Operational Assessment
Snohomish County Sheriff’s Office
(Jail System)
Everett, Washington

National Institute of Corrections
Technical Assistance No. #13J-1072
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Introduction

Over the period, Wednesday, August 21, through Friday, August 23, 2013, Timothy P. Ryan (Director of the Miami-Dade Corrections and Rehabilitation Department, Miami, Florida) and John Ford (Undersheriff of the Davidson County Sheriff's Office, Nashville, Tennessee) were Technical Resource Providers for an onsite operational assessment of the Snohomish County Jail System in Everett, Washington. Their work, conducted under the auspices of the National Institute of Corrections (NIC), a Federal Agency, under the Federal Bureau of Prisons, Jails Division, was initiated by a Technical Assistance Request from Ty Trenary, Sheriff of the Snohomish County Sheriff's Office.

A letter of authorization was issued on August 6, 2013, signed by Ms. Virginia Hutchinson, Division Chief of the NIC Jails Division. It designated Ms. Panda Adkins, Correctional Program Specialist, as the contact person for the Snohomish County Technical Assistance Project (TAP) identified as NIC/TAP No. 13J-1072.

The following report represents the observations, findings, conclusions, and recommendations of Tim Ryan and John Ford. These determinations were a result of their review of documents, facility inspections, and interviews with the leadership team, general staff, as well as inmates. Their recommendations, although recognized to have been developed over only a three day review, reflect their extensive knowledge and experience in managing major jail systems, as well as, involvement in national professional organizations including the American Jail Association, American Correctional Association, as well as the active participation in other operational assessments and audits/accreditations under the Commission on Accreditation for Corrections. This includes previous reviews on domestic United States jail sites, and international examinations, like Mexico. Mr. Ford also has many years of service in the Military Corrections Systems, and Mr. Ryan has served as a leader of four (4) of the largest jail systems in America. However, even with these credentials, it is important to acknowledge that such a short site review (3 days) develops impressions and perceptions that will always require further in depth assessments by site managers as part of their considerations of this report.
According to the guidelines provided by NIC, the operational assessment expectations included the following:

1. Goal: The direct on site assistance and the subsequent report are intended to assist the managers in addressing issues outlined in the original request and in efforts to enhance the effectiveness of the agency. (Note: The original request desired an in depth review of the medical/mental health operations which was not part of this report. It was said that this part of the request would be addressed, via another NIC T/A, in late September, 2013).

2. Statement of Work: The operational assessment will include a review of the following areas:
   - Intake/Release
   - Housing Units
   - Classification
   - Medical (limited due to September review pending)
   - Policy and Procedures
   - Staff Training
   - Food Services
   - Conditions of Confinement and Overall Sanitation
   - Programs and Inmates Services
   - Security
   - Inmate Supervision

3. Preparation Activities:
   - Contact Major Mark Baird and discuss the expectations for the Technical Assistance (T/A)
   - Request required documentation for T/A:
     - Any previous jail inspections
     - Staff plans
     - Policy, Procedures, and Post Orders
     - Program Schedules
     - Housing Plan
• Mission Statement

• Service Contracts (medical/food)

Special Note: It was identified that the policies, procedures, and post orders were being developed and not fully available. Also, program schedules are in transition due to budget reductions and the need for volunteers. And, further, there is not an overall medical contract, but rather several that together incorporate the services.

• Develop an Agenda for the T/A event

• Review all requested documentation and make notes of any clarification needed

• Prepare a timeline of tasks to be completed onsite

• Prepare any questions that need to be resolved prior to the T/A on site visit

4. On Site Activities:

• Meet with Major Mark Baird (and Bureau Chief Jeff Miller) to discuss the purpose of the T/A and scope of work.

• Review the facility staffing and meet with all key personnel.

• Tour the facility including:
  • Housing Units
  • Intake/Release Areas
  • Medical/Food Service Areas
  • Program Areas
  • Maintenance Areas

• Review any documentation/contracts not previously received

• Conduct interviews with Facility Staff and other criminal justice administrators as designated by Major Baird.

