JLARC
JOINT LEGISLATIVE AUDIT AND REVIEW COMMISSION

September 16, 2019

State Oversight of Local and Regional Jails

Commission Briefing

JLARC reviewed the state's jail oversight to address part of the OSIG study resolution

- OSIG study resolution included two items related to whether OSIG should have expanded authority for jail oversight
- JLARC found no compelling reason to recommend expanding OSIG's jail oversight role
- JLARC is reporting the results of its review of state jail oversight separately from its OSIG report

JLARC study resolution, authorized October 10, 2017. Resolution's primary directive regarding OSIG performance is addressed in a separate JLARC report, *Operation and Performance of the Office of the State Inspector General.*

Research activities

Observation and analysis of Board of Corrections (BOC) meetings

- Four BOC closed sessions (April–July 2019)

Structured interviews

- BOC members
- DOC staff
- Other state agencies, stakeholders, national experts

Analysis of BOC death review process and reports and DOC jail inspection process and files

In brief

BOC and DOC have the independence, expertise, and authority to oversee local and regional jails. There is no compelling reason to transfer this responsibility to OSIG.

DOC's jail inspections are fairly comprehensive but could more rigorously assess compliance with the most critical standards.

BOC's death review process is improving but additional policies and better staff support are needed.

Inspection and death review processes have operated separately and should be integrated into a cohesive jail oversight program.

BOC - Board of Corrections; DOC - Department of Corrections

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Background

Organizations granted jail oversight responsibility

Inspections of jails

Reviews when an inmate dies in jail custody

State jail oversight program

State and local jails house a challenging population in a difficult environment

- Frequent turnover of inmates
  - Average inmate stay is 17 days
- Jails sometimes have little information about inmates, and inmates sometimes have complex needs
  - Jails may initially know little about an inmate's medical history
  - ≈ 20 percent may have a mental illness

BOC and DOC oversee Virginia's 59 jails through standards and inspections

- Jails must comply with 128 standards set by BOC
  - 43 high-priority standards on life, health, & safety
- DOC verifies compliance with standards through inspections and audits
  - Inspections of 43 high-priority standards every year
  - Audits of all 128 standards every three years

BOC was given new responsibility in 2017 to review all jail inmate deaths

- For each death, BOC must determine whether the jail
  - was in compliance with BOC standards
  - directly or indirectly contributed to the death
- Circumstances of death summarized in written report by BOC investigator
- BOC has a Jail Review Committee that now meets monthly in closed meetings to discuss cases
- BOC employs one part-time investigator and one policy analyst

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Finding

BOC and DOC are appropriate governmental bodies to set jail standards, conduct jail inspections, and review inmate deaths.

BOC and DOC are appropriate governmental bodies to oversee jails in Virginia

Assessment criteria	JLARC assessment
Sufficient independence to reach objective conclusions	●
Expertise to understand & assess jail operations	●
Full access to jail facilities, records, and staff	●
Authority to change standards, impose penalties	●
Unique, non-duplicative oversight role	◐

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DOC jail inspections are fairly comprehensive but could be more rigorous and used to support jail compliance and strengthen state standards.

DOC inspects local and regional jails annually in a fairly comprehensive manner

- All required inspections and audits were conducted in 2016–18
  - About half of inspections and audits find some violations of standards
  - Jails implement a correction action plan when DOC finds violations
- Jail inspectors use multiple inspection methods and are consistent across jails and over time

Compliance with critical life, health, and safety standards could be assessed more rigorously

Jail standard	Current inspection method	Potential, more rigorous inspection method
Observation rounds twice/hour	Review logbooks	Review video footage when available
24-hour emergency health care	Verify written policy in place	Review sample of inmate health requests
Suicide prevention & intervention plan	Obtain documentation that plan was reviewed	Interview selected staff about plan

Option

BOC and DOC could identify critical life, health, or safety standards to be assessed using more rigorous inspection methods.

Inspection results are not always used to support jail compliance or strengthen state standards

- One of the goals of inspections is to detect problems and make improvements
  - Inspectors should "detect systemic problems affecting prisoners … and make recommendations for improvement … the inspection body's work is intended to be preventive in nature" – Standards for the Treatment of Prisoners, American Bar Association
- BOC and DOC do not systematically use inspection findings to support broad improvements among jails
  - Not using inspection results systematically to identify common problems across jails that need to be addressed

Recommendation

Jail inspection staff should summarize jail audit and inspection results and report this information annually to BOC.

