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COUNTY MANAGER

December 22, 2004

Kevin Watson
CCA Facility Administrator
Bay County Jail/Annex
314 ½ Harmon Avenue
Panama City, Florida 32401

SUBJ: UNUSUAL INCIDENT REVIEW—LABOR DAY HOSTAGE AND THIRD FLOOR TAKE OVER AT THE BAY COUNTY JAIL

Dear Kevin:

I have attached for your and your staff's review my unusual incident review concerning the hostage and third floor take over at the Bay County Jail on Labor Day. It includes my findings, required corrective actions and some recommendations for improvement. Please distribute it to your entire management team including your Health Care Administrators.

Please provide me by January 17, 2005 a corrective action plan and time line for, at a minimum, all of the required corrective actions.

If you have any questions, please contact me at your earliest convenience. I want to thank you and your staff for your cooperation while I was reviewing this matter

Sincerely,

Roger E. Hagen Ph.D.
Correctional Program Manager/Contract Monitor

Cc: Chief, Emergency Services
County Manager

Attachment

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PAMELA D. BRANGACCIO
COUNTY MANAGER

December 21, 2004

TO: Pamela D. Brangaccio, County Manager

THROUGH: Robert J. Majka Jr., Chief of Emergency Services

FROM: Roger E. Hagen, Correctional Program Manager/Contract Monitor

SUBJ: UNUSUAL INCIDENT REVIEW—LABOR DAY HOSTAGE AND THIRD FLOOR TAKE OVER AT THE BAY COUNTY JAIL

At approximately 2125 hours on September 5, 2004 the Corrections Corporation of America (CCA) PIO Mary Hughes notified me that four lockdown inmates had taken over the third floor of the jail and were holding a correctional officer and three nurses hostage. I have conducted a review of this incident to assess level of compliance with the: Florida Model Jail Standards (FMJS); CCA policies, procedures and instructive memos; and the terms and conditions of the contract between the County and CCA to provide jail operator services. The review included: the CCA incident report; FDLE investigative report of the September 6, 2004 officer involved shootings at the Bay County jail; relevant staff and inmate interview transcripts provided by the FDLE and BCSO(personal interviews were not conducted with these individuals); third floor maintenance logs and other maintenance records; third floor post duty logs before and after the incident; CCA authorized staffing patterns; third floor post orders both before and after the incident; appropriate CCA written policies; staff personnel records; appropriate inmate count sheets; prior segregation confinement records for the involved inmates; inmate case files; prior incident reports for the involved inmates; prior third floor security inspection reports; prior monthly/weekly safety inspection reports; results of a follow up door security audit by the manufacturer; discussions with appropriate management, security and health care staff; and personal observation during the incident and thereafter.

BACKGROUND

At approximately 1940 hours on September 5, 2004 four adult inmates (Kevin B. Winslett, Kevin L. Nix, Matthew R. Coffin and James R. Norton) took over the third floor of the Bay County jail seizing four hostages (Correctional Officer James C. Hall, Nurse Ann (Amy) M. Hunt, Nurse Glena L. Baker, and Nurse Kathleen L. Baucum).

All four inmates were housed in either single or double bunked cells in the ten bed (eight cells designated as C-1 through C-8) segregation/lockdown housing pod on the third floor of the jail. All of the cells and beds were occupied. Two of the inmates were awaiting adjudication of their charges and two were convicted felons awaiting movement to state prison.

Three of the hostages were employed by CCA with the fourth being a contract registry nurse assigned to CCA. The officer was a state certified correctional officer (certified in November 2001) who had been employed at the jail since June 22, 2004. Previously he had worked as a correctional officer at Bay CI for CCA (December 10, 2001-Janruary 26, 2004). The two CCA nurses had worked at the jail and/or annex in excess of one year. The registry nurse had just reported for her first shift of work at the jail.

Three of the four hostages were released through-out the twelve hour standoff and negotiations. Ultimately, the BCSO SWAT team had to use lethal force to gain the release of the fourth hostage and to recover control of the third floor of the jail. The hostage and two of the four inmates were injured.

The FDLE took the initial investigative lead and focused solely on making a determination of the appropriateness of the officer involved shootings by the BCSO. The BCSO is completing their criminal investigation relative to the acts of inmates and other parties.

CHRONOLOGY OF EVENTS PRIOR TO TAKEOVER

This chronology of events was developed from information in the interviews between the FDLE and the BCSO investigators and Nurse Baucum (conducted September 9, 2004), Nurse Hunt (conducted September 10, 2004) and Correctional Officer Hall (conducted November 22, 2004 well after the date the FDLE submitted their investigative report to the States Attorney for review). The latter interview was not part of the FDLE report since it did not focus on any issues relevant to the BCSO use of force. Personal interviews were not conducted with these individuals so as not to interfere with the law enforcement investigations being conducted by the FDLE and the BCSO.