• Conduct an exit briefing with Major Baird and other staff providing:
  • Observations
  • Preliminary findings
o And recommendations


Relative to the required work actions and the ultimate observations and recommendations, both, Mr. Ryan and Mr. Ford recognized the difficulty in conducting an in-depth review of the 1100+ inmate Snohomish County Jails, the Oakes and the Wall Street (including Work Release) sites in three days. The results will be the impression and perceptions of this short examination through the eyes of longtime professionals, but certainly are not absolutes and will need further assessment and review prior to direct actions by the Snohomish County Sheriff’s Office.
Historical Perspective
(Snohomish County Jail)

Sheriff's Office Corrections Bureau Mission: The mission of the Sheriff's Office Corrections Bureau is to serve the community and criminal justice system by providing safe, secure, human and cost effective detention in accordance with Constitutional guidelines.

Commitment: The Snohomish County Sheriff's Office Corrections Bureau provides protection to the community through secure detention of both pretrial detainees and those sentenced on criminal matters.

History: The Snohomish County Sheriff's Office was formed on January 14, 1861 when the State of Washington was still a territory. At present it encompasses 2,098 square miles and with a citizen population of 713,335 (2010 census). Snohomish County is the third largest county in Washington State and is made up of urban areas in the south and suburban and rural areas in the north and east where a large portion of the county is National Forest.

The jail is operated under the Revised Code of Washington (RCW) which was last updated December 27, 2012. The specific laws are listed under Title 70, entitled Public Health and Safety, in Chapter 70.48 RCW called the "City and County Jail Act". Subordinate to State Law, but directly on point for the Sheriff's Corrections Bureau Operation is Title 5 under the Snohomish County Code entitled "Operational Standards for Snohomish County Corrections Bureau". This code was apparently updated in 2009 to incorporate the Sheriff's oversight and responsibility. However, of particular note, even though the jail leadership staff indicated that they were developing policies and procedures, this code is very detailed and to a certain extent can be said to address jail policies and procedures as well.

Relative to the jail itself, prior to April 1983, the Snohomish County Jail was located on the 5th Floor of the County Courthouse Building. It was designed as an indirect, linear supervision jail with an average daily
population (ADP) of 120 inmates. Apparently, the jail was under the authority and direction of the Sheriff’s Office at that time.

In April 1983, the Snohomish County Jail was moved from under the Office of the Sheriff to the Office of the Snohomish County Executive’s Office. It was apparently renamed the “Corrections Department” as a department under the County Table of Organization. It was not made clear why this occurred. However, one of the immediate recognitions was that the 5th floor jail was no longer sufficient for the growing inmate population. As such, construction was begun to replace the existing 5th floor jail with the new Wall Street Jail.

The Wall Street Jail opened in 1986. It was designed under the direct supervision model of inmate supervision. The rated capacity of this jail is 477 inmates. It is presently a multi-story building with six floors of inmate housing while the first floor is utilized as a Work Release Facility. (Note: By 1987 the ADP was nearly 300 and growing.)

Between 1987 and 1998 the Wall Street Jail grew into an “overcrowded” condition in which inmates were required to sleep on the floor in plastic boats. By 2001, the ADP went over 1,000 inmates and it was clear that another jail needed to be constructed. By 2003, construction had started on the new Oakes Street Jail.

In 2005, the Oakes Street Jail was opened and the jail systems rated capacity became 1196 exclusive of medical and booking beds. Again, this new facility was designed under the direct supervision model, as well as including the opening of a new booking site (also designed under the open booking concept). (Note: At the time of our visit the count was 892 males with 1,006 capacity (89%) and 173 females with 190 capacity (91%). Since jails are essentially designed to best be operated at 90% of capacity, the Snohomish County Jail was operating at its optimum level.)

In 2009, the Corrections Department was reassigned back under the direction of the Snohomish County Sheriff’s Office. The Corrections Department became a “bureau” under the Sheriff with a Bureau Chief in charge reporting to the Sheriff, not the County Executive. The Table of Organization of the Corrections Bureau was restructured to better match
the Sheriff’s Office model. Again, the reason for the change was not clear to the TRPs, but was said to have had something to do with the Correction’s Guild labor organization. However, the relevance of this to general operations will be assessed later in this report.