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Death rates in Virginia jails are similar to national average

- About 50 to 60 inmates die in the custody of a Virginia jail each year
- Virginia's jail death rate is similar to the national average
  - Virginia = 0.16%
  - National = 0.14%

Deciding whether a jail's action (or inaction) contributed to the death of an inmate is complex

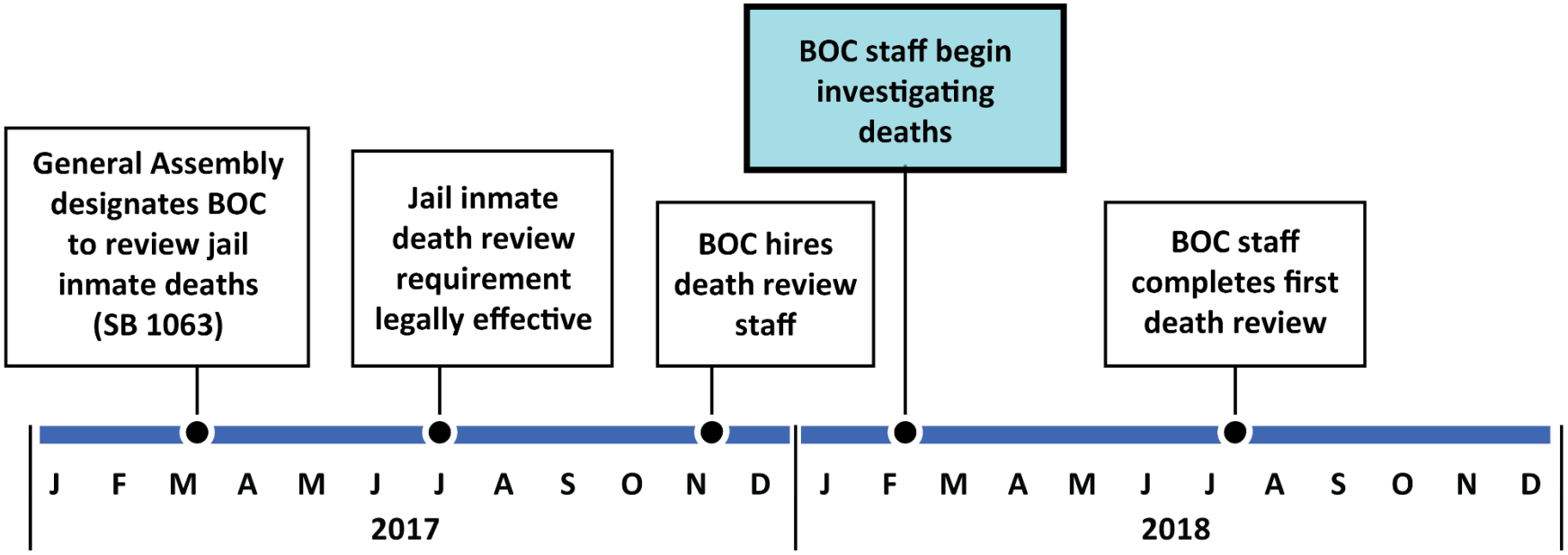
- It can be difficult to determine after the fact whether actions or negligence of a jail contributed to an inmate's death
- Inmates die for many reasons, including
  - Natural causes
  - Suicide
  - Accidents

Findings

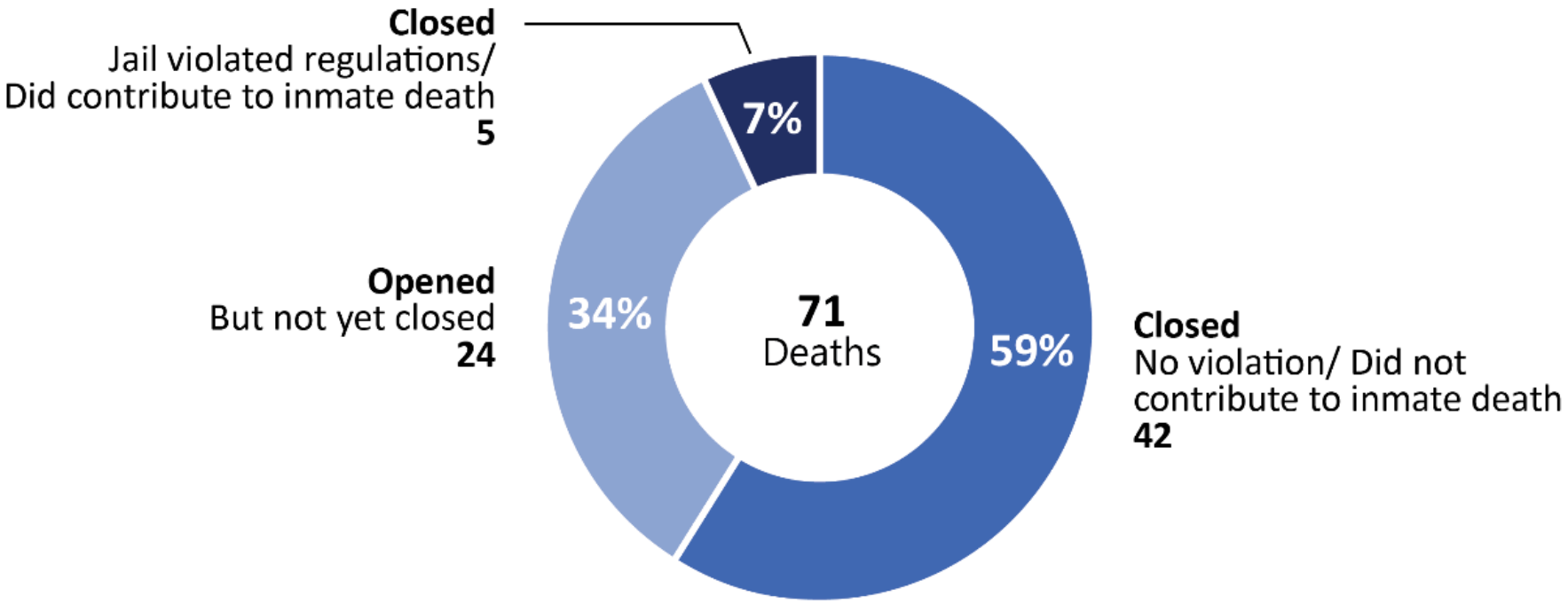
BOC's newly assigned death review process is still evolving but is becoming more effective.

