

Report to the Governor and the General Assembly of Virginia

# State Oversight of Local and Regional Jails

2019



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# Summary: State Oversight of Local and Regional Jails

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## WHAT WE FOUND

### **Board and Department of Corrections have the right expertise and independence for oversight of state jails**

There is no compelling reason to transfer the state's jail oversight responsibilities from the Board of Corrections (BOC) and Department of Corrections (DOC) to the Office of the State Inspector General. BOC and DOC are sufficiently independent from local and regional jail operations to conduct effective oversight. The General Assembly's recent decision to grant BOC responsibility to review deaths in jails was a prudent step to improve state oversight of jail operations.

### **DOC's jail inspections are fairly comprehensive but could be more rigorous and useful**

DOC conducts timely and comprehensive inspections of regional and local jails to assess compliance with state standards that have been developed by BOC. Inspectors use standardized, consistent processes and ensure that jails correct any violations. However, inspectors could use more rigorous methods to assess compliance with the most critical standards, such as those related to life, health, and safety. Additionally, inspection results are not used in a strategic way to improve jail operations overall. For example, DOC does not proactively disseminate best practices to jails to support their compliance with the most frequently violated standards.

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

BOC's new responsibility to review all deaths of jail inmates strengthens the state's oversight of jail operations. While other entities review jail deaths, no entity reviewed each jail death nor assessed jails' compliance with the state standards after an inmate died until the General Assembly gave BOC the responsibility to conduct death reviews.

BOC's policies and processes for death reviews are still evolving, which is reasonable for a new responsibility. Board members conduct detailed and thoughtful reviews of each death, and as a group possess the needed expertise to conduct effective reviews. However, the death review reports from investigators do not always contain all the

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#### WHY WE DID THIS STUDY

In 2018 the Joint Legislative Audit and Review Commission (JLARC) directed its staff to study the Office of the State Inspector General (OSIG), including its role and authority in inspecting and investigating incidents in jails.

#### ABOUT JAIL OVERSIGHT

There are 59 local and regional jails in Virginia. The Board of Corrections establishes mandatory standards for jails and reviews inmate deaths, and the Department of Corrections inspects jails. OSIG is responsible for oversight of the Department of Behavioral Health and Developmental Services broadly, which includes any services in that agency's jurisdiction provided to jail inmates. Other agencies have responsibilities related to jails, but are not a focus of this report.

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information required to determine whether a jail contributed to an inmate's death or whether the jail was in compliance with state standards. Investigative staff also have had difficulty reducing a backlog of death review cases.

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

Jail inspections and death reviews have been conducted as two separate processes, despite sharing the same purpose of assessing jail compliance with the state's standards. DOC employs two staff who inspect jails on behalf of the BOC, while death reviews are conducted by two BOC staff. This separation hinders the effectiveness of the state's overall oversight of jails. For example, staff who conduct death reviews and inspections sometimes interpret the same standard in substantially different ways. In addition, problems found during death reviews could be used to target technical assistance to jails and strengthen jail standards. Virginia's jails oversight would be strengthened by integrating DOC jails inspection staff and death review staff under BOC.

## **WHAT WE RECOMMEND**

### **Legislative action**

- Authorize and fund a director of state jail oversight position reporting to the Board of Corrections
- Authorize the transfer of current Department of Corrections jail inspection staff to the Board of Corrections

### **Executive action**

- Develop an annual report that summarizes jail audit and inspection results to identify potential improvement in jail operations around the state.
- Develop more detailed guidance governing the information investigators should include in death investigation reports.
- Improve death investigation staff capacity, efficiency, and expertise.

The complete list of recommendations is available on page iii.

# Recommendations: State Oversight of Local and Regional Jails

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## RECOMMENDATION 1

State staff who inspect jails should summarize jail audit and inspection results and report this information annually to the Board of Corrections. The report should include (i) the frequency of violations of each jail standard as determined during inspections and audits; (ii) recommendations for training or other activities that would improve jail compliance with commonly violated standards; and (iii) any recommendations for changes to standards. (Chapter 3)

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## RECOMMENDATION 2

The General Assembly may wish to consider amending § 53.1-5.5 of the Code of Virginia to require the Board of Corrections to annually develop and make publically available a report summarizing death review results, notable trends across death reviews, and potential policy changes that would help reduce the number of inmates that die in jail custody. (Chapter 3)

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## RECOMMENDATION 3

The Board of Corrections (BOC) should work with the Virginia Freedom of Information Act (FOIA) Advisory Council to examine whether and how FOIA should be amended to clarify or expand the circumstances in which the BOC may conduct closed meetings to consider jail death review cases. (Chapter 3)

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## RECOMMENDATION 4

The Board of Corrections should reduce its backlog of open death reviews through a combination of (i) employing at least one full time investigator; (ii) temporarily adding another investigator until the backlog is reduced; and (iii) improving the efficiency of its investigators through training, process improvements, or job reassignment. (Chapter 3)

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## RECOMMENDATION 5

The Board of Corrections should develop written guidance listing the minimum information required in death investigation reports. (Chapter 3)

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## RECOMMENDATION 6

The Board of Corrections should ensure that at least one of its staff receive training on the medical conditions, treatment protocols, and medications most commonly necessary to understand when reviewing jail inmate deaths. (Chapter 3)

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#### **RECOMMENDATION 7**

The Board of Corrections should require jail death investigators to transmit the investigation report to board members on a designated date before the meeting for which the case is scheduled and give members the opportunity to request additional information from the investigators before the meeting. (Chapter 3)

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#### **RECOMMENDATION 8**

The General Assembly may wish to consider including language in the Appropriation Act transferring current Department of Corrections jail inspection staff positions—and the funding to employ them—to the Board of Corrections. (Chapter 4)

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#### **RECOMMENDATION 9**

The General Assembly may wish to consider amending § 53.1 of the Code of Virginia to grant the Board of Corrections authority to hire a director of state jail oversight to manage its jail inspection and jail inmate death reviews as part of a cohesive state jail oversight program. (Chapter 4)

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#### **RECOMMENDATION 10**

The General Assembly may wish to consider including language and adequate funding in the Appropriation Act to fund a director of state jail oversight position reporting to the Board of Corrections. (Chapter 4)

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#### **RECOMMENDATION 11**

The Department of Corrections (DOC) and Board of Corrections (BOC) should develop and agree to a memorandum of understanding clarifying the administrative support that DOC will provide to BOC for the state's jail oversight program. (Chapter 4)

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#### **RECOMMENDATION 12**

The General Assembly may wish to consider amending § 53.1 of the Code of Virginia, and other sections as necessary, to rename the Board of Corrections to more accurately reflect its primary responsibilities for oversight of local and regional jails. (Chapter 4)

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# 1 Overview of Local and Regional Jails

**SUMMARY** Virginia’s 59 jails are operated by localities and regional authorities but are subject to state oversight. Jails vary widely in the size of their inmate population, available resources, and services provided. Jails are responsible for ensuring safety and security and providing adequate health care to inmates. However, jails face significant challenges to meet these responsibilities, including the fact that many inmates have complex medical needs and mental illness or substance use disorders. The Department of Corrections annually inspects all jails and conducts audits every three years to ensure jails meet standards developed by the Board of Corrections. The Board of Corrections establishes these mandatory standards for jail operations and reviews the deaths of all jail inmates, a new responsibility required by the General Assembly beginning in FY18.

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This report is a companion to the JLARC report *Operation and Performance of the Office of the State Inspector General* (OSIG). The study mandate for the review of OSIG directed JLARC staff to evaluate OSIG’s “role and authority in inspecting jails” and “role and authority in investigating incidents in jails.” OSIG authority over local and regional jails is currently limited to services provided or regulated by the Department of Behavioral Health and Developmental Services (DBHDS). For example, OSIG could investigate a specific complaint about a DBHDS-licensed provider serving an inmate, or conduct a broad evaluation of those services. OSIG does not appear to have authority over any other aspect of jails.

JLARC’s review of OSIG found no compelling reason to recommend expanding OSIG’s role in jail oversight. This conclusion was based on the review of OSIG itself but also review of the state’s current oversight of jails, which is discussed in this report.

There are 59 local and regional jails in Virginia. These facilities include 37 local jails that serve a particular city or county. These jails are the responsibility of sheriffs, elected officials who also typically are responsible for law enforcement, court security, and other duties. In addition, there are 22 regional jails in Virginia, which can either replace or supplement a local jail. Regional jails are operated by a superintendent under the authority of a board consisting of sheriffs and local government representatives from member localities.

Virginia jails differ vastly in their size, resources, and operations. The average daily population of jails in FY17 ranged from 26 inmates in Lancaster County to 1,930 inmates in Southwest Virginia Regional Jail (across its four locations). A jail’s size and location typically influence the way it provides required services. For example, a small

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**BOC has the authority to request OSIG assistance with jail death reviews, but it has not found the need to use this authority.** Under statute, BOC can request that OSIG review the operations of entities other than jails, such as providers licensed by state agencies.

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rural jail may employ a doctor to visit the jail twice weekly, while a large urban jail may employ dozens of medical staff to care for inmates.

## **Jails house a vulnerable population in a challenging environment**

Local and regional jails are legally responsible for maintaining security, safety, and the health of inmates. Jails' primary functions include:

- conducting intake of new inmates and classifying them based on the threat they pose and level of security required;
- ensuring that jail inmates do not escape while in custody;
- maintaining a safe and secure environment for inmates and jail staff;
- providing basic living necessities to inmates, such as food and medications; and
- providing health care directly or through contractors.

One major challenge for jails is the frequent turnover of inmates, which is much higher than state prisons. The average stay of a jail inmate in Virginia is 17 days, compared with six years for state prison inmates. Jail inmates include those awaiting trial, awaiting sentencing, or serving sentences.

In addition, jails sometimes have little information about inmates' health history when they arrive. At intake, jail staff often are limited to inmates' self-reported medical and mental health history, with few or no medical records. New inmates may not disclose serious health conditions, particularly when they have behavioral health or substance use disorders.

