the most frequent contact with inmates and excluded the higher ranks that are generally responsible for administrative matters.

Using the previously described statistics, the "average" deputy used force as described 3.28 times during the 41 months. A group of 20 deputies, representing 2.1% of all deputies in the study, were involved in 599 UOFs, or 19.5% of the total. The top five were involved in 204 UOFs, representing 6.6% of all UOFs. In the group of 20, the number of UOFs ranged from 48 to 19 for the 41 months, with an average of 31.7 UOF per deputy, just under 10 times the department average. (Note:

Assailant Control Investigator Reports (ACIRs) were removed from the above numbers for the two deputies in the group of 20 who became Corporals during the period and thus became responsible for the review of some ACRs).

The length of service for the 20 deputies ranged from 39 months to 21.9 years, with an average of 9.4 years.

Many of the ACRs for these incidents were reviewed for trends, to determine the propriety of the UOF, and to examine the internal review process. Of the 599 UOFs involving these 20 deputies, three resulted in Internal Affairs investigations. In one instance, charges of excessive force and use of profanity were determined to be unfounded and unsubstantiated, respectively. In another, a charge of excessive force was unfounded, allegations of use of profanity were unsubstantiated, and a charge of failure to follow Standard Operating Procedures/Directives was sustained for deputies' failure to complete an ACR. A third deputy resigned from service following a separate incident. Overall, there were 17 investigations (including the above) into allegations of the use of unnecessary or excessive force against Detention personnel during the study period. Four of those allegations were sustained; the others were unfounded.

A review of ACRs (and the resulting ACIRs) of the 20 deputies with the highest UOFs revealed those other than those noted above were determined to be appropriate and valid. Of the 3078 UOFs examined, the rate of those found to be inappropriate was 2/10^{ths} of 1 percent.

ITEMS 3, 7

Also examined were the types of incidents that resulted in UOFs, and the locations where they occurred. HCSO defines 19 types of incident by which it classifies UOFs, the most commonly used of which are "Disruptive Inmate", "Assaults on Staff", and "Inmate Altercations". The following reflects their frequency at the two largest facilities, by the number of deputies involved:

	ORJ	FRJ	Total
Disruptive Inmate	1,129	562	1,691
Inmate Altercations	169	271	440
Assault on Staff	215	162	377

As previously mentioned, there is a relatively small group of inmates which is involved in a disproportionate number of incidents involving UOF. The direct supervision style of detention used by HCSO requires appropriate department by the

inmates, with sanctions for those who refuse to comply. The expected behavior standards are provided to inmates as part of the booking process. This analysis of UOF identified a number of inmates who, based on their multiple arrests/bookings, would be expected to be aware of the behavior standards, but whose records indicate they consistently refuse to behave according to those standards.

One inmate, for example, was involved in 11 UOFs between January 2005 and May 2008, requiring 31 deputies to control him. These 11 incidents took place during 7 separate arrests/bookings. (These numbers do not include this inmate's multiple confrontations with law enforcement prior to 2005.) Another inmate was also involved in 11 incidents, requiring 21 deputies to use force during 3 jailings. This pattern of behavior is not limited to male inmates; one female inmate was involved in 4 UOF incidents, requiring 11 deputies; she was arrested and booked nine times during the 41-month period.

There were 230 inmates involved in multiple UOF incidents, ranging from 2 to 11 each, for a total of 560 incidents. Said differently, one tenth of 1% of the inmates booked into Hillsborough County jails since January 2005 were involved in 18.2% of the UOFs. Some of the deputies and supervisors interviewed in focus groups said current classification practices make it difficult for them to place dangerous or disruptive inmates in administrative confinement, which results in more confrontations, and thus more UOFs. They attributed the problem to what they described as inflexible classification clerks, and felt the ultimate classification decision should rest with first line supervisors each shift.

ITEM 4

Discussion of the types of force used should note that there have been no instances of Deadly Force (Level 6) used in HCSO detention facilities during our 41 month period of study, nor were less than lethal munitions used. As previously described, Levels 1 (presence and dialogue) and 2 (escort, touch, restraint devices) do not require an ACR and are not considered UOFs for the purposes of this report.