**Special Note:** On or about 2003, the Correctional Staff’s uniforms were changed from the Sheriff’s green and tan to blue. The dark blue is still the standard uniform of detention staff today. However, there is some consideration, in an effort to provide continuity in the staff, to return to the Sheriff’s uniform model.

Unlike most jails in America, the inmate population of the Snohomish County Jail has not reduced since 2007. However, a part of this has to do with the jail assuming some contract housing of inmates for other surrounding counties. But even with this, the total bookings have increased by 2000 in 2011 and 2012 while ADP has only dropped by 25 inmates daily.

In 2012, the ADP was 1,179 (1,198 in 2011). The number of bookings was 27,120 (27,411 in 2011). Essentially, it has been stable in the last two (2) years. As to daily bookings, the jail averages about 75 a day. The average length of stay has come down from 18.7 days in 2008 to 15.7 days in 2012. Of note, the jail has experienced nine (9) inmate deaths since 2009 of which one was a suicide. There have been no escapes.

**Aside:** The jail also oversees a Work Release Program, as well as a Home Detention Unit. However the NIC team did not fully assess these as part of their onsite assessment.
Overview of Technical Assistance Activities

Prior to our visit, Mr. Ford and I coordinated with Major Baird in order to obtain background information, as well as data regarding the operation of the SCSO Jail. This was provided to each of us in the form of a large binder of information on the day before the visit including:

- Organizational chart;
- 2013 Operating budget;
- Staff schedule;
- Code of Washington (City and County Jails Act);
- Snohomish County Code (Title 5 - Operational Standards for Snohomish County Corrections Bureau);
- Jail History;
- 2009 Jail Transition to Sheriff's Office;
- Vendor Contracts including:
  - Keefe Commissary Contract;
  - Dental Services;
  - Aramark Food Services Correctional Services;
  - Health Services (Several Contracts);
  - Pharmacy Services;
- Jail Management Reports;
- Jail Website

We also reviewed the following information while onsite including:

- Inmate Handbook;
- Certain Policies, Procedures, and Rules;
- Training curriculum outline from Washington State Academy/In-Service;
- SCSO Jail Orientation 2 week curriculum outline;
- Inmate death reviews;
- Miscellaneous forms;

Relative to the site visit itself, we began with an orientation briefing of our jail review at the Oakes Street Jail Administrative Office Conference Room. The following individuals were present:
• Ty Trenary, Sheriff
• Brent Speyer, Undersheriff
• Jeff Miller, Bureau Chief (Corrections)
• Mark Baird, Major (Corrections)
• Chris Bly, Captain (Corrections/Administration)
• Tad Seder, Assistant Chief (Prosecutor’s Office)
• Becky Guadamad, Deputy Prosecutor
• Keith Mitchell, County Risk Manager.

At this meeting, it became clear that Sheriff Trenary was very intent on us examining any and all areas of the jail. Although NIC outlined eleven (11) areas of concern for our review, the Sheriff, although focused on these, also recognized a concern of working closely with staff organizations and representatives. We agreed to assess these concerns as we addressed the other scope of our work. In addition, he mentioned a need to review the policies and procedures, mental health collaboration concerns, the Table of Organization, morbidity considerations, overtime concerns, and the culture of the jail.

After the orientation briefing, we were escorted on a tour of the Oakes Street Jail starting at the point of intake. We spent some time in this area, and then progressed through intake, to classification, to inmate transfer points, to the kitchen, housing, medical, clinics, laundry and all the areas of the two jails on Wednesday and Thursday. On Friday, we started at court transfer and separated to visit unique areas of our personal concerns. On Friday afternoon, we prepared our notes and conducted a two hour exit briefing with Sheriff Trenary and the following persons:

• Brent Speyer, Undersheriff
• Jeff Miller, Bureau Chief
• Mark Baird, Major
• Chris Bly, Captain
• Randy Harrison, Lieutenant
• David Oster, Classification Supervisor
• Jim Woodward, Budget Analyst (Finance)
• Gary Haakenson, Executive Officer
• Jacob Hoff, Deputy
- Becky Guadamud, Deputy Prosecutor
- Keith Mitchell, Risk Manager

Although we fear that we will miss several staff members who assisted us along our visit path, we do wish to thank the following for their assistance:

- Dan Stites, Training Sergeant
- Maria Moore, Grievance Processor
- Susie McQueen, Program Manager
- Greg Chinn, Aramark Food Services Manager
- Dan Young, Booking Sergeant
- Marla Fritts, Sergeant (Swing Shift)
- Debbie Payne, Administrative Officer
- and several others – Thank you.