Jail inmates often have complex medical needs and tend to be less healthy than the general population. Some inmates have serious health problems, including chronic medical conditions that have not been adequately treated. Other inmates have serious behavioral health conditions, including both mental illness and substance use disorder. The state's annual survey of jails found that, as of June 2018, approximately 20 percent of jail inmates were known or suspected to be mentally ill—likely an undercount given the difficulty of estimating the prevalence of mental illness in a correctional setting. In addition, some inmates enter a jail while undergoing detoxification from alcohol or drugs, such as opioids and heroin.

## **State conducts jails oversight through inspections, audits, and death reviews**

The state has a strong interest in helping to ensure that regional and local jails operate efficiently and effectively. As in most states, Virginia jails are a function of local governments. However, in 2018, one-quarter of all inmates in local and regional jails were

state inmates. The Department of Corrections (DOC) uses jails to house state inmates serving a sentence of less than 12 months or awaiting transfer to a state prison. The state provides more than one-third of all regional and local jail funding, totaling more than \$350 million.

## **Board of Corrections sets jail standards and Department of Corrections conducts jail inspections**

For more than 20 years, Virginia has required local and regional jails to comply with state standards developed by the Board of Corrections (BOC). Statute requires the BOC to develop standards for the “construction, equipment, administration, and operation” of jails, giving the BOC significant discretion over the nature and rigor of standards. The BOC has developed 128 standards, including 43 standards classified as high-priority for ensuring the life, health, and safety of inmates. Statute requires annual inspections of all jails to assess their compliance with state standards. BOC consists of nine members who are appointed by the governor (sidebar).

DOC is primarily responsible for operating state prisons but also is responsible for conducting jail inspections on BOC’s behalf. Two DOC inspectors conduct inspections and audits to ensure jails meet the standards developed by BOC. The inspectors conduct annual inspections of jails’ compliance with the 43 high-priority standards governing life, health, and safety. Every three years these inspectors also complete more in-depth inspections, called audits, to determine each jail’s compliance with all 128 standards. If the inspectors identify violations of the standards, they require corrective action plans by the jails. Based on jail compliance with standards, BOC determines whether jails receive full certification or probationary certification. If BOC chooses to decertify a jail, the jail cannot legally operate.

## **State expanded jail oversight by giving BOC responsibility to investigate deaths of jail inmates**

The BOC is also now responsible for reviewing all inmate deaths in local and regional jails. In response to the death of Jamycheal Mitchell, an inmate at the Hampton Roads Regional Jail (sidebar), the 2017 General Assembly passed legislation giving BOC the authority to investigate all deaths in Virginia jails. Code requires the BOC to determine

- the circumstances surrounding the death of an inmate, including whether the jail directly or indirectly contributed to the death, and
- whether the facility was in compliance with state standards for jails.

To assist BOC with its new responsibility of reviewing inmate deaths, the General Assembly authorized the board to create two staff positions. BOC now employs a part-time investigator and a full-time policy analyst.

Virginia appears to be one of only a few states that require state-level reviews of jail inmate deaths (sidebar). In its reports about death reviews, statute also gives the BOC

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In addition to jails, **BOC also has oversight of** community residential programs (e.g., halfway houses). BOC does not have oversight of state prisons or of the state Department of Corrections.

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In 2015, the **death of Jamycheal Mitchell** resulted in substantial legislative and public concern. Mitchell died in his cell after a period of physical deterioration and heightening psychotic symptoms. His family sued the state, jail, and jail’s health-care contractor, which resulted in a \$3 million settlement.

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**Other states also inspect jails, but it is rare for states to investigate inmate deaths.** Many states set jail standards and conduct inspections. JLARC found only three states, though, that investigate deaths: Tennessee, New Jersey (only suicides), and North Carolina.

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authority to recommend changes to state standards for jails in order to “prevent problems, abuses, and deficiencies in and improve the effectiveness” of jails.

### **Jails are also subject to oversight by other agencies**

In addition to BOC and DOC oversight, Virginia jails also are overseen by other agencies. For example, the Virginia Department of Criminal Justice Services develops mandatory minimum training requirements for jail officers. Local fire departments, or the State Fire Marshal’s Office, conduct annual fire safety inspections. Jail administrators and staff also can be prosecuted for potential crimes, such as falsifying legal records or abuse of incapacitated adults.

While rare, federal investigations can occur when a jail has allegedly violated inmates’ constitutional rights, the Civil Rights of Institutionalized Persons Act, or the Americans with Disabilities Act. The U.S. Department of Justice investigation into Hampton Roads Regional Jail was prompted by the death of Jamycheal Mitchell and several other inmates. The investigation concluded that the jail violated the constitutional rights of inmates by failing to provide adequate medical and mental health care and that the jail’s treatment of inmates with mental health disorders violated the Americans with Disabilities Act.

## 2 BOC and DOC Oversight Authority of Jails

**SUMMARY** The Board of Corrections (BOC) and Department of Corrections (DOC) are the appropriate governmental bodies to oversee jails in Virginia. BOC and DOC have sufficient independence from jail operations and are state-funded. In addition, BOC and DOC hold statutory authority to access jail facilities and records and have the necessary expertise for jail oversight. It is strategically sound for BOC, which is responsible for developing jail standards, to also assess whether jails are complying with those standards through inspections and reviews of inmate deaths at jails. While several agencies may investigate the death of a jail inmate, BOC is the only agency that reviews all deaths of jail inmates.

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In order to assess whether OSIG should have a greater role in jail oversight, JLARC reviewed the suitability of the Board of Corrections (BOC) and Department of Corrections (DOC) to conduct jail oversight for the state. Jail oversight authorities need sufficient independence from jail operations to reach objective conclusions. In addition to independence, jail oversight authorities need sufficient knowledge of jail operations and must have access to jail facilities, records, staff, and even inmates when necessary. Ideally, the entity also should have the authority to improve standards as necessary and impose and enforce penalties (or provide assistance) when it concludes standards are not being met. In addition, the oversight entity should not impose any undue burden on jails by duplicating oversight conducted by other entities.

Collectively, BOC and DOC generally meet these criteria and are therefore suitable agencies for regional and local jail oversight (Table 2-1).

**TABLE 2-1**  
**BOC and DOC meet JLARC criteria for being suitable state oversight entities**

<b>Assessment criteria</b>	<b>JLARC assessment</b>
Sufficient independence to reach objective conclusions	●
Adequate expertise to understand and assess jail operations	●
Full access to jail facilities, records, and staff	●
Authority to change standards and impose penalties when necessary	●
Unique, non-duplicative oversight role	◐

SOURCE: JLARC.

## BOC has sufficient independence and adequate expertise

BOC has the independence needed to reach objective conclusions about jail operations. BOC is a state entity that is separate from the localities and regional authorities operating jails. The BOC's members are appointed by the governor and confirmed by the General Assembly. This separation from jail operations allows BOC to conclude, when necessary, that jails need to improve without pressure to downplay or withhold its conclusions.

BOC also is sufficiently insulated from the financial implications of its conclusions. The General Assembly appropriates state funds for jails, and the state Compensation Board allocates state funding to jails, which total about one-third of all jail funding.

Collectively, BOC's board members have the expertise necessary to understand and oversee jail operations. In 2017, as part of the legislation giving BOC responsibility to conduct reviews of jail inmate deaths, the General Assembly established new board requirements to ensure its members had a wide range of experience and skills useful for jail oversight. For example, the board must include a physician and a former sheriff or other manager of a state or local correctional facility (Table 2-2). This expertise is vital to overseeing jails' complex, challenging environments.

**TABLE 2-2**  
**BOC members collectively possess necessary expertise for jail oversight**

Expertise	Members on board	Membership requirement (§ 53.1-2)
Correctional operations	1	Former sheriff or former warden, superintendent, administrator, or operations manager of a state or local correctional facility
Investigative	2	Experience conducting criminal, civil, or death investigations
General medical	1	Physician licensed in the Commonwealth
Mental health	1	Employed by a public mental health services agency (or other experience with mentally ill individuals in the criminal justice system)
Financial	1	Experience in financial management or auditing
Legal	1	Experience overseeing a correctional facility's or mental health facility's compliance with applicable laws, rules, and regulations

SOURCE: JLARC interpretation of § 53.1-2 of the Code of Virginia.

NOTE: BOC is composed of nine members, seven of whom must have specific types of experiences.

## BOC and DOC have sufficient access and authority to conduct oversight

BOC appears to have sufficient access to jails to conduct its oversight. DOC inspections staff, who conduct inspections for BOC, reported a positive working relationships with jails. A JLARC review of staff inspection reports noted inspections staff

have full access to jail facilities and records and routinely interview jail staff and inmates.

BOC has sufficient authority over jails through its ability to set standards and respond when it finds jails out of compliance. BOC can use inspections, death reviews, or other means to determine jail compliance with its standards. The board has the authority needed to obtain information about jails, including the ability to conduct formal hearings about jail operations and issue subpoenas to jail staff or other relevant individuals to attend hearings or provide records. BOC has the authority to take disciplinary actions against jails, including requiring more frequent inspections, limiting the number of inmates in a jail, and withholding the salary of a sheriff or jail superintendent. BOC also has the legal authority to ask a circuit court for an injunction to compel compliance when necessary.

## **BOC is the only entity reviewing all jail inmate deaths in Virginia**

Jails are subject to oversight by agencies at the national, state, and local levels (Figure 2-1). However, until BOC was designated in 2017 to investigate inmate deaths, none of these agencies investigated all inmate deaths in Virginia jails.