Combining facility statistics for the period resulted in the following numbers of times each level was used:

- Level 3: 881 (684, or 78%, were "redirects")
- Level 4: 1,189 (930, or 78%, were "takedowns". Additional 238, or 20%, were use of OC, further described below)
- Level 5: 92 (79, or 86%, were "defensive strikes")

ITEM 5

The review also illustrated specific patterns regarding the location of these UOFs. Of the 20 deputies responsible for the highest number of UOFs, 18 spent all or most of the period assigned to Central Booking at ORJ, most of them working the 7p.m to 7a.m. shift. Examinations of all data confirm the greatest rate of UOFs occur as part of the booking process, with 56% of them taking place during the night shift. Thus, it is reasonable to expect those deputies assigned to work nights in CB to demonstrate the highest incidence of UOF.

Since 2005, 28.6% of all incidents involving force, and 35% of all UOFs in all Hillsborough County detention facilities took place in CB. Another 2.6% of the incidents occurred in the booking area of the JAC, which performs the same duties for juveniles as CB does for adult inmates. The remainder was spread throughout the other parts of ORJ, FRJ, the JAC, the Work Release Center and Transportation. UOFs each year were highest at ORJ (52-59%), followed by FRJ (36-42%).

The reasons for the preponderance of UOF in CB were addressed by Colonel David Parrish at the Commission's open meeting on March 10, 2008 when he described CB as the "most overtaxed area in the jail system." From deputies through middle management, many of those interviewed described low staffing levels as the greatest problem throughout the jails. They said staffing levels impact UOF statistics in opposing ways: because they believe no backup deputies are readily available, some deputies (primarily in housing units) ignore violations by inmates to avoid a confrontation they would have to handle by themselves. Following recent events, there now exists some confusion over what actions constitute a UOF; some deputies are now instructed by supervisors to submit ACRs for even minor contacts with inmates in order to avoid potential criticism.

ITEM 6

Our work group also examined the frequency and degree of injuries suffered by inmates and by jail staff during UOFs:

UOF Injuries to Inmates	ORJ	FRJ	JAC	Totals
Hospitalized	1	0	0	1
Known Visible	5	3	0	8
Minor scrapes	12	17	2	31
Totals	18	20	2	40

UOF Injuries to Jail Deputies	ORJ	FRJ	Totals
Hospitalized	1	0	1
Known Visible	4	3	7
Minor scrapes	7	15	22
Totals	12	19	30

These numbers reflect injury rates of 1 injury to every 6200 inmates, and 1 injury to every 125 deputies. Deputies and supervisors advise that many minor injuries to deputies are never reported, because doing so could further complicate what they describe as dangerously low jail staffing levels. Some of those deputies said they expect more deputies to be injured because of the understaffing if it continues.

ITEM 7

The results of our examination of the relationship between the types of incidents and their locations were included in the response to ITEM 3, above.

ITEM 8

There were 238 incidents in which OC foam was used, involving 383 deputies. Most OC incidents occurred at FRJ (68%), with 31% taking place at ORJ; the remaining 1% at the JAC, WRC, and Transportation. OC uses represent 14% of the total UOF incidents.

There were 6 Taser uses during the study period; five at FRJ and one at ORJ, representing 2/10ths of 1% of all UOFs by detention personnel. A study was conducted of 23 OC uses in 2007 and 6 Taser uses in 2006 and 2007 by reviewing IRs, ACRs and ACIRs.

OC Incidents

Most of the incidents involving OC spray in 2007 were precipitated by inmate altercations. Deputies reported they ordered inmates to stop fighting and, when they did not, used OC spray against one or more of the involved inmates. This use of OC spray is consistent with the policy allowing for OC spray to defend against physical force/resistance (against a jail employee or against other inmates).

Generally, the incident descriptions are satisfactory. In many cases the incident report has greater detail than the ACR.

The reports by the investigators present facts as well as conclusions. The investigators usually indicated the specific individuals whom they interviewed as part of the investigation. Generally, this included all involved inmates and deputies; sometimes there were specific notations indicating why a particular inmate was not interviewed or that the inmate was uncooperative. In one exception, a supervisor did not explain why he did not interview an Inmate. Another investigator's report did not provide sufficient detail on the nature of his/her investigation but only reported, "I conducted interviews regarding Deputy XXXX's use of force." This lack of detail should have been questioned by supervisors who reviewed the paperwork for this incident.