Relative to our research, review and interviews, we developed certain observations and with these, recommendations. The next phase of this report will deal with these items. As such, it is very important to recognize that these are our quick perceptions developed in a three day review. Therefore, each requires Snohomish County Sheriff's staff in-depth review before action.
Observations and Recommendations

As we completed our initial briefing and throughout our tours, it became increasingly clear that the SCSO Jail has some communication obstacles which seem to be significant impediments to good operational efficiencies. These tended to play themselves out between management and line staff, but, in particular, at the mid manager level of Lieutenant. In addition, there was a lack of consistency and continuity of care between areas of the facility. In a couple of these the differences were striking. And finally, it was clear that, even though procedures were in the updating process, those that did exist were not being read and followed (i.e., intake procedures). Each of these factors is in both observations and recommendations that comprise the substance of this report.

For the sake of clarity, the report is divided into the following sections:

General Observations/Recommendations:
- Life Safety;
- Sanitation and Cleanliness;
- Building Maintenance;
- Tool Control;
- Emergency Response;
- Policy, Procedures, Rules and Post Orders;
- Medical Services;
- Mental Health Services;
- Intake Processing;
- Release;
- Inmate Housing/Supervision;
- Food Services;
- Administrative Segregation;
- Training;
- Inmate/Staff Interviews.

General Comments (No Particular Order):

Future Thoughts and Considerations:

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As to the details of these items, the following is provided:

**Life Safety**

A critical component of jail operations is its level of safety and security relative to inmates, staff and visitors. Anything that adversely impacts this can lead to potentially dangerous situations. There were a couple of observations on the intake operations, in movement to the courts, the laundry, as well as other notes that can lead to concerns.

**Life Safety Recommendations**

1. At booking intake the initial detention deputy search process does not follow the written procedure. It was seen that handcuffs are removed and a single pat search is conducted when procedure states one before handcuffs removed and a second after. (Note: We were advised that a knife was recently discovered at this point which is a positive for the intake search process, but the sergeant apparently just cautioned the arresting officers. In Miami-Dade we send a notice to the respective Chief of Police as a safety issue.) Staff needs to follow departmental procedures.

2. During the movement to court, in the long underground tunnel, detention deputies arm themselves before movement. It was unclear what the goal of this was as weapons in this process are seen as more dangerous to staff, than inmates. (Note: Firearms within the custody envelope have never been seen as appropriate.)

   Aside: We observed a three person detention deputy transfer team in the tunnel with a very dangerous inmate. Unfortunately, at each door, all three deputies were watching the doors, and not the inmate. However, the inmate was clearly watching them.

3. In the laundry room, the dryers are heated by natural gas (high flames). There was a serious lint issue in this same area. Clearly, a fire danger which needs assessment for resolution.
4. There were many chemical cleaners seen throughout the facility. Many were in unlocked storage areas or under the direct control of inmates, not staff. There were two direct problems including 1) no MSDS safety sheets were readily available, and 2) the containers were not being marked for daily use which means inmates could take supplies for adverse use against staff and staff would not know. A procedure to correct this is absolutely needed.

5. While in booking on Wednesday, there was a mentally ill inmate in a cell for observation. On Friday, this same inmate was still in the same cell. We were told he was recalcitrant and had not been booked. The failure to move this type of person to mental health housing seems inappropriate and a direct danger to staff and clearly the inmate. This process needs to be immediately changed to move the mentally ill out of booking to proper housing and mental health assessment.