Several different state and local agencies have some jail oversight, but only BOC reviews all deaths and investigates whether the jail may have violated the state's jail standards (Figure 2-1). It is common—but not required—for deaths in jails to be examined by the sheriff's office, local law enforcement, or the Virginia State Police. About three-quarters of the cases reviewed by BOC also have been investigated for potential criminal activity by one or more of these law enforcement agencies. Any policy changes or staff discipline in response to investigation findings are at the discretion of the jail and sheriff, while the commonwealth attorney determines whether to criminally prosecute the case. The Department of Health's chief medical examiner also is required to conduct an autopsy for all jail deaths. However, the autopsies determine the immediate cause of death, rather than investigate the root cause (such as whether jail staff consistently provided an inmate prescribed medications).

**FIGURE 2-1**  
**Jails are subject to local, state, and federal oversight, but BOC is the only oversight body to review all jail inmate deaths in Virginia**

NATIONAL/FEDERAL	U.S. Department of Justice	American Correctional Association	National Commission on Correctional Health Care				
STATE	Compensation Board	Board of Corrections	Department of Corrections	Department of Criminal Justice Services	Department of Behavioral Health and Developmental Services	Department of Health	Virginia State Police
LOCAL/REGIONAL	Regional board or authority	Local law enforcement	Health department	Fire department			

SOURCE: JLARC interviews and reviews of agency publications and the Code of Virginia.  
NOTE: National accreditation by the American Correctional Association and National Commission on Correctional Health Care is voluntary. Eleven Virginia jails are accredited by the American Correctional Association and at least five jails are accredited by the National Commission on Correctional Health Care.



# 3 Jail Inspections and Death Reviews

**SUMMARY** The Board of Corrections (BOC) and Department of Corrections (DOC) conduct jail inspections and death reviews, but refined processes can improve jail oversight. Inspections by DOC staff are consistent and fairly comprehensive, but compliance with certain key standards could be assessed more rigorously. In addition, inspection findings should be analyzed to proactively improve operations at Virginia jails. BOC began reviewing jail deaths one year ago and is still developing its process for this new responsibility. The multidisciplinary expertise of the board and the depth of the discussions by BOC members indicate the board has a strong foundation for effective death reviews. Going forward, several changes would make the death review process more efficient and effective. BOC staff should provide board members more detailed investigation reports in advance of death review meetings to reduce the time it takes to close cases. To ensure that investigation reports contain sufficient information, the BOC should develop guidelines for the minimum information death investigation reports should contain and ensure that its death review staff collectively understand health-care terminology and practices. The BOC also should regularly share summary information with the public about its death reviews and better use information from inspections and death reviews to consider changes in jail standards or other policies to address the preventable causes of jail deaths.

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The Board of Corrections (BOC) and the Department of Corrections (DOC) use two main approaches to oversee jails: jail inspections and reviews when an inmate dies in jail custody. DOC has been conducting jail inspections and audits on BOC's behalf for at least 20 years and has a well-defined process. In contrast, BOC's death review process is relatively new and still evolving.

## **DOC inspections are fairly comprehensive but could be more rigorous and used to improve state policy**

Inspections are one of the simplest and most effective ways to ensure compliance with regulatory standards. They are especially critical because of the importance of assuring the security of jails and the safety of inmates and staff. Visiting a facility, interacting with staff and inmates, and reviewing documentation are among the most effective methods to evaluate a facility's compliance with standards. All Virginia jails were inspected annually and audited every three years as required in calendar years 2016, 2017, and 2018. Audits assess compliance with all BOC standards, while inspections assess compliance with the subset of standards governing life, health, and safety.

### About half of DOC's inspections find at least one violation of standards and jails generally remedy any violations

DOC inspectors conducted 138 inspections and 55 audits of jails between FY16 and FY18. About half of these identified no violations, while most that found violations cited one or two violations (Figure 3-1). The most common violations across jails included failure to annually train staff on safe handling of biohazardous materials and ensure that all inmate food service workers receive and test negative on a tuberculosis test.

**FIGURE 3-1**

**Audits and inspections periodically find that some jails are violating standards (FY16–FY18)**



SOURCE: JLARC analysis of DOC inspection and audit files.

NOTE: Audit data reflects all local and regional jails audited by DOC in CY16 through CY18. Jails with American Correctional Association certification are not audited unless requested by the jail. Inspection data reflects all local and regional jails inspected by DOC in FY16 through FY18, excluding inspections conducted as a follow-up to ensure implementation of corrective action plans.

When inspectors find violations of standards, jails generally correct them. Inspectors and their supervisors say jails submit appropriate corrective action plans and implement them in a timely manner. Inspectors may conduct a follow-up visit to verify the change was made or request relevant documentation from jails, such as a copy of a health inspection or CPR training certificate. A JLARC review of a sample of inspection files confirmed that DOC staff regularly verify that jails have remedied the violations consistent with corrective actions plans.

### DOC inspections are conducted consistently but could more rigorously evaluate the most critical standards

DOC's jail inspection staff use multiple methods to assess compliance with state standards, including interviews with selected inmates, interviews with staff and management, reviews of policies, examination of selected records (e.g., logbooks, intake questionnaires), and reviews of annual documents (e.g., certifications by the local health department, external financial audits).

Inspections appear consistent across jails and over time. DOC inspectors use standard inspection materials, and interviews with inspectors and a review of files confirmed that inspectors use similar processes for enforcing standards. For example, each inspector follows the same approach of not citing jails for violations if they address them before the inspection is complete. In addition, DOC inspectors said BOC standards were clearly written and easy to translate into compliance activities.

While jail inspections are conducted consistently, DOC could assess compliance with some of the most critical standards more rigorously. DOC inspections staff sometimes rely on reviews of jail policies or statements from jail management as evidence of compliance with standards. This approach is sufficient to evaluate some standards, but a more rigorous assessment may be needed to more fully assess jail compliance with standards governing the most significant risks, such as suicide prevention, health care, and regular observations of inmates (Table 3-1).

**TABLE 3-1**  
**Some jail inspection methods could be more rigorous**

<b>Standard</b>	<b>DOC inspection method (current)</b>	<b>More rigorous inspection method (potential additional methods)</b>
The suicide prevention and intervention plan "shall be reviewed every 12 months by staff having contact with inmates. Such reviews shall be documented." <sup>a</sup>	Verify whether jail has written statement indicating the plan was reviewed (statement must include appropriate signatures and have been written within the last 12 months)	<ul style="list-style-type: none"> <li>Interview selected staff about the plan contents to ensure staff are aware of and operate consistent with the plan</li> </ul>
"Written policy, procedure, and practice shall provide 24-hour emergency medical and mental health care availability." <sup>b</sup>	Verify whether jail has written policy regarding how 24-hour emergency care will be available	<ul style="list-style-type: none"> <li>Interview selected staff about how and where to obtain needed health care</li> <li>Review a random sample of inmate requests for health care and determine whether and how health care was provided</li> </ul>
"All inmate housing areas shall be" observed "a minimum of twice per hour at random intervals..." <sup>c</sup>	<ul style="list-style-type: none"> <li>Determine whether a sample of records indicate at least two rounds per hour at random time intervals</li> <li>Ask inmates about frequency of observations</li> </ul>	<ul style="list-style-type: none"> <li>Verify the accuracy of the sample of records by comparing to video footage (if available)</li> </ul>

SOURCE: JLARC review of inspection files, inspection policies, and interviews with DOC.

NOTES: <sup>a</sup> 6VAC15-40-450. <sup>b</sup> 6VAC15-40-360. <sup>c</sup> 6VAC15-40-1045.

Given the additional time needed to assess compliance more rigorously and the new health-care standards that BOC is developing, it may be necessary for inspectors to prioritize standards for more close review. DOC could adopt a risk-based approach to assess more rigorously a subset of life, health, and safety standards or other standards deemed most critical to safety and security in jails. For example, given the elevated risk for suicide among inmates with mental health or substance use disorders, DOC could

evaluate more rigorously the standard requiring a suicide prevention and intervention plan. DOC inspections staff could work with BOC to identify the standards requiring a more rigorous assessment during inspections or audits. After identifying these high-priority standards, DOC inspections staff could develop more rigorous methods. DOC could consult with jail representatives to ensure the new methods would not be unreasonably burdensome for jails and could also request the input of subject-matter experts at other state agencies, such as the Department of Behavioral Health and Developmental Services.

#### **OPTION 1**

The Department of Corrections and Board of Corrections could identify the critical life, health, safety, or other standards for which inspectors should use more rigorous methods to determine a jail's compliance.

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

The current inspections approach taken by DOC and BOC is not fully consistent with a comprehensive oversight program. The American Bar Association's Standards for the Treatment of Prisoners provision regarding regular inspections explains that a correlating duty is to "detect systemic problems affecting prisoners... and make recommendations for improvement... the inspection body's work is intended to be preventative in nature." However, neither BOC nor DOC use inspection findings to support broad improvements among Virginia jails. While statute does not require BOC and DOC to review inspection findings to identify any common problems, doing so would support the state's goal of assuring jail compliance with standards and improving the standards as needed. Moreover, the recent addition of a BOC policy analyst expands the board's ability to conduct comprehensive reviews of inspection findings.

One way to use inspection results is to identify patterns across jails of standards violations and then focus technical assistance on these standards. However, DOC staff do not regularly tabulate the most commonly violated standards across jails, nor have they shared effective practices used by particular Virginia jails or supported by national research that could help jails improve compliance with standards. To support jail compliance, BOC and DOC should identify the barriers to compliance and consider the effectiveness of options to address them. For example, the requirement to provide training for biohazardous materials handling was the most frequent standard violation, according to JLARC's review of 2016–2018 inspections. If a common barrier to compliance is difficulty finding trainings for staff to attend, DOC could work with regional training academies or the Department of Criminal Justice Services to expand the number of available trainings.

Another way to use inspection findings is to identify potential changes needed to state standards. For example, a standard's wording may need to be clarified if jail manage-

ment expresses confusion about how to comply with the standard or if jails have different interpretations of a standard. Additionally, if inspections identify concerns about an aspect of jail operations for which no standard exists, that could indicate the potential need for a new standard.