The chronology is not time based, but provides insight into how the lockdown inmates were able to takeover the third floor and seize the four hostages.

>>Correctional Officer Hall reported to work on the third floor at approximately 1400 hours.

>>First medication pass is completed without incident. Nurse Baker left medication cart in hallway and both Officer Hall and Nurse Baker go into the housing pod day room. The nurse passed medication through the food slot in the cell doors.

>>Officer Hall allowed lockdown inmate Nix out of his cell through the day room and out into the hall because the inmate wanted to talk to him. The officer said he did this because he thought the inmate had something important to say to him. The inmate wanted the officer to get him some pizza.

>>According to Officer Hall, Inmate Nix, while unrestrained in the hall way, started messing or playing with the unlocked outside cell door lock control box and opened at least one cell door.

>>Nurse Hunt observed Nix in the third floor hallway "popping doors" when she reported for work at approximately 1800 hours.

>>Officer Hall told Inmate Nix to move away from the lock control box and to return to his cell.

>>Officer Hall said the lock indicator lights never worked and was very vague about what the lights meant relative to the lock position of the doors. He stated he relied on whether or not the switch was in the closed or open position to tell door lock status

>>Officer Hall said he thought Nix had opened and closed the door of cell C-5 (Pierce). Officer Hall also stated Inmate Norton (C-1) did not come out of this cell and that the door only moved a little and stopped. The Officer believed all cell doors were in closed position.

>>Inmates Winslett and Norton told Officer Hall they wanted to be let out of their cells into the day room for their one hour out of cell time.

>>Officer Hall returned to the lock control box, opened it and opened three cell doors (C-1 Norton/Brown, C-3 Nix, and C-8 Winslett) letting them into the day room at the same time.

>>Officer Hall said he has done this on prior occasions and was aware it was in violation of CCA policy.

>>Officer Hall locked the sally port door, hallway door and the lock control box door while the inmates were in the day room.

>>Assistant Shift Supervisor Pointer arrived on the floor and Officer Hall yelled for the inmates to go back into their cells before the supervisor sees them out.

>>Officer Hall said that he did not realize when the inmates closed their cell doors with the switch in the open position the doors would not lock.

>>Officer Hall does not remember putting the cell door lock positions back into the closed position.

>>Nurse Baker returned to pass medications and Officer Hall opened the hall way and sally port doors. Officer Hall said when he opened the lock control box he did not check the open/closed status of the cell doors.

>>The Nurse Baker passed medication into cell C-1 (assigned to Inmates Norton and Brown) and noticed door slightly open but said she was not aware of what it meant.

>>Inmate Pierce (C-5) did not come to his door for his medication and Officer Hall returned to the hall way and opened the inmate's cell door so he could go in and wake him up (inside sally port door, outside hallway door and lock control box door were open).

>>Officer Hall said when he went to wake up Inmate Pierce Inmate Norton came up behind him and scared him. He said his radio fell from his pocket when Norton struck and knocked him to one knee. Officer Hall said he was not knocked unconscious as he previously had reported to law enforcement.

>>Officer Hall said when he stood up Inmate Norton had his radio and that Inmates Nix, Winslett and Coffin were with him. Inmates Coffin and Norton also had home made weapons.

>>Officer Hall said the inmates cut his shirt by pulling it from his body just prior to releasing him during the negotiations.

INCIDENT TIME LINE

Detailed timelines are presented in the CCA incident report and the FDLE officer involved shootings investigative report. Listed below are excerpts from those timelines to highlight key events relevant to this administrative review. All times are approximate.

September 5, 2004

1940>>CCA Shift Supervisor Brown discovers inmates loose on the third floor while making his security rounds. He returned to the staff elevator and radioed the control room to turn off the elevators to restrict inmate access to third floor. The notification of CCA management and BCSO was initiated.

2000>>CCA Facility Administrator notified.

2020>>Facility Administrator assumed role of Incident Manager and trained BCSO negotiators arrived onsite.

2030>>CCA SORT teams from the jail/annex and Bay CI were notified as was the BCSO SWAT team. CCA Bay CI Warden arrived and eventually took over as Incident Manager from the jail Facility Administrator.