6. Once the medical staff have identified an inmate in need of a therapeutic meal, it is important that the inmate actually receive such a meal. Unfortunately, we observed a “cardiac diet meal” that, in our belief, could not have been “heart appropriate”. As such, it seems critical that, in order to avoid vulnerability, a separate audit of the Aramark plan and actual meals be conducted to determine if the contractor is actually meeting proper medical standards.

Sanitation and Cleanliness
(Observations)

The importance of Facility Sanitation cannot be overstated. It is critical that this be one of the highest general priorities of any jail operation. However, the jail is in need of attention when it pertains to sanitation. From booking to the housing units, the facility needs to be deep cleaned and a schedule established to maintain it. An inmate cleaning crew needs to be designated on all shifts to ensure that the level of cleanliness, clutter control, and sanitation is never diminished.

Specifically, it was noted:
1. The inmate housing areas should be clean and orderly at all times. The day rooms, cells, and work areas are not. There is a lot of clutter in the day rooms and the cells have items lying around. The officer stated that there is a regulation for how the inmates are to keep their cells, but no one enforces the rules. The day rooms had dirty floors, graffiti on the cell walls, and some offices looked like mini warehouses. Return air vents throughout the facility are in need of initial cleaning and regular maintenance.

2. Postings of rules, programs, and schedules littered the walls. It is recommended that bulletin boards be installed for that purpose and these items not taped to walls or windows. Windows are there for security reasons and this prohibits proper and secure sight lines.

3. Individual offices are for the most part cluttered, dirty, and in disarray. Individuals assigned to these offices need to be held accountable for their areas and they need to make sure they are neat and presentable.

4. Mop closets are cluttered, have unaccounted chemicals, and have numerous wet mops lying around. There should be a standard issue equipment list and inventory in each closet that is regularly checked by security staff.

5. Time was spent looking into closets, cupboards, desks, and drawers with clutter and seemingly unnecessary “items” everywhere. Some areas looked more like storage closets than work areas. There were old books, boxes, security equipment, and miscellaneous items. The facility needs a thorough cleaning and a process to de-clutter all areas.

6. The main control room is another area that is cluttered. There are cabinets for each shift/officer to store items. There were medications, food, and other items of contraband that should not have entered the facility or be permitted in a control room.

7. The exterior entrance of the Oakes Street Facility is not clean (Cigarettes, weeds, etc.).
8. The loading dock area was quite dirty, with an unsanitary smell, and old food stuffs, etc. on the ground, affixed to garbage holder, etc.

9. When we first entered the facility, it was noticed that an empty drink bottle was next to the entrance door. There were also cigarette butts, littered throughout the outside seating area. This area is the first impression the staff, the public, and any official visitors get when approaching the facility. The area was not addressed during our three day visit because the empty drink bottle was in the same place when we left the facility on the last day.

10. When entering the lobby, the area seemed dark and uninviting. It was not as dirty as some areas, but it does need attention to make it look more presentable. The visitor lockers had broken doors and the walk through metal detector was not utilized during our visit. There were also documents/notices attached to walls and windows. This area should have a bulletin board so that information can be contained to one area designated for that purpose.

Sanitation and Cleaning
(Recommendation)

Relative to actions surrounding the maintaining of the highest of sanitation and cleaning levels, it is recommended that:

1. A process should be established by the leadership to walk through, inspect by opening drawers and doors, and removing excess items. This usually cannot be accomplished by individuals that occupy those areas. Once this is accomplished, a regular inspection process should be established to ensure future compliance.

2. Regular inspections should be conducted by the housing unit officers and members of the command staff should do a weekly inspection. This inspection requires support and
guidance from the leadership to ensure it is maintained and not a flash in the pan. Incentives can be tied to the results of the inspection.

3. Cleaning crews need to be established and utilized on a regular basis. They must be taught the cleaning expectations, and then, held accountable to achieve and exceed them. Basically, if inmates are used for office cleaning, they must also be closely supervised.