### RECOMMENDATION 1

State staff who inspect jails should summarize jail audit and inspection results and report this information annually to the Board of Corrections. The report should include (i) the frequency of violations of each jail standard as determined during inspections and audits; (ii) recommendations for training or other activities that would improve jail compliance with commonly violated standards; and (iii) any recommendations for changes to standards.

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## BOC is improving its death review process but further refinements are needed

Between 50 and 60 inmates die in jail custody annually in Virginia. Federal data indicates that Virginia's rate of jail inmate deaths (0.16 percent) is about the same as the national average (0.14 percent). Of the jail inmates that died in Virginia during the last two years, about two-thirds died of natural causes (sidebar). Another quarter of the deaths in Virginia jails were suicides.

It can be difficult to determine whether the actions or negligence of jail staff contributed to an inmate's death. For example, if a jail inmate died from complications related to diabetes or heart disease, an investigation would need to consider many factors, including whether:

- the jail staff or health-care contractors gathered all available information about the inmate's health conditions during intake, and whether the inmate provided relevant information during this process;
- the jail staff or health-care contractors provided adequate health-care services, and whether additional care—such as more frequent visits by nurses or more timely provision of medication—would have prevented the death;
- records were comprehensive, and if not, whether the lack of documentation was deliberate or due to staff error; and
- the inmate cooperated with the jail's efforts to provide needed health-care services.

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**"Natural causes"** is one of the four possible causes of death determined by the Office of the State Medical Examiner. A death due to natural causes may or may not have been preventable with better health care.

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## BOC's death review process is still evolving but appears to be becoming more effective

BOC's death review process is relatively new. While legislation required reviews to start with deaths occurring on or after July 1, 2017, the BOC did not hire staff until November 2017, and the staff did not begin death reviews until February 2018 (Figure 3-

2). The BOC closed its first death review case in July 2018. According to BOC members and staff, the death review process was created “from scratch.”

**FIGURE 3-2**

**BOC has been reviewing jail deaths since early 2018**



SOURCE: JLARC interviews, review of BOC minutes, and Code of Virginia.

The BOC is still developing and refining its death review process. Currently, when a jail inmate dies, BOC staff first gather evidence regarding the circumstances surrounding the death. Evidence typically includes information provided by the inmate during intake, medical records, inmate observation records, any formal complaints or requests for medical services from the inmate, written statements by jail staff, and the autopsy results. Additionally, BOC staff review the conclusions of other investigations, such as the criminal review into the death conducted by Virginia State Police or local law enforcement.

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Governing boards are generally required to hold **open sessions**, meaning the public can observe. Under certain circumstances, boards may hold **closed sessions**, which the public cannot observe.

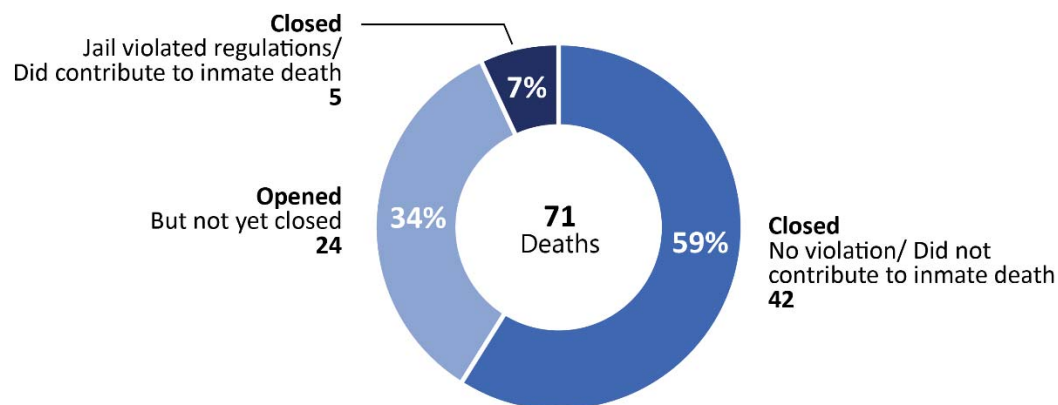
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This information is summarized in a written report by BOC staff and presented to BOC members in closed board sessions (sidebar). During these sessions, BOC members are given time to read the report. They then discuss the circumstances surrounding the death and attempt to determine whether the jail (1) violated any state jail standards and/or (2) otherwise contributed to the inmate’s death. After the BOC makes its determinations, the board must decide whether to take any enforcement action against the jail.

BOC so far has found that in a few cases, jails were in violation of state standards and contributed to the death of an inmate. BOC had begun to investigate 71 jail deaths as of May 31, 2019. Of those 71 deaths, BOC had closed 47 investigations and still has 24 open. Of the 47 closed investigations, BOC found that jails violated state standards and contributed to the death in five cases (Figure 3-3). In four of these cases, BOC downgraded the jail to probationary certification status, ordered quarterly unannounced audits of the jail, required quarterly progress reports from the jail, and planned to decertify the jail if it failed to comply with standards within a designated time period. In the fifth case, BOC determined that the jail had subsequently addressed the standards violation found in the death review and therefore took no enforcement actions.

**FIGURE 3-3**

**BOC has so far concluded that a jail violated state standards and contributed to the inmate's death in five cases**



SOURCE: JLARC observations of BOC meetings and review of BOC meeting minutes and investigation reports.  
NOTE: Figure reflects case status through July 2019.

### **BOC members are informed, engaged, and thoughtfully make decisions about death reviews**

JLARC observations of four closed session meetings found that the BOC members were earnestly attempting to reach sound conclusions about jail deaths. BOC members engage in robust and in-depth reviews of cases. In the four closed meetings observed by JLARC, nearly all members asked questions or made comments at least once in every case discussed. On average, members took about 30 minutes to discuss a case (sidebar), but discussion lengths varied widely. For example, BOC took over two hours to discuss a case in which it determined the jail violated state standards.

During discussions of cases, board members sought to understand the events leading up to the death of an inmate, including the actions that jail staff and contractors did or did not take. BOC members leveraged their respective expertise regarding physical health, mental health, or jail operations to inform the discussion. Members also displayed a healthy degree of skepticism when jail staff provided questionable explanations for their actions.

### **BOC should share more information publicly and clarify its exemptions under FOIA**

The BOC currently releases only minimal information to the public about the results of its death reviews. The board announces its findings for each death review in a public meeting, but does not provide any information beyond whether any standards were violated or the jail otherwise contributed to the death of the inmate. Statute requires the board to send a report on each review to the governor, the speaker of the House of Delegates, and the president pro tempore of the Senate.

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**30 minutes** is the minimum time BOC averaged for each case, not the total time. The total time is unknown because some cases observed by JLARC also were discussed at meetings held before or after JLARC's observation period.

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Several other Virginia state agencies responsible for similar death investigations publish annual reports that contain summaries of deaths reviewed. These annual reports are typically available to the public on agency websites and include recommendations to improve the agency's death review process or change state policies to reduce the risk of future deaths. For example, the Office of the Chief Medical Examiner publishes such a report for its child fatality reviews, as does the Department of Behavioral Health and Developmental Services for deaths in its training centers for the developmentally disabled.

The state should require the BOC to produce and make publically available an annual report summarizing its reviews of jail inmate deaths. Current statute does not address whether summary information should be produced or made available. Given the strong state interest in ensuring effective local jail operations, summary information across individual jail death reviews—but not about individual case files—should be publically available. This would include descriptive information, such as the cause of death determined by the medical examiner. It also should include the BOC's determinations regarding which (if any) standards were violated by jails, whether jails contributed to the deaths, and any actions taken by BOC, such as enhanced monitoring.

An annual BOC report about death reviews would be useful to help improve jail conditions and operations around the state. As with inspections, identifying common deficiencies in jail operations that have contributed to inmate deaths would help BOC consider opportunities to ensure adequate jail operations. For example, the standard requiring medical and other screenings upon admission was the most frequent violation found in death reviews through July 2019; if this trend continues, BOC could share best practices with all jails. Similarly, the Virginia Sheriffs' Association said information from BOC's death reviews could be useful for planning annual trainings. This information also could be useful to the General Assembly in determining whether statutory requirements need to be strengthened to ensure adequate jail conditions.

## **RECOMMENDATION 2**

The General Assembly may wish to consider amending § 53.1-5.5 of the Code of Virginia to require the Board of Corrections to annually develop and make publically available a report summarizing death review results, notable trends across death reviews, and potential policy changes that would help reduce the number of inmates that die in jail custody.

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While it is important to share aggregate information about death reviews with the public, it also is essential for the BOC to be able to conduct comprehensive death reviews without disclosing sensitive information of individual cases. The Freedom of Information Act (FOIA) gives BOC the statutory authority to close its meetings to the public for the purpose of reviewing health information or to consider legal advice from counsel. However, it could be beneficial to discuss other sensitive information,



such as staff actions, in closed session to ensure witnesses interviewed are willing to share pertinent details.

Other entities that conduct death reviews in Virginia have specific exemptions in FOIA that allow them to conduct their death review investigations in closed meetings. The Child Fatality, Adult Fatality, and Maternal Mortality Review teams at the Virginia Department of Health all have the authority to conduct individual death reviews in closed meetings.

To protect sensitive case information and allow the board to conduct efficient death reviews, BOC should work with the Virginia FOIA Council to assess how FOIA might be amended to expand the circumstances in which BOC would be able to conduct its jail death reviews in closed meetings. The assessment should balance the need to protect individual case information and encourage full consideration of vital information with the need to ensure public access to the BOC jail death review process and its overall findings.

### **RECOMMENDATION 3**

The Board of Corrections (BOC) should work with the Virginia Freedom of Information Act (FOIA) Advisory Council to examine whether and how FOIA should be amended to clarify or expand the circumstances in which the BOC may conduct closed meetings to consider jail death review cases.

