Summary: State Oversight of Local and Regional Jails

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.

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.

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

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.