BOC members are informed, engaged, and thoughtfully make decisions.

BOC has reviewed jail deaths since only 2018



As of July 2019, BOC concluded a jail violated standards and contributed to 5 inmate deaths (FY17,18)



BOC members are engaged and make thoughtful decisions about death reviews

- Members engage in robust, in-depth reviews of cases.*
  - Nearly all members participate in every case discussed.
  - Some discussions last several hours.
- Members actively seek to understand the circumstances of the death.
  - Actions taken or not taken by jail staff and contractors
  - Typical jail operations

* Based on JLARC observations of closed BOC sessions in spring and summer 2019.

Findings

BOC is having difficulty closing a backlog of death review cases.

BOC has been using closed session meetings to discuss death review cases, but it releases very little summary information to the public.

BOC not investigating and closing death reviews as efficiently as possible

- Completion of cases has been delayed until additional information can be gathered
  - Investigators do not always report fully useful information about inmate medical conditions, treatments, or medications
  - BOC members do not receive report until meeting when case is discussed
- Reviews take average of 10 months to complete
- BOC has been unable to eliminate its backlog of 24 open death reviews (as of July 2019)

Recommendations

BOC should

- develop guidance listing minimum information needed in investigative reports
- ensure at least one staff member receives training on common medical conditions & treatment protocols
- send death investigation reports to BOC members before each meeting
- reduce its backlog of open reviews by employing at least one full-time investigator, hiring a temporary investigator, and improving staff efficiency

In contrast with other similar entities, BOC releases minimal information to the public

- Board announces its findings in a public meeting
  - Indicates whether standards were violated and/or the jail otherwise contributed to the inmate's death
  - Submits conclusion to the governor and legislative leadership
- Virginia entities responsible for investigating other types of deaths release annual summary reports to the public

BOC uses general FOIA exemptions to close meetings about death reviews to the public

- Board typically uses either general health information or legal advice exemption to enter closed session
  - It could also be beneficial for the board to discuss other information (such as jail staff actions) in closed session
- Other Virginia entities that review deaths have specific FOIA exemptions

Recommendations

The General Assembly may wish to require BOC to make publically available an annual report summarizing death review results and potential policy changes to reduce inmate deaths.

BOC should work with the Virginia Freedom of Information Advisory Council to balance (i) the need to protect sensitive information and encourage full board discussions with (ii) the need to ensure public access.

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Finding

Jail inspections and death reviews are not part of a cohesive jail oversight program.