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### **BOC does not appear to be investigating and closing cases as efficiently as practicable**

While there is no deadline to complete a death review, the BOC likely could investigate and close death review cases more quickly. The BOC took an average of about 10 months to complete the death review for the 42 cases it had closed as of May 31, 2019 (Figure 3-4). Some cases were closed within several months of the inmate's death, while some more complex cases took considerably longer. One case took 19 months to close, and two others took 16 months each.

Perhaps of more concern is the backlog of cases that remain open. BOC had 24 open cases as of May 2019. The inmates had died an average of 14 months earlier for these cases, and it had been about two years since the inmate's death for several cases (Figure 3-4). Delays in completing death reviews potentially increase the time during which jails provide inadequate care, placing inmates at greater risk. When BOC determines a jail has violated standards, it takes actions to ensure the jail improves care. The sooner that BOC identifies problematic conditions in jails, the sooner these conditions are likely to be corrected.

Delays also could make it more difficult to obtain evidence in death reviews, as inmates and staff depart the jail and memories fade. While BOC staff said delays have not prevented them from obtaining needed evidence, there have been instances in which jail staff were unable to recall certain facts about an inmate's death.

The length of time required to close a case and the number of open cases stem from two separate issues. First, BOC already had a backlog when it began death reviews because of the delay between July 1, 2017—when the statute requiring it to conduct reviews became effective—and when staff began investigations in February 2018. This seven-month delay resulted in a backlog of 37 deaths. Despite opening 71 cases and closing 47, BOC’s staff have been unable to appreciably reduce the backlog between February 2018 and July 2019.

To eliminate the backlog of open death reviews, BOC should increase the number of staff (perhaps only temporarily until the backlog is eliminated) dedicated to investigations and determine if these investigators can become more efficient. BOC has allocated only a part-time position to conducting investigations. The full-time policy analyst supports the BOC with broad research related to the death reviews and assists DOC inspections staff with responsibilities unrelated to jails but has periodically helped conduct investigations. BOC should consider reallocating its existing staff positions in order to obtain the equivalent of at least one full-time investigator. BOC also should ensure that staff conducting investigations maximize their efficiency through training, process improvements, or job re-assignment. If additional investigative staff are needed to eliminate the backlog after these measures are taken, BOC could submit a budget request for an additional part-time or full-time investigator position.

#### **RECOMMENDATION 4**

The Board of Corrections should reduce its backlog of open death reviews through a combination of (i) employing at least one full time investigator; (ii) temporarily adding another investigator until the backlog is reduced; and (iii) improving the efficiency of its investigators through training, process improvements, or job reassignment.

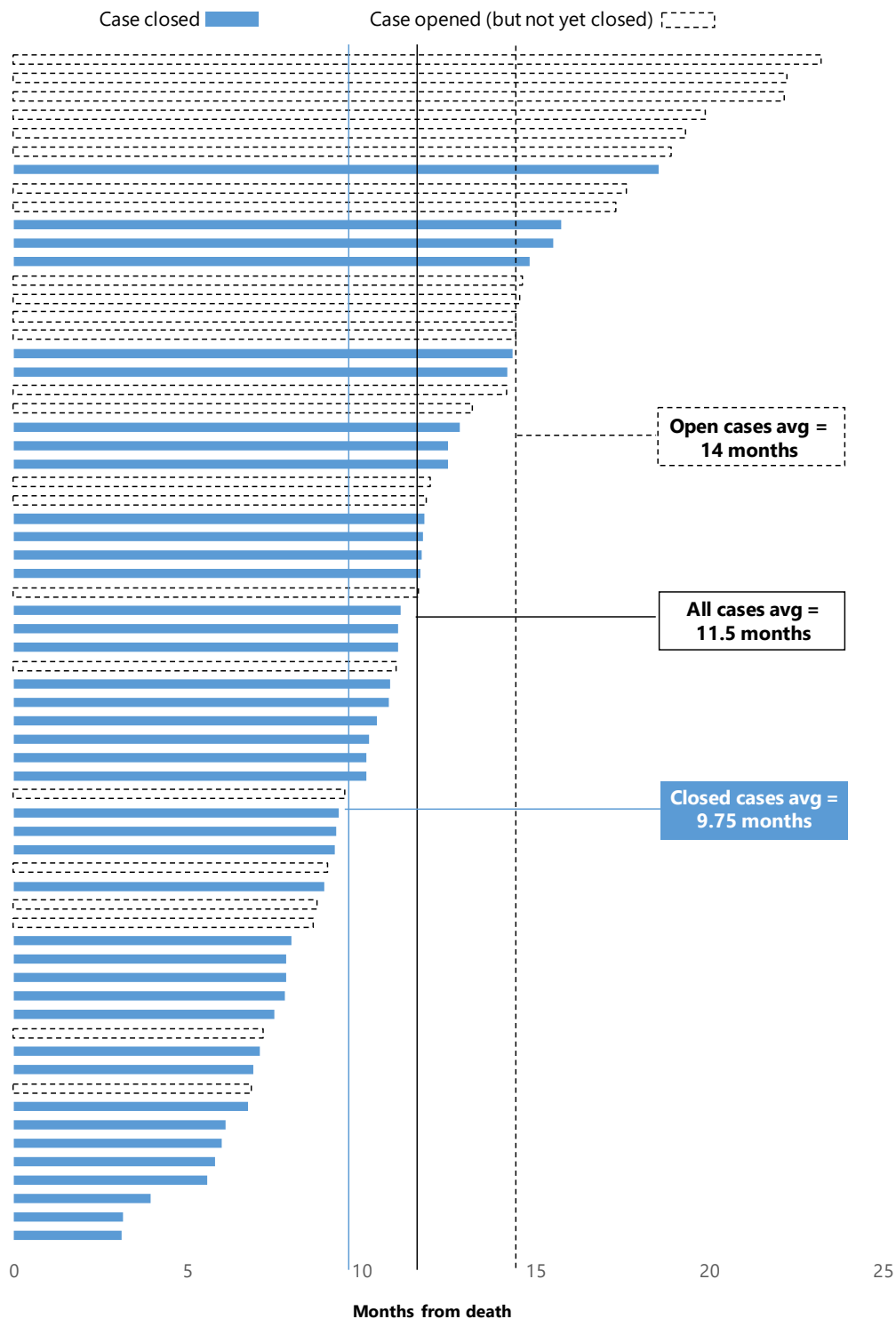
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Second, the death investigation and review process also could be improved to close cases more efficiently. At the board meetings, BOC members frequently request additional information when BOC staff present their written report in closed session. Board members often request more information about

- the events leading up to an inmate’s death, such as the number of times an inmate refused medications or the inmate’s response to a question on the jail’s intake interview, and
- the content of the jail and contractor’s written policies, such as whether an inmate’s admission of prior suicide attempts would automatically trigger more intensive monitoring by jail officers.

FIGURE 3-4

BOC took an average of about 10 months to close investigations after an inmate's death, and many cases remain open more than a year after the death



SOURCE: JLARC analysis of BOC investigation reports and meeting minutes.

NOTE: Figure reflects case status as of May 31, 2019.

Investigative reports often lack adequate information about the health conditions of the inmate, the health care needed to treat those conditions, and the health care provided by the jail. During BOC meetings observed by JLARC, the need for additional health-related information was a common reason BOC determinations were delayed. Current BOC staff do not always have a full understanding of medical terminology and practices—especially as it relates to health-care decisions by jail staff in the time preceding an inmate’s death. It appears there are certain medical conditions (e.g. high blood pressure, diabetes, or depression), treatment protocols, or medications that have been common among some of the inmates who have died in jail custody. Not fully understanding these conditions has hindered death review staff’s ability to obtain the full information necessary in all cases.

In many cases, the BOC must wait to resume its review of an inmate death until at least the following month’s board meeting when BOC staff can provide the requested information. BOC members also must take time at the next board meeting to re-familiarize themselves with the case. The inefficiency of the death review process requires an intensive time commitment for BOC members, who are volunteer citizens. Making the process more efficient would likely reduce the workload on these board members, allowing them to focus less on information collection and more on determining whether a jail was at fault when an inmate dies in custody.

BOC should make two procedural changes to improve the efficiency of its death reviews. First, to minimize board members’ need to request additional information during a death review, the BOC should develop written guidelines for standard content of death reports. The guidelines should be considered a guide, not a comprehensive list, because the type of information needed varies significantly with the case’s complexity and nature of the death. One model is the Office of the Chief Medical Examiner’s guidebook for investigators (sidebar).

#### RECOMMENDATION 5

The Board of Corrections should develop written guidance listing the minimum information required in death investigation reports.

To ensure that the adequate health-related information is included in death investigation reports, BOC should ensure that its staff collectively have some minimum understanding of medical terminology and practices. The BOC could require this among the skills and experience required for either of its current staff positions, or for the additional investigator hired to reduce the backlog of open cases (see recommendation 4). Ensuring that BOC staff collectively have a minimum level of understanding also would strengthen their ability to assess jail compliance with the new physical and mental health-care standards currently being developed.

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Statute requires the **Office of the Chief Medical Examiner** to investigate particular deaths, including inmates and psychiatric hospital residents. The office provides a guidebook for investigators that lists the minimum information required to be collected. Investigators are expected to collect additional information as appropriate to the circumstances.

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### **RECOMMENDATION 6**

The Board of Corrections should ensure that at least one of its staff receive training on the medical conditions, treatment protocols, and medications most commonly necessary to understand when reviewing jail inmate deaths.

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The second change needed to improve the efficiency of the death review process is to provide BOC members with investigation reports for death cases in advance. BOC staff should transmit a copy of the death report to board members by a designated date before the meeting at which the case will be discussed. This would allow board members time to read the reports and to request additional information before discussing a case in a board meeting.

### **RECOMMENDATION 7**

The Board of Corrections should require jail death investigators to transmit the investigation report to board members on a designated date before the meeting for which the case is scheduled and give members the opportunity to request additional information from the investigators before the meeting.