Only a few of the investigators reported interviewing inmates who had witnessed the incident but were not involved in it, even though a number of the UOF incidents (e.g., precipitated by inmate altercations in housing) were likely in view of many. One investigator is an exception; he reports that he interviewed "the inmates in the pod that witnessed the incident." This report would have been further strengthened by indicating the names of the people with whom he spoke.

In just one of the examined incidents did the investigator note that he reviewed the video. Focus groups with supervisory personnel indicate they now routinely review video on UOF investigations. That review was confirmed by examining recent ACIRs.

Taser Incidents

It is notable and important that the Taser incident reports included detailed narratives. Incident report narratives averaged a full single spaced page. Generally, these narratives provided detail on the circumstances that led to the request to use a Taser, the preparations for its use (e.g., bringing a video to the scene), the use of it and the follow-up (e.g., probe removal and nurse check on subject). The reports appeared to include all information required per SOP DTN 909.60.

In all but one incident, the jail staff reported a single 5-second activation of the Taser. The other incident involved one activation using the probes, and two more with direct contact. The reports of five of the six incidents mentioned that a video was brought to the scene prior to weapon activation. Some reports mentioned that a nurse was called to the scene prior to weapon activation; all reported that a nurse was present at the scene after the activation to check on the subject. Deputies are trained to apply handcuffs during the activation phase to take greatest advantage of the inmate's temporary incapacitation.

In several incidents the narrative did not indicate why immediate action was necessary. All of these inmates appeared to be in single-person cells. All were agitated and acting out, but only a few of the reports explained why *immediate* cell entry was necessary. There may have been reasons that were not documented. Taser devices have the ability to record various data whenever employed, which can later be downloaded as part of an investigation. The presence of a video camera and multiple witnesses in the jails makes collection of such data there less critical than in Taser usage by deputies in street settings.

The Pro-Strait Chair was used 1195 times during the 41 months, with a peak of 400 in 2006 and a declining trend matching drops in booking and UOF rates in subsequent years. It is noted that use of the restraint chair is generally not reported on an ACR, unless Level 3 or higher force was used getting the inmate into the chair. All chair use does require submission of an Incident Report.

ITEM 9

One of the fields on the computerized ACR is "Squad", leading us to include in our original outline of potential issues an examination of UOF by squad assignment. However, our inquiry determined that detention deputies are not assigned by squad, and that the 4 digit numbers appearing in the "Squad" field on ACRs in reality refer to a telephone extension number in the area where the UOF took place. A list of those telephone extension locations was used to assist in determining the location issues addressed in item 5.

ITEM 10

HCSO has in place a review system and a program to monitor detention deputies' uses of force. SOPs require each deputy who uses force above the level of "Escort" to complete an ACR by the end of the work shift during which the UOF occurred. The primary deputy also completes an Incident Report; deputies who assist in the incident complete an ACR where appropriate, and a Supplement to the IR. In spite of current record keeping requirements that assisting deputies in a UOF incident also complete a supplement to the IR (DTN SOP 909.28), review of some files indicates these supplements are not being prepared in all cases.

The immediate supervisor then conducts an investigation of the UOF, most commonly consisting of interviews of the parties involved. He/she then completes an Assailant Control Investigator Report (ACIR), and the package is forwarded up the chain of command. Detention SOP 909.43 requires that oversight be conducted up to the level of the facility commander. Since February, those reviews have been extended to include the Colonel in charge of Detention. A substantial number of supervisors interviewed advised that the incompatibility of ACRs/ACIRs and the Blue

Team program requires them to write UOF narratives twice, which they say wastes time and creates potential trial problems.

Camera oversight of much of the jail, particularly CB, has been in place for about ten years. Since February, shift Lieutenants are required to review one hour of randomly selected camera footage during each shift.

The Sheriff's Office also conducts quarterly command staff "Strategic Management" reviews, including the use of force in the jail system. Examination of the 59 page "Use of Force" graphic presentation created for the "Strategic Management" review of December 2007 includes quarterly data for calendar years 2006 and 2007, with graphs showing UOF by facility, the rates of UOF, locations of UOF, the frequency of UOF by shift and location, the use of OC foam by shift and location, and the use of the restraint chair and Taser, again by shift and location. The depth and detail of this review appears to be adequate to alert the command staff to shifting trends in the frequency, nature and/or location of the UOF.