2102>>Inmate demands started

2103>>SORT team arrived

2120>>CCA Corporate notified

2125>>Contract Monitor notified

2220>>Correctional Officer Hall released in exchange for cigarettes and pizza

2346>>All hostage families notified

September 6, 2004

0006>>Sick inmate and Registry Nurse Baker released

0322>>CCA Nurse Baucum released

O358>>Breakfast food preparation begun

0536>>Master security count completed on all floors except the third

0553>>One inmate with health issues removed via the stairwell

0800>>Gunshots heard and SWAT team moved onto the floor

0804>>Injured CCA Nurse Hunt removed from floor and transported to hospital

0812>>Injured inmate removed from floor and transported to hospital

0815>>Injured inmate removed from floor and transported to hospital

0916>>CCA IM team reestablished

0928>>Third floor inmate count cleared by physically comparing each inmate to their quarter card photograph

0929>>FDLE secured crime scene and started interviews of inmates

1046>>Health care services reestablished on the first floor

1059>>Trustees allowed to return to work only under direct supervision

1250>>Doctor arrived to check medication, schedule and coverage

1740>>Third floor partially released by FDLE for cleanup

1900>>Third floor cleanup begun

2225>>Third floor cleanup reported 80% complete

<u>September 7, 2004</u>

0805>>Inventory of lost or damaged commissary items completed

0930>>Started releasing jail from lockdown

FINDINGS AND CORRECTIVE ACTIONS OR RECOMMENDATIONS

Violations of both CCA policies and procedures and the Florida Model Jail Standards were found to exist at the time the incident occurred. These violations resulted from a correctional officer not complying with written CCA policies and procedures and a posted instructive memo directing how the segregation/lockdown unit was to be managed. Listed below are specific findings and required corrective actions or recommendations for improvement.

(1) The third floor correctional officer opened the cell, sally port and the third floor hallway doors at the same time to allow a segregation/lockdown unrestrained inmate access to the outside third floor hallway. There was even a note on the floor inmate status board that explicitly directed that

this particular inmate was to always be in full restraint whenever out of the lockdown pod. This action was in violation of FMJS (11.12) which requires two certified correctional officers be present when a high risk inmate is moved in or out of a detention housing unit. CCA policy, which is compliant with this standard, requires a shift supervisor to be with the floor officer during such moves.

While the inmate was in the hallway he was allowed access to the pod's cell door control box and to open and close doors. This was confirmed by the officer's own interview statements and by those of a nurse who observed this when she reported to work on the third floor. This is in violation with FMJS 11.15 which essentially states inmates shall be prohibited from having control over another inmate.

The floor officer allowed up to at least four inmates access to the day room at the same time. This was in direct violation with an instructive policy memo stating procedures for managing the lockdown unit that was posted at the officer station and on the wall/window of the lock down unit. The officer in his own interview statements said he was not sure when the inmates went back into their cells whether or not he locked their doors. As many as four cell doors control switches could have been in the open position, even though the doors were closed, when he and the nurse entered the pod day room to pass inmate medications just prior to the take over.

In the officer's initial interview with law enforcement he stated he was knocked out. In his second interview he recanted this saying he was pushed/knocked to one knee, thereby being less than truthful with law enforcement, which is an act highly unacceptable for a state certified correctional officer.

Finally, in his own interview statements the third floor Correctional Officer repeatedly acknowledged his acts were in violation of CCA written policies.

Required Corrective Action: Take appropriate disciplinary action against the officer for multiple violations of CCA Policies, guidelines and instructive memos.

(2) The C-1 cell door either could be easily defeated by the inmates in the cell or was malfunctioning. This was repeatedly validated by officer and nurse interview statements, discussions with officers and nurses, a post duty log statement by a correctional officer on August 30, 2004 and on a maintenance log by another correctional officer on August 22, 2004. On the day of the incident the maintenance log entry concerning the door condition remained unclear or uncorrected by the CCA maintenance staff.

The two inmates in C-1 were well known for cell door "capping" (and act of placing something like, a tooth paste tube cap, in the door track as the door closes to prevent the door lock from fully engaging). This past behavior was clearly noted on the floor inmate status board posted at the officer station to constantly remind officers of the inmates past actions or behavior patterns.

Officers on prior shifts had successfully managed to work around the C-1 door condition by complying with CCA policies concerning inmate management on the floor and in the segregation/lockdown housing pod.

Required Corrective Action: All security related maintenance issues shall be corrected within twenty four hours or less or the housing area affected shall be rendered unoccupied until such time it is corrected. If overcrowding mandates use of the housing area, then extra correctional officers shall be assigned to the housing area to perform direct observation and control of the area.

(3) The procedures for managing the segregation/lockdown area were posted as an instructive memo on the wall/window of the housing pod. Critical policy elements of that procedure, such as only one cell can be opened at a time or only one resident (inmate) can be out of a cell at a time, were not documented in the correctional officers post orders for the third floor.

Required Corrective Action: Revise the fifth floor (segregation/lockdown unit has been relocated to this floor from the third floor) post orders (rev. December 1, 2004) to include appropriate elements of the lockdown procedures to be utilized by officers when managing inmates in the segregation/lockdown housing unit.

(4) Monitoring of staff/inmate activity on each floor is done by the Shift Supervisors or their assistants moving from floor to floor making observations from the floor gate or actually entering the floor and checking the housing pods.