4. Relative to internal actions, the following is specifically recommended:
   - Inmate workers should be identified to vacuum and clean floors, empty trash cans, dust, etc. in the administration and areas outside the security perimeter, but inside the building.
   - Inmate workers should be identified to clean all the common areas of the secure areas of the jail to include the hallways, offices, elevators, etc.
   - Inmates in the living areas need to clean their individual cells daily and a diagram placed on the housing area “bulletin board” that shows them where everything in their cell should be placed. Unfortunately, cells are littered with graffiti and the showers are in need of attention.

5. Relative to external actions, the following is noted.
   - Inmate workers should be identified to clean the front entrance area, both exterior and interior, seven days a week. In the morning prior to the established work day and in the afternoon to pick up trash, clean windows, mop and wax the lobby, etc.
   - The perimeter of the facility should be walked daily to also pick up trash.
   - The back dock area should be kept clean and orderly every day.
Observations and Recommendations

- Cleaning crews used externally need to be escorted by an officer to ensure security, but to also show to the public that inmates are maintaining the Sheriff's area of responsibility.

Overall, our recommendation surrounds the development of pride in the building and its work areas. We observed a couple of areas that were exceptional, like the inmate court movement area which was in stark contrast to the booking area, even though, they were side by side. It seems clear that "if leadership was not interested in sanitation and cleanliness, the line staff were equally as complacent."

Building Maintenance (Observations)

There was no evidence developed that the building had any serious maintenance issues. However, upon inspection of the maintenance office and equipment area, there were some observations that are worthy of review though. These included:

1. Caution is offered to give some attention to posters on the office walls as some might take offense to them.

2. The Key Control box in one area did not seem to have an inventory listed so it would be difficult to determine if any were missing.

3. It was unclear as to the key cutting process and inventory control. Basically, could a person have a key made, if it were lost, and it not be appropriately documented.

4. The MSDS book was readily available, but was not indexed so a chemical emergency response could not be immediately found.

5. Relative to the tool carts used by the maintenance personnel, it was not clear that they maintained a running and complete inventory every time they left the office. (Note: This might be done, but it was not observed on the cart.)
Building Maintenance (Recommendations)

It is recommended that an inventory of the maintenance office and all its tools be audited. This seems especially important regarding all key control areas. Further, if cart inventories are not being done prior to leaving the area and upon return, this needs to be immediately addressed.

This area and staff do not answer to the Sheriff when they enter the secure facility. As such, they need to have accountability for what they bring in and take out. Carts that enter the facility should have a laminated sheet that identifies every tool and item that enters the facility. This inventory should be checked regularly by the maintenance staff, maintenance supervisor, and the security officers to ensure all items are accounted for. Tools, as well as plumbing and electrical supplies, can be transformed by the inmates for numerous adverse purposes.

Tool Control (Observations)

This is an operational area that has much safety and security vulnerability to jail operations. Our observations gave us the distinct impression that it was not given the priority it requires. Inmates were seen pushing cleaning carts all about the facility with chemicals and mops/buckets, etc. with no inventory sheets. Chemicals were not being marked when used. (Note: Tool control was of even more concern in food services and the medical area, but this will be discussed later.)

Although trust of staff is important, there was no direct observation of staff and what they might be carrying into the facility at the staff security entry point. It appeared to be only a video recognition, and then, immediate entry. Apparently, others enter via this means as well.
Tool Control (Recommendations)

As noted above the facility security needs a security assessment whether from the perspective of the maintenance cart inventory to the staff entry point concerns. Every jail should expect a breech of some sort which allows contraband to enter. Therefore, a serious review of these possible vulnerabilities is needed as just a couple of areas of concern.

Specifically, the facility should establish a security checkpoint so that any and all staff is screened/searched prior to entry. Bags and personal items should not be allowed into the secure area. If bags are allowed, they should be clear plastic to ensure all items contained are visible, identifiable and permitted.

Emergency Response (Observations)

Although all jails hope to have as few as possible “emergency responses”, all jails have them from medical crisis (heart attack) to suicide to fires to power outages, etc. Since these are to be expected, it is a critical as to how the staff responds to such events. Unfortunately, it was not clear how much training staff has had relative to such events, nor how often mock events are tested.

Relative to some specific observations, the following was noted:

1. An AED was found in a closet in booking. Does all staff know where it is? Does it work? Should it be there?

2. The Medical Clinic’s “Crash Cart” was observed to have a multitude of items on it, but no inventory sheet to determine what actually should be there. For example, an AED was not observed.