The system historically used for most of the study period to monitor deputies' UOF was supplanted in February with the adoption of the Blue Team program, a topic detailed by Sgt. Danny Tewmey in the Independent Review Commission on Jails public meeting on March 21, 2008. The data base that has been in use since 1999 to track use of force and misconduct investigations, among other items, is IA Pro. Blue Team is an adjunct program by the same software company that allows standardized entry of events such as UOFs, and with IA Pro, generates early intervention warnings of a deputy's performance, including UOFs. The adoption of Blue Team is to provide warnings of potential problems earlier than was possible during the previous paper based system.

It appears that the monitoring system is functioning as intended. Of the 20 deputies with the highest number of UOFs (described in ITEM 2, on page 3) identified by our examination, a review of records found that 10 of them had been flagged by the system, including the top six, and 10 of the top 12. These flags do not indicate wrongdoing on a deputy's part, but give supervisors an opportunity to examine the patterns of behavior to determine if they are appropriate or not given an employee's specific assignment.

Conclusions/Recommendations

Our research uncovered no systemic problems regarding the use of force in Hillsborough County Jails. Statistically, an arrestee entering the jail system faces less than a one percent chance of being involved in a use of force incident at any time during his/her time in jail. In 99.8% of those incidents in which force is used, an investigation has deemed it necessary and appropriate to the circumstances.

Most of our recommendations address record keeping or other administrative matters such as training, procedures and staffing.

1. Data down to the individual deputy level should be added to the quarterly command staff reviews of the UOF, to include multiple UOFs as in ITEM 2. This would permit a comprehensive overview of the individuals using force, and thus would identify contributing (and mitigating) factors such as their location of assignment, shift, etc. that may not be apparent from the broader scope of the current reviews.
2. Consideration should be given to more frequent fixed rotations of employees in high stress positions, particularly those in booking. With acknowledgement of the bid process currently in use, and the preference of many deputies to remain in those challenging jobs, the reality of leaving an employee with fewer than four years of experience in a position where he/she has needed to use force (albeit appropriately) almost 15 times as often as other deputies could create liability, or the appearance of impropriety in future incidents. However, basing assignments and transfers solely on legitimate UOFs may be perceived by deputies as punitive, which could discourage the appropriate UOF, thus exposing deputies to increased physical danger. These issues could be overcome if high UOF assignments are rotated on a fixed & published schedule, regardless of the number of UOFs amassed by any individual deputy.
3. Additional categories should be created on the ACR template for the types of force used. In the 3078 UOFs for the period examined, 436 listed “other” to describe the nature of the force. Expanding the menu of options from those currently offered would minimize the use of the catch-all “other” category and thus provide a more clear and accurate portrait of the type of force being used. Some types of force, such as OC, appear one place on some ACRs, and in two places on others, permitting confusion and possibly inaccurate data being recorded.
4. Relatedly, attempts should be made to integrate ACRs/ACIRs with Blue Team to avoid having supervisors duplicate efforts. Supervisors say they are so burdened with administrative responsibilities that they are often unable to supervise. They recommended formation of dedicated UOF investigation team(s) to review all UOF incidents, rather than the current system of immediate supervisors doing so.
5. We recommend amending the ACR template to include the name and/or PID of the supervisor of the deputy submitting the ACR. We further recommend

monitoring UOFs by supervisor, which would offer early notice of an unusual pattern of UOF by deputies working for a particular supervisor.