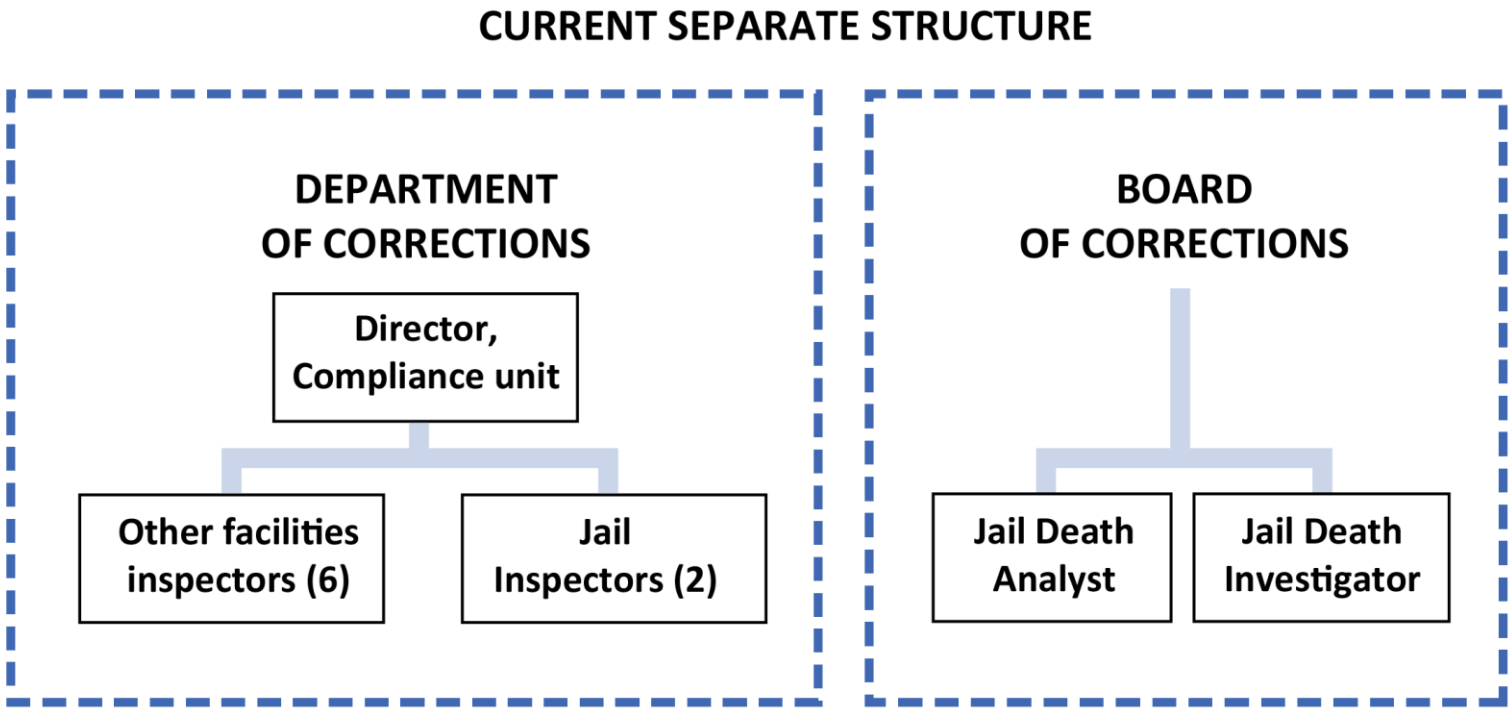
Effective jail oversight program requires coordinated oversight activities

- Ideally, jail inspections and death reviews should be coordinated as part of a jail oversight program
- Inspection results should inform the death review process
- Subsequent inspections should specifically address standards found to be violated during prior death reviews
- Standards found to be violated during a death review should be reviewed to decide whether
  - the standard needs to be changed or clarified
  - jails could benefit from additional guidance or technical assistance

Jail inspections and death reviews operate as separate processes

- Several jails found in violation of standards through death reviews but found in compliance by inspections
  - Death reviews use more in-depth approach to assessing compliance.
- Inspections and death reviews both assess compliance with standards.
  - Little information shared between inspections and death review staff.

Jail oversight staff are segmented across DOC and BOC



Strengthened administrative structure for BOC would improve jail oversight

- Other boards employ a director and a small staff to support citizen members
  - Compensation Board
  - Board of Workforce Development
- Strengthened administrative structure
  - Director of jail oversight position
  - Inspections and death review staff report to director and BOC

Recommendations

The General Assembly may wish to

- transfer jail inspection staff from DOC to BOC
- give BOC authority and funding to hire a director of state jail oversight

Board of Corrections name is misleading and should be changed

- BOC no longer has statutory responsibilities for oversight of DOC operations or state prisons
- BOC's main responsibilities are now related to local and regional jails
- Current name of BOC creates confusion

Recommendation

The General Assembly may wish to rename the BOC to more accurately reflect its primary responsibilities for oversight of local and regional jails.

Key findings

BOC and DOC have the independence, expertise, and authority to oversee local and regional jails. There is no compelling reason to transfer this responsibility to OSIG.

DOC's jail inspections are fairly comprehensive but could more rigorously assess compliance with the most critical standards.

BOC's death review process is improving but additional policies and better staff support are needed.

Inspection and death review processes have operated separately and should be integrated into a cohesive jail oversight program.

JLARC staff for this report

Justin Brown, Associate Director

Jamie Bitz, Project Leader

Sarah Berday-Sacks, Senior Legislative Analyst