3. A visit to the facility armory showed a location that was in disarray. There was sand piled in front of the door showing that it was seldom visited by staff. There were shotguns, but no shot gun ammunition. There were bullets, but no guns.
4. There were "red phones" in main control for the fire department contact and use, but it could not be determined when last the fire department lines were tested, equipment tested, mock events occurred, etc.

5. The good news is that it was said that there have been "few events"; however, on one of the nights of our visit, there was a power outage, but only one flashlight in Main Control?

**Emergency Response (Recommendation)**

With the consideration that the jail must always be ready, the following needs to be addressed:

1. Since it was said that the Sheriff's Special Response Team would "most likely" respond to a serious inmate disturbance event, it is recommended that their team leader meet with Jail Command to discuss the response priorities. These should include an examination of the armory and it should have facility plans, riot equipment, and other items that may be needed available inside. Upon that, there should be mock events, at least, annually (and these should include fire and medical response teams as well).

2. Quarterly mock events should be conducted on each shift.

3. Medical emergency responses should be given special consideration to include mock events, but also equipment movement (crash cart/inventories). These should include outside contact with "911" paramedics to insure smooth response. *(Note: Are elevators equipped to give medical response personnel direct control to prevent unnecessary stops when responding?)*

**Policy, Procedure, Rules and Post Orders (Observations)**

We were told on several occasions that the above were under review and that this had been occurring since the Sheriff's Office took over in 2009. However, we tended to discover that policies and procedures did not
Observations and Recommendations

exist, or they were old, and, if they existed, they were not understood by staff and followed.

This was first observed at booking intake where the exchange between the law enforcement/arrestees is brought into SCSO custody by the Detention Deputy. There was clearly confusion regarding the search requirements/process. However, it became more evident when staff was asked to provide their specific Post Order for their specific duty assignment. None was available. (Note: If true, how can staff be held accountable?)

However, it was also noted that other officers did not have post orders either and several stated that the policies on the computer were hard to find or not all there. They didn’t seem to really know where to find the information. These auditors felt that the officers were not interested or motivated to look for the policies.

Also, there seemed to be some confusion at the administrative level as to the difference between a “policy” (i.e., Sheriff’s level directive like “professional appearance”) and a “rule” (like the uniforms a detention deputy is expected to wear on duty). Before anything is written, the determination of mutually understood definitions is critical.

Policy, Procedure, Rules and Post Order (Recommendations)

This entire area is seen as extremely critical by the TRP’s. The Jail Leadership should immediately make contact with ACA accredited jails and get copies of all their Policies and Procedures (P&P’s). The SCSJ P&Ps should then be compared and updated by a team of jail staff (from all levels) in the next 90 days. They should then be implemented with a comprehensive training plan by 1/1/14.
Observations and Recommendations

Medical Services (Observations)

These services were not a direct part of our review as NIC is sponsoring another T/A for this in late September, 2014. However, we did conduct a quick review which surfaced the following:

1. The medical area was quiet and officer and medical staff were present.

2. However, it was discovered that drawers and cabinets were not secured in open exam rooms. The drawers contained medication, needles, scissors, etc. that should be on an inventory and secured when not in use. The nurse was questioned about security procedures and the explanation was sketchy, at best.

3. As noted above the crash cart was in disarray and there was no inventory or order to the cart. When items are used, there should be a procedure to show the usage and replacement procedures. Further, all staff must be knowledgeable of these processes.

4. The dental area had left over personal food on the cabinets and there was a carton full of salt packets on the floor which seemed out of place.

5. There are medical alarms (button in the examination rooms). These apparently are not tested very often. However, when tested, they give alarms off in the main control, but only a light goes on outside the exam room. If the officer is not watching, it will not be seen and response delayed.

6. When “medical protocols” were requested, they did not seem to be available. It was unclear if they existed, or if they just were not available.