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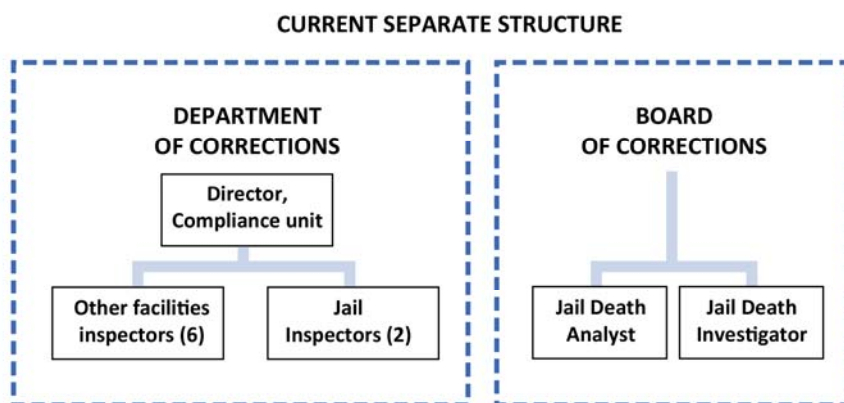


# 4 Coordination of Jail Inspections and Death Reviews

**SUMMARY** Despite the potential value of a coordinated jail oversight program, jail inspections and jail death reviews essentially operate as separate processes in Virginia. Inspections and death reviews both seek to identify jail violations of the same state standards. However, different staff conduct the two activities and do not fully share information that could support the other’s work. This lack of integration is primarily the result of two factors: the death review process is relatively new, and jail inspection staff report to the Department of Corrections, while death review staff report to the Board of Corrections. The effectiveness of death reviews and inspections—and therefore of the state’s oversight of jails—could be improved by several administrative refinements to better support the board in its jail oversight role.

The four state staff involved in jail oversight are employed by two separate entities (Figure 4-1). The Department of Corrections (DOC) employs two jail inspectors. The Board of Corrections (BOC) employs a jail death investigator and a policy analyst. The jail inspection process has been in place for decades, while the death review process began in 2018 and is still evolving.

**FIGURE 4-1**  
Jail oversight staff are segmented across DOC and BOC

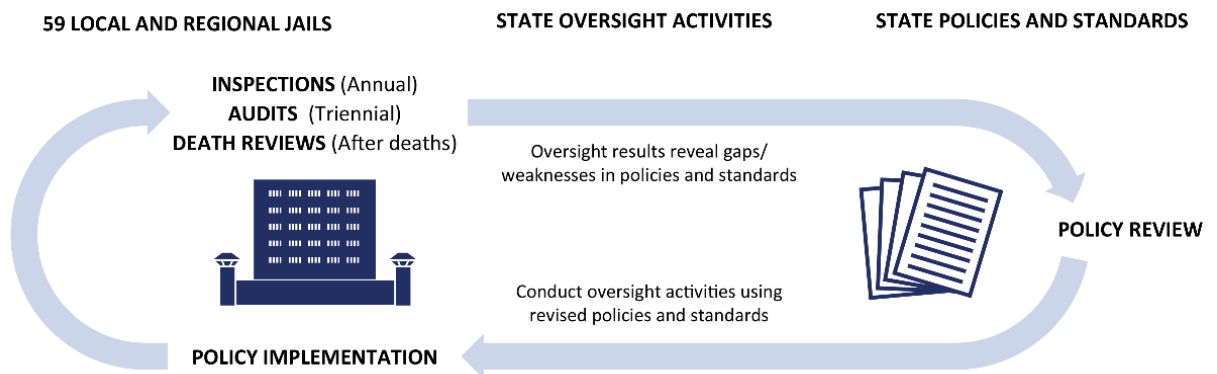


SOURCE: JLARC.

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

Ideally, a jail oversight program would consist of coordinated inspections, audits, and death reviews (Figure 4-1). The results of these oversight activities not only would address specific violations of jail standards, but be reviewed over time to identify opportunities to revise state policies and jail standards to improve jail operations around the state. Any changes to standards would then be used as the basis for future inspections, audits, and death reviews. Additionally, jails in which death reviews found deficiencies could be subject to more focused inspections.

**FIGURE 4-2**  
Ideal model of a cohesive state jail oversight program



SOURCE: JLARC.

In contrast with this ideal jail oversight program model, inspections and death reviews in Virginia are essentially separate processes. Death reviews and jail inspections are conducted as parallel work processes by different staff who know little about each other's work. This separation creates a variety of problems because the jail inspection and death review processes have the same policy goal: to ensure that jails adhere to state regulations intended to make jails secure and safe for inmates.

The most fundamental problem of separate inspection and death review processes is conflicting findings about jail compliance with standards. BOC has found jails in violation of standards when investigating the death of five inmates; yet in each of these cases the most recent inspection or audit found the jails in compliance with those standards. These discrepancies likely reflect the different focus, expertise, and approaches between inspections and death reviews. Jail inspections are conducted by inspectors, assess at least 43 standards, and include all jails annually. Death reviews have a more in-depth approach because they only review the standards most likely to be relevant to an inmate's death, and are limited to the jails where deaths have occurred. For example:



- Inspectors and death review staff both review jail records regarding the standard for twice-hourly checks of inmate cells. In addition, though, death review staff also compare these records to video footage when available. Using this method, death reviews have identified four instances in which jail staff falsified records to indicate cell checks that never occurred.
- Inspectors regard a written health-care policy as sufficient to comply with the health-care provision standard, while death reviews assess the timeliness and adequacy of the actual health care provided to an inmate.

When interviewed by JLARC staff, jail inspectors did not know that inspection reports are reviewed by BOC staff for death investigations. Similarly, jail inspectors are not provided with completed death reviews. Further, when asked by JLARC staff, inspectors said their inspections were unrelated to death reviews. Inspectors disagreed with the notion that findings from death reviews should inform and improve the general process for jail audits and inspections. While inspectors were willing to conduct intermittent inspections to follow up on death reviews if requested by the BOC, they did not see a need for the results of death reviews to inform inspections of those jails in subsequent years.

As the state entity responsible for jail standards and death reviews, BOC members say they see value in better coordinating the inspection and death review procedures and recently took the first step to do so. In July 2019, the BOC decided for the first time to use a “focused audit” to monitor two jails it determined through death reviews to be out of compliance with state standards.

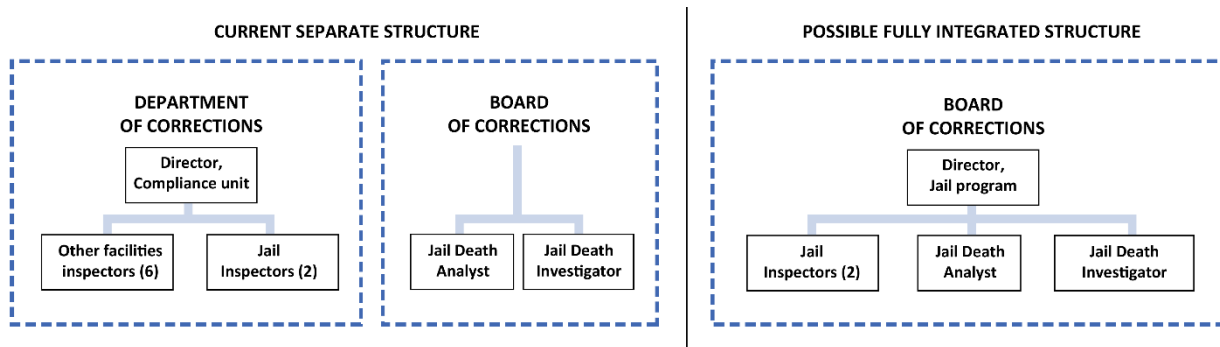
## **BOC’s strengthened administrative structure would improve jail oversight**

Despite their separation, the BOC chair and DOC senior leadership said they had a positive working relationship, as did jail investigations and death review staff. Some administrative challenges arose during implementation of the death review process, but these have since been addressed. However, better coordination between jail inspections and jail death review staff likely could improve the state’s jail oversight program. Additionally, administrative staff’s support to the board needs to be strengthened.

While DOC and BOC have the independence and expertise to conduct jail oversight, refining BOC’s administrative structure would better support its citizen members. Two administrative changes would help the board be more effective and efficient. First, a director of jail oversight needs to be created who reports to the BOC. Second, both the inspections and death review staff should report to the new director (Figure 4-3).

**FIGURE 4-3**

**Jail inspection and death review staff should report to a director of jail oversight as part of an integrated state jail oversight program**



SOURCE: JLARC interviews with DOC and BOC staff.

NOTES: DOC's other facilities inspectors conduct inspections of probation and parole units, community residential programs (e.g., halfway houses), and state prisons. A jail program director would be a new position.

State boards in Virginia sometimes employ a director and a small staff to support citizen board members. For example, the Compensation Board, which funds constitutional officers (including sheriffs who operate local jails), employs an executive secretary. The Board of Workforce Development employs an executive director. A senior staff member can be especially helpful for a citizen board conducting complex oversight or other activities. A senior staff member can provide more direction than citizen board members and be mindful of short-term and long-term policy and administrative considerations, which can be essential for newly granted responsibilities.

Under this refined administrative structure, BOC also would be able to better ensure that jail inspections and death reviews use the same methods to assess jail compliance with standards. In addition, creating a director position would increase staff's capacity to support BOC members in performing their responsibilities.

### **RECOMMENDATION 8**

The General Assembly may wish to consider including language in the Appropriation Act transferring current Department of Corrections jail inspection staff positions—and the funding to employ them—to the Board of Corrections.

### **RECOMMENDATION 9**

The General Assembly may wish to consider amending § 53.1 of the Code of Virginia to grant the Board of Corrections authority to hire a director of state jail oversight to manage its jail inspection and jail inmate death reviews as part of a cohesive state jail oversight program.

### **RECOMMENDATION 10**

The General Assembly may wish to consider including language and adequate funding in the Appropriation Act to fund a director of state jail oversight position reporting to the Board of Corrections.