6. Most UOF statistics appear to be kept by the number of deputies involved, and the number of ACRs filed (which in theory would coincide). It is recommended that data also be kept in a manner to permit easy identification of the number of incidents, regardless of the number of employees involved. We were able to eventually retrieve that number, but it does not appear to be a standard means of data collection.
7. In view of the disproportionately high number of incidents involving a relatively small number of repeat inmates (ITEM 1, pgs.3, 4), it is recommended that the records of those inmates involved in multiple UOF incidents be flagged so additional caution may be exercised during future bookings, and appropriate housing is arranged during classification.
8. Similarly, in current practice, intake deputies are unaware of an inmate's identity/level of resistance until he or she arrives in the sally port. Consideration should be given to requiring law enforcement officers from all involved jurisdictions to contact booking via a designated radio channel or by telephone when initiating transportation to ORJ to provide at least the name/DOB of arrestee(s), and notification of any resistance, medical issues, etc. which would permit booking to appropriately prepare for the inmate's arrival. Modifications to current classification procedures should allow at least corporals and sergeants, if not deputies, to determine the appropriate type of housing for historically dangerous inmates.
9. It is recommended that training be amended to broaden the understanding of "Use of Force" and its parameters. It appears through review of files and personnel interviews that some confusion exists over what out-of-the-ordinary circumstances must be reported on an ACR. Some instances that fall outside of the existing categories, including the Sterner incident, are not seen as UOF by the involved deputy(ies), and thus never recorded via an ACR. Some deputies said their supervisors now require ACRs for even escort force or handcuffing, because of what they described as an environment where "everyone is walking on egg shells." Other supervisors apparently tell deputies to avoid UOFs, so the supervisor will not have to "waste time entering it in Blue Team." Training should clarify the definition of force to ensure more consistent reporting, and thus a more accurate record of jail activities. This would avert a sudden spike in UOF statistics which is likely to occur if current practices continue.

10. Training topics requested during interviews or focus groups were:

- A. training for all sworn jail staff in recognizing and dealing with mental health issues (this training has since been announced and scheduled).
- B. more cell entry/inmate extraction techniques and practice for detention deputies.
- C. supervisors also requested specific training in investigating UOFs. We concur that training in these areas should be considered. Beyond these issues, many employees were highly complimentary of the current training & FTO programs.

11. IRs and ACRs in Taser incidents should include the reason that immediate use of the Taser was required. Consideration should be given to downloading usage data from Tasers after each time a Taser is activated, and to mandating review of both the jail camera videos and those shot specifically to document the incident. Currently, Tasers are maintained by Lieutenants. Mid-level supervisors support continuing the current practice; Corporals and Sergeants urge increasing Taser availability by extending the authority and carriage of Tasers to their level.

12. Some deputies said the currently available soft pads are rarely used for inmate control because they are ineffective in protecting deputies. Consideration should be given to obtaining hard shields for that purpose.

13. We reviewed two incidents in which UOF was not reported, apparently because of confusion over those unusual events that fall outside of the common definition of UOF. In both instances the deputy was sanctioned. Such omissions generate the question, "How can the Sheriff's Office ensure that all uses of force are being reported *by someone*?"

A recent requirement was established that every employee must report anything he/she sees that might be improper. The grievance process, examined by another work group of the Commission, provides all inmates with the means to report any deputy's wrongdoing. Surveillance cameras, coupled with random reviews of their images, are intended to serve as deterrents, and are accomplishing that task according to deputies interviewed. The camera system used in the jails, particularly ORJ, has been updated since its installation. We recommend the addition of audio recording (as is utilized in some other area jails) be explored as a means of further monitoring the facilities. The existence of an audio record to enhance the existing video

would protect both inmates and deputies. Most supervisors interviewed are confident that all uses of force are being reported, especially in the current atmosphere; a few remain less convinced, but offer no recommendations.

14. Following are various recommendations made during focus groups by sworn personnel that they feel would positively impact their safety, and reduce the UOF:

- A. Remove some privileges from inmates sent to disciplinary confinement (DC), such as their access to canteen, visitation, daily showers, etc. Perception of current system is that there is no disincentive in DC, and that some inmates even provoke a confrontation with housing deputies to be transferred to DC where they have a “private” cell and few obligations. They recommended the same limitations for juvenile DC inmates.
- B. Some deputies perceive the greatest priority of the administration is the cleanliness of the jails, rather than the deputies’ safety; some say the effect has been lowered morale.
- C. Several focus groups repeatedly described a staffing shortage that negatively impacts their safety by reducing the number of deputies available when a violent incident does occur. This was most commonly voiced by FRJ personnel, because of the extended distances between some units. They attributed some of the shortage to recruiting standards. An opinion repeatedly expressed suggests prohibitions against recruits with tattoos and tobacco usage are responsible for the unfilled positions by excluding many applicants with a military background. They noted that contract medical personnel and CSOs are permitted to have tattoos.