Recommendation: Install video cameras on each floor and place monitors in the basement Shift Supervisor's office to augment the amount of direct monitoring of inmate/staff floor activity.

(5) Correctional officer staffing on the third floor the day of the incident was compliant with CCA policy and FMJS. However, it may not have been sufficient given the amount of overcrowding in the jail at that time. CCA policy required the use of Shift Supervisors or other floating utility correctional officers to deal with high risk inmate movement or other

special responses. Such back up becomes less readily available as the number of inmates to be managed in a facility increases. CCA has recognized this and has added an additional correctional officer on all floors that house high risk (maximum and some medium security level and all segregation/lockdown) inmates (floors 3 and 6) and not just on the fifth floor which was the policy at the time of the incident. Further, they have added one 24-7 security post to the medical area and post a second officer when sick call is being conducted.

Required Corrective Action: Maintain this level of correctional officer staffing and evaluate the need for similar correctional officer staffing at the annex should high risk inmates (male or female) be housed there.

(6) The segregation/lockdown unit has been located on the third floor for many years. That floor also performs three other jail processing functions in addition to inmate housing (i.e. commissary storage and distribution, inmate personal property storage and distribution, and provision of inmate health care services). The latter two processing functions require active involvement of the floor correctional officer in addition to their performing their lockdown housing pod and other housing pod duties. CCA has since relocated the segregation/lockdown area to a housing pod on the fifth floor which is a floor that is only responsible for housing inmates.

Required Corrective Action: Continue to locate the segregation/lockdown unit on a floor that only performs inmate housing, thereby allowing the floor officers to totally focus on the inmate housing management functions and not other jail processing functions.

The officer station should be located on the floor directly adjacent to the segregation/lockdown housing pod to enhance sight and sound observation of the unit. Further, ensure the annex continues to provide separate segregation/lockdown housing areas with dedicated correctional officers for those areas.

(7) Floor or post duty logs and maintenance logs are maintained by the floor correctional officers to document completion of their various duties, movement on the floor and maintenance issues that need to be addressed. When reviewing this documentation, for a 2-4 week time period prior to the incident, it was apparent that managers or supervisors are either not regularly reviewing the logs or if they are, they are not addressing the issues they document. As an example, a broken key and a missing flashlight were repetitively documented by different shift floor officers in the third floor post duty log for the entire time frame I reviewed.

Required Corrective Action: A member of management should review these logs and document in the log their review and any actions taken at least weekly. A supervisor should do the same on a daily basis.

(8) The quality of the documentation in the duty logs and the inmate segregation confinement records (to be updated every thirty minutes) was in many cases lax. As an example, in some cases it was impossible to determine if and when the inmate was receiving their required out of cell time or showers.

Recommendation: Conduct refresher training for all appropriate staff on how activity information is to be documented in the logs/records in a manner that can be used at some later date to prove something had or had not occurred. Also, specialized training should be developed for all officers assigned to the segregation/lockdown unit addressing the unique requirements for managing inmates housed there.

(9) The incident management team was immediately established per the CCA Emergency Response Procedures and Plan. All internal and external agency notifications were made per policy. Both the CCA Jail and Bay CI SORT teams were deployed in a timely manner to support the BCSO hostage negotiation and SWAT teams as well as to maintain the security and operation of the remainder of the jail facility. Jail operations including feeding and health care delivery were maintained throughout the take over and thereafter. The third floor was restored for use in less than two days and full jail operations in a non-lockdown mode in less than a week.

Recommendation: Continue to conduct incident management team response exercises and training and expand the scope of the exercises to include a variety of incident scenarios of this magnitude. Also, consider large scale incident scenarios that may be weather related such as loss of total power on a floor or to the entire facility.

(10) The crippling elements of the proverbial "Correctional Code of Silence" appears to be more pervasive in the jail among the correctional officers, health care and support staff and their superiors. This was evidenced when the nurse observed the inmate unrestrained in the third floor hallway popping doors and she did not immediately notify the Shift Supervisor. Also most of the staff I had discussions with were concerned about being identified if they shared issues or concerns with me.

Recommendation: CCA management should issue a strong statement to all staff stating their position against the "Code of Silence" and that any acts of retaliation or reprisal will not be tolerated against any staff who make managers or supervisors, both within or outside their chain of

command, aware of any problems, staff errors or performance deficiencies.

I follow-up and address any and all issues CCA personnel share with me. If they want me not to know their identity, they can leave their issue in written form in my internal locked mail box on the first floor or verbally on my voice mail. Relocation of the mail box to an area more accessible to all staff should be considered.

Documentation supporting this review is on file in my office. If you have any additional questions or require additional information please contact me at your earliest convenience. Upon your approval a copy of this review will be sent to the CCA Facility Administrator with a time line to implement the required corrective actions.

CC: Ann Cahall