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DOC currently provides administrative support to the BOC and should continue to do so. DOC has substantial administrative capacity (technology, human resources, financial management, etc.) already in place. DOC provides similar administrative support for the staff and members of the Parole Board.

The BOC and DOC should develop a memorandum of understanding to clarify the responsibilities and authorities of each entity under the new jail oversight program, such as administrative employee management (e.g. interviewing and hiring, payroll management) and management of the regulatory process.

### **RECOMMENDATION 11**

The Department of Corrections (DOC) and Board of Corrections (BOC) should develop and agree to a memorandum of understanding clarifying the administrative support that DOC will provide to BOC for the state's jail oversight program.

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Finally, the Board of Corrections name is misleading and should be changed. In 2011, the General Assembly passed legislation to remove BOC's responsibilities for oversight of prisons and supervision of DOC operations and funding. Since then, the vast majority of the board's responsibilities have been related to overseeing local and regional jails through inspections and death reviews and establishing jail standards. DOC leadership said the board's current name has created confusion over its responsibilities, authorities, and relationship to DOC. The BOC's name should more accurately reflect its primary activities, which are related to jail oversight. Possible names for the board are the Board of Local and Regional Jail Oversight or Board of State Oversight of Jails.

### **RECOMMENDATION 12**

The General Assembly may wish to consider amending § 53.1 of the Code of Virginia, and other sections as necessary, to rename the Board of Corrections to more accurately reflect its primary responsibilities for oversight of local and regional jails.

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## Appendix A: Study mandate

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### **Resolution of the Joint Legislative Audit and Review Commission directing staff to review the Office of the State Inspector General**

Authorized by the Commission on October 10, 2017

WHEREAS, it has been five years since the creation of the Office of the State Inspector General (OSIG) as an executive branch agency; and

WHEREAS, the OSIG was created by consolidating a variety of functions that existed at other agencies; and

WHEREAS, when created, the OSIG was granted a new function to evaluate state agency performance; and

WHEREAS, the OSIG is statutorily directed to inspect facilities and providers; review and make comments on Departments of Behavioral Health and Developmental Services (DBHDS), Corrections, and Juvenile Justice reports and critical incident data; investigate state agency operations and evaluate state agency performance; investigate complaints alleging fraud, waste, abuse, or corruption; and administer the State Fraud, Waste and Abuse Hotline; and

WHEREAS, the OSIG has full authority to inspect DBHDS facilities and mental health units in correctional facilities, but has less clear and more limited authority to inspect and investigate incidents in jails and non-DBHDS state facilities where individuals are held under state authority; and

WHEREAS, OSIG's investigative and performance evaluation roles create the potential for duplication with other state agencies that have similar missions; and

WHEREAS, the OSIG has authority to designate up to 30 of its staff with the same powers as a sheriff or a law-enforcement officer when investigating allegations of criminal behavior; and

WHEREAS, the OSIG was appropriated \$6.7 million (FY17), the majority of which was general funds, and employs 33 full-time equivalent staff, and staffing has fluctuated annually; and

WHEREAS, other states use centralized and decentralized structures that feature varying degrees of independence to perform inspection, investigation, performance evaluation, and fraud complaint response functions; now, therefore be it

RESOLVED by the Joint Legislative Audit and Review Commission (JLARC) that staff be directed to review the Office of the State Inspector General. In conducting its study, staff shall evaluate the agency's (i) role and authority in inspecting jails and state facilities where individuals are held; (ii) role and authority in investigating incidents in jails and state facilities where individuals are held; (iii) role in performance evaluations of state agencies; (iv) sufficiency of staffing levels and staff expertise (v) performance, management, and stability; and (vi) effectiveness, efficiency and independence of the current centralized OSIG in general, and as compared to when its role was de-centralized in different agencies. Staff shall make recommendations as necessary and review other issues as warranted.

All agencies of the Commonwealth shall provide assistance, information, and data to JLARC for this study, upon request. JLARC staff shall have access to all information in the possession of state agencies pursuant to § 30-59 and § 30-69 of the Code of Virginia. No provision of the Code of Virginia shall be interpreted as limiting or restricting the access of JLARC staff to information pursuant to this statutory authority.

JLARC staff shall complete its work and submit a report of its findings and recommendations to the Commission by December 10, 2019.

## Appendix B: Research activities and methods

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Key research activities performed by JLARC staff for this study included:

- interviews with Board of Corrections (BOC) members, BOC and Department of Corrections (DOC) staff, other state agencies, stakeholder groups, and national experts;
- observation of formal meetings, including of the BOC;
- collection and analysis of data, including data regarding BOC death reviews and DOC inspections; and
- review of documents, including OSIG publications related to jails, BOC investigation reports, and national literature.

### Interviews

JLARC staff conducted 60 interviews during research for this report. Key interviewees included BOC members, BOC and DOC staff, other state agency staff, stakeholder groups, and national subject-matter experts.

#### ***BOC members***

JLARC attempted to conduct interviews with members of the BOC. Three BOC members participated in interviews with JLARC. Members also were given the option of providing anonymous written feedback if they preferred a confidential means to share information and opinions with JLARC. Topics included BOC's jail standards, the adequacy of information provided about each death case, BOC's options for taking action after its determinations, information gained across the death reviews, the balance between confidentiality and sharing information with the public, coordination between BOC and DOC staff, and any additional training or authority needed by BOC. Four of the nine BOC members provided feedback to JLARC in this manner.

#### ***BOC and DOC staff***

JLARC staff conducted 23 interviews with 15 individual BOC and DOC staff. The primary purposes of these interviews included clarifying DOC's roles relating to jails, learning about inspection processes and documents, learning about death investigation processes and documents, and obtaining staff perspectives on current practices and policies. Interviews were conducted with both BOC staff, both DOC jail inspectors and their supervisors, and staff from the Office of the Attorney General representing the board. JLARC also interviewed other DOC staff with responsibilities related to jails or investigations generally.

#### ***Other agencies***

JLARC staff conducted 16 interviews with staff of state agencies other than DOC and BOC. Depending on the agency, the purpose of these interviews included clarifying their responsibilities relating to jails, obtaining their perspectives on which state agencies should be responsible for jail inmate death reviews, gathering perspectives on key elements for effective death reviews, and learning about jail operations and challenges. Interviews were conducted with:

- The Compensation Board;
- The Department of Behavioral Health and Developmental Services (DBHDS);
- The Department of Criminal Justice Services;
- The Office of the Chief Medical Examiner;
- The Office of the State Inspector General (OSIG) staff; and
- Virginia State Police.

### ***Stakeholders***

JLARC staff conducted 10 interviews with Virginia stakeholders. JLARC interviewed the Virginia Association of Regional Jails and the Virginia Sheriffs' Association to learn about differences across Virginia jails, challenges faced by jails, and the associations' perspectives on DOC and BOC oversight activities. JLARC interviewed two groups representing local government and five mental health, disability, or other inmate advocacy groups for similar purposes. Additionally, JLARC obtained information on local law enforcement and Commonwealth Attorney's investigations of inmate deaths through interviews with the Virginia Association of Chiefs of Police and a commonwealth attorney.

### ***National experts***

JLARC staff interviewed experts from six national associations or federal agencies. The purpose of these interviews include identifying national standards or recommended practices for state oversight of jails, activities commonly used by states to oversee jails, and perspectives on Virginia's processes and standards. Interviews were conducted with staff and/or board members from the National Conference of State Legislatures, American Jail Association, American Bar Association's Criminal Justice Standards Project, and U.S. Department of Justice's National Institute of Corrections. JLARC also interviewed a national consultant specializing in jails that was recommended by the National Institute of Corrections.

### **Attendance at open and closed sessions of the Board of Corrections**

JLARC attended all BOC meetings held between March 2019 and July 2019. These included all meetings of the full Board, closed and open sessions of the Jail Review Committee (JRC), and the Liaison Committee. JLARC observed BOC's and JRC's open session meetings in order to understand the roles of BOC, DOC, and other state agencies with jail-related responsibilities. Additionally, JLARC obtained information about BOC's oversight activities including making certification decisions in response to inspections and audits, promulgating regulations, and sharing information with the public and stakeholders.

Between March and July 2019, JLARC observed all five closed sessions of the JRC to better understand how the board reviews investigative reports of jail inmate deaths and determines whether the jail violated regulatory standards or otherwise contributed to an inmate death. JLARC tracked the amount of time members spent reading each investigative report and discussing each death case. JLARC counted the number of BOC members who participated at least once in the discussion of each case. Finally, JLARC monitored the nature of the discussion, including instances when members requested additional information about the death cases or jail operations, identified commonalities



across death cases, assessed the role of the jail in an inmate death, recused themselves from the discussion because of a conflict of interest, or suggested potential changes to the minimum standards for jails and other state policies.

JLARC also observed two meetings of the advisory group on jail health-care standards. The advisory group was established to provide recommendations and cost estimates to the BOC regarding the various types of BOC health standards required to be developed by 2019 legislation (Chapter 695 and Chapter 827).

## Data analyses

JLARC staff conducted structured reviews of inspections files and investigation reports. In combination with information gathered from other sources, this information was the basis for JLARC data analysis.

JLARC created a database to analyze BOC's reviews of jail inmate death. The database was built to contain information from three sources: (1) investigative reports and other documents created by BOC staff for each inmate death; (2) notifications of inmate deaths sent by jails to DOC; and (3) minutes for meetings of the BOC and its Jail Review Committee. The database created by JLARC included information about all inmate deaths that occurred in FY18 and FY19. In addition to these three primary sources of information, JLARC interviewed the BOC death investigator to clarify information about particular cases as needed. The database included the following elements for each inmate death:

- inmate name
- jail name
- cause of death (e.g., suicide, homicide, accidental, natural, undetermined)
- date of death
- other investigations (e.g., Virginia State police, local law enforcement, Commonwealth's Attorney)
- date investigation was completed
- date of JRC and BOC determinations
- JRC and BOC determinations (e.g., any standards violated by jail, whether jail otherwise contributed to an inmate death)
- case status (e.g., investigation report complete, BOC discussion of case)

Most analyses in this report exclude eight out-of-scope cases. These cases were determined by JLARC to be out of scope because of at least one of the following reasons:

- related to a critical incident other than a death (such as an attempted suicide);
- related to a death of an individual other than an inmate in jail custody (such as an individual who died after transfer to a psychiatric hospital or shortly after release from custody); or
- related to the death of a jail inmate, but the BOC investigator determined that circumstances prevented an assessment of the jail's violation of state standards or contribution to the death (such as inmates who died while on electronic home monitoring or at a general hospital).

However, if the case met the above criteria but was discussed by BOC or received a determination from BOC, the case was included in JLARC analyses.

## **Review of documents**

JLARC conducted structured reviews of OSIG publications and BOC investigation reports. Additionally, JLARC's research for this study included reviews of Virginia-specific publications and national literature.

### ***Death investigation reports***

JLARC conducted a structured, in-depth review of all 71 investigation reports completed by the BOC death investigator as of June 3, 2019. These reports encompass inmate deaths occurring from July 2017—the first month BOC was required by statute to review inmate deaths—through December 2018. JLARC collected the following information from each report:

- apparent problems in jail operations, such as failure to appropriately respond to identification of risk factors during intake (e.g., inmate's admission to suicidal thoughts) with more intensive monitoring;
- apparent problems in jail health care, such as delays or failure to access health care, and failure to transfer medical records or other information between staff or jails;
- missing or falsified records (e.g., medication provision, twice hourly inmate checks);
- barriers to BOC conducting a comprehensive investigation, such as a refusal by a jail or its contractor to provide documents or on-site access;
- state policy recommendations from the investigator;
- missing or unclear information, particularly regarding the timing of events, jail policies and protocols, and the results of internal investigations; and
- potential weaknesses in the investigative methods, such as reliance on written statements or responses from jail management instead of interviews with field staff.

Rather than record all examples of the above information in all reports, JLARC identified representative examples. In addition to this list, JLARC used the reports more generally to learn about jail operations and inmate experiences.

### ***Inspections***

JLARC reviewed DOC inspection files for several purposes: (1) to learn about the methods used by inspectors to assess compliance with standards, (2) to assess DOC's adherence to requirements for annual inspections and triennial audits, and (3) to count the number of standards violations identified in inspections and audits. JLARC conducted on-site reviews of paper files, because the information needed was not available electronically. These reviews included all local and regional jails, and excluded lock-ups.

#### **Consistency of methods used by inspectors**

JLARC evaluated the consistency of methods of assessing compliance across multiple jails, inspectors, and standards. Because evaluating the consistency of all inspections and audits would be too time-consuming, the evaluation was limited to a sample of jails, audit years, and standards. The five jails were chosen randomly, and reflect a mix of geographical location and size. The audit year for each jail was chosen randomly, but was limited to 2016 through 2018, because that time period was used for

the other inspection research questions. Audits were selected instead of inspections because unlike inspections, audits cover all state standards. Lastly, the seven standards were chosen to align with research on BOC's death reviews, as those are all the standards that have been considered in death investigation reports. These standards were:

- 6VAC15-40-360 (twenty-four-hour emergency medical and mental health care);
- 6VAC15-40-370 (receiving and medical screening of inmates);
- 6VAC15-40-380 (inmate access to medical services);
- 6VAC15-40-400 (management of pharmaceuticals);
- 6VAC15-40-450 (suicide prevention and intervention plan);
- 6VAC15-40-990 (administrative segregation); and
- 6VAC15-40-1045 (supervision of inmates).

#### Timeliness of inspections and audits

JLARC reviewed all inspection and audit files for all jails for CY 2016–2018. The dates of all inspections and audits in this time period were recorded and analyzed to assess if DOC met statutory and regulatory requirements for (1) annual inspections and (2) triennial audits. Calendar years were used instead of fiscal years because DOC has interpreted the annual inspection requirement to refer to calendar years.

#### Frequency of standards violations

JLARC recorded all violations of standards identified by DOC inspectors in audits or inspections conducted CY 2016–2018. For each standard, inspectors determine if the jail is compliant with the standard, violating the standard, or if the standard is non-applicable.

#### ***OSIG publications and data***

In addition to interviewing OSIG staff, JLARC used two approaches to ascertain the extent of OSIG's oversight and authority relating to Virginia jails. First, JLARC reviewed both publications addressing jails that OSIG has produced since it was created: the 2014 "A Review of Mental Health Services in Local and Regional Jails" report, and the 2016 "Investigation of Critical Incident at Hampton Roads Regional Jail" (the review of Jamycheal Mitchell's death). Second, JLARC reviewed the three complaints about jails it identified in a search of OSIG's internal complaints database. This database contains complaints submitted to OSIG between July 2014 and March 2019.

#### ***Review of other documents and literature***

JLARC staff identified and reviewed a wide variety of documents as resources for research on jails in Virginia, including:

- Virginia state statute, proposed bills, regulations, regulatory documents on Town Hall (e.g., explanations regarding proposed or abandoned regulatory changes), and Appropriation Acts;

- BOC policies, orientation materials, meeting minutes, EWP, statistical summaries of jail death investigations, and samples of formal letters to jails requesting information and case closure letters;
- presentations, analyses, and other documents prepared by BOC staff;
- DOC policies, inspection guidance, and ACA accreditation lists;
- websites and publications by other Virginia agencies relating to jails, including DBHDS's 2018 "Mental Health Standards for Virginia's Local and Regional Jails" report; DCJS's minimum standards for jail officers; Compensation Board's FY 2017 Jail Cost Report and FY18 Mental Illness in Jails Report; several studies of health care in Virginia jails or reports relating to jails presented to the Joint Commission on Health Care, Joint Subcommittee to Study Mental Health Services in the Commonwealth in the 21st Century, and House Appropriations Committee;
- media coverage of Virginia's jails, particularly related to jail inmate deaths; and
- reports about the death of Janycheal Mitchell by OSIG, DBHDS, and the City of Portsmouth Office of the Commonwealth's Attorney.

JLARC staff reviewed and synthesized publications by federal agencies as well as national associations, advocacy groups, and other national entities. These include policies, reports, data, and other documents from the:

- U.S. Department of Justice's Civil Rights Division, Bureau of Justice Statistics, and National Institute of Corrections - Jail Division,
- National Conference of State Legislatures compilation of state statutes regarding state responses to inmate jail deaths (conducted for JLARC),
- Americans for Effective Law Enforcement's database of litigation prompted by prison and jail conditions,
- Vera Institute of Justice,
- Treatment Advocacy Center, and
- The Pew Charitable Trusts.

JLARC identified and reviewed key national standards for jails, which include accreditation standards and recommended practices by the following entities:

- American Correctional Association's "Core Jail Standards";
- National Commission on Correctional Health Care's "Standards for Health Services in Jails";
- American Bar Association's "Treatment of Prisoners" standards; and
- The National Institute of Corrections' Jail Design Guide.

## Appendix C: Agency responses

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As part of an extensive validation process, the state agencies and other entities that are subject to a JLARC assessment are given the opportunity to comment on an exposure draft of the report. JLARC staff sent an exposure draft of this report, or relevant sections of it, to the Secretary of Public Safety and Homeland Security, chairman of the Board of Corrections, the Department of Corrections, and the Office of the Attorney General.

Appropriate corrections resulting from technical and substantive comments are incorporated in this version of the report. This appendix includes response letters from the

- Secretary of Public Safety and Homeland Security and the
- Chairman of the Board of Corrections.



# *COMMONWEALTH of VIRGINIA*

## *Office of the Governor*

Brian J. Moran  
Secretary of Public Safety  
and Homeland Security

September 10, 2019

Hal E. Greer, Director  
Joint Legislative Audit and Review Commission  
919 East Main Street  
Richmond, Virginia 23219

Dear Mr. Greer:

As Secretary of Public Safety and Homeland Security, I would like to take this opportunity to thank you and your staff for allowing me the opportunity to review and comment on the draft report regarding the State Oversight of Local and Regional Jails. While meeting with your staff to discuss their findings, it was clear that they demonstrated a collaborative and professional audit.

I also would like to acknowledge their engagement on how the Board of Corrections operates based on their legislative directives. JLARC staff recognizes and acknowledges that the BOC is operating as a newly formed and appointed Board with new and growing responsibilities. They noted areas for improvement while acknowledging of the Board and how it carries out its many important and evolving duties.

I look forward to working with the Board of Corrections and your staff in implementing several of the recommendations. Thank you for allowing my office to assist in your efforts.

Sincerely,

A handwritten signature in black ink, appearing to read "B. Moran", written over a horizontal line.

Brian J. Moran  
Secretary of Public Safety and Homeland Security



# COMMONWEALTH of VIRGINIA

## *Board of Corrections*

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September 10, 2019

Hal E. Greer, Director  
Joint Legislative Audit and Review Commission  
919 East Main Street  
Richmond, Virginia 23219

Dear Mr. Greer,

On behalf of the Virginia State Board of Corrections, I wish to thank you and your staff for the opportunity to review and comment on the exposure draft report entitled *State Oversight of Local and Regional Jails*. The professionalism of your staff was outstanding.

We are pleased with the attention given to the challenges relating to the review of deaths in jails as well as grateful for the report's finding that the review of the jail deaths will remain with the Board of Corrections.

Additionally, we are grateful for the recommendations regarding needed improvements in our operations and organization. We stand ready to meet these challenges.

We look forward to continuing to work with the Virginia General Assembly.

Sincerely,

A handwritten signature in dark ink, appearing to read "Vernie W. Francis, Jr.", written over a horizontal line.

The Honorable Vernie W. Francis, Jr.  
Chairman, Virginia State Board of Corrections

VWF/dpf







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