Medical Services (Recommendations)

It seems that the NCCHC Accreditation Standards should be provided and that the medical staff be directed to work towards accreditation. There is also an immediate need for a safety and security action plan to include:
1. The locking of all doors, drawers, cabinets, etc. when not in use.
2. There is a need for an immediate inventory and monitoring/auditing process implemented.
3. If medical protocols are not documented, these need to be prepared and made immediately available.
4. Emergency response procedures for the clinic itself should be tested weekly and there is a need for an “auditory (bell/buzzer) notice along with the light”.
5. The “Crash Carts” need an immediate assessment to ensure everything that is needed is on-board and any extraneous items removed.
6. The medical staff must be trained in security procedures, the expectation pertaining to securing examination rooms, and the accountability of tool while adhering to security procedures.
7. The Medical Clinic corrections officer also has a duty to ensure that the medical area is secured and that any and all equipment, like sharps, are stored and locked.

Mental Health Services (Observation)

Mental Health is a major concern in the SCSO. When we toured the booking area on the first day, a male inmate was in a cell and was identified as needing assistance from a mental health professional. This same inmate was in the same cell two days later and we were told it was because they did not have space in the special housing area and did not want to move him because it would end up being a use of force.

An inmate in this condition needs to be housed in a manner that is best for him and the agency. Leaving him in a cell in the booking area is neither. Mental health should be on hand to evaluate, almost immediately, to access his condition and make appropriate treatment recommendations. Early intervention by mental health staff should
reduce the possibility of a use of force and the improper housing of the mentally ill inmate.

An opportunity was taken to visit medical housing which included negative pressure cells (which were functioning appropriately), as well as observing the suicide watch process. The staff member in this area was well versed on her duties and all was addressed.

This is an extremely vulnerable arena and the NIC T/A in September should give it significant attention during their visit.

Mental Health Services (Recommendations)

The discovery of the mentally ill inmate in booking for multiple days needs immediate corrective actions. This should never occur. Administration needs to take appropriate corrective actions to not let this occur in the future. In addition, supervisory staff and officers in the booking area need to be trained in the basic techniques so they can safely and securely deal with these individuals for the short time they should be in the booking area.

Overall, it was not known whether staff involved with the mentally ill had received Crisis Intervention Training (CIT). This is presently an expectation of all custodial staff who are directly involved with the mentally ill in custody. If they have not, training should be immediately addressed.

Intake Processing (Observations)

The booking area was where the tour started and the booking process was explained. The process does allow for the arrested individual to be searched, booked and dressed out, but the process should be organized in a more streamlined manner. The search policy states one process and the officers practice another. When this was discussed with the booking sergeant, he was unaware. When brought to the attention of the
lieutenant, he said that they should be following policy. If true, who is watching?

Additionally, the booking area was cluttered and the sanitation of this area was not at an acceptable level. The floors either have not been cleaned or the old dirt has been waxed over. The cell areas are equally unacceptable and there is a lot of graffiti on the walls. The sergeant’s office is unorganized and paperwork and equipment are lying around. Phone books were stacked on the phone island, postings were taped to the walls, and there was no sense of a professional environment.

Boxes and items are stacked in areas not meant for storage. This gives the area a sense of being cluttered and there is no way to adequately clean this area. Ceiling tiles are very dirty around the heating/cooling vents. Proper tool control is not practiced in this area. A pair of pliers used to apply the wristbands was lying on the fingerprint table. The pliers at one time had been tethered, but the cable broke and no report was filed nor was the tool reattached. A paper cutting board, which is a possible weapon, was lying directly behind the 10-print machine.

The booking area receives individuals that are unknown to the deputies in the booking room. It should be addressed that any item that could be used as a weapon is secured to ensure officer and arrestee safety. This is the responsibility of the officers working the individual posts and the supervisors in those areas.

While in the booking area, the officers were feeding sandwiches to the inmates. As they were delivering the chicken salad sandwiches, the contents of the sandwich was falling on the floor. No attempt was made to have this cleaned up while we were there and the food was still there that afternoon. The booking room is a revolving door and has more traffic than almost any other area and therefore needs to be cleaned on a routine basis. The security staff and supervisors need to ensure this is accomplished on a regular basis.
Other observations included:

1. There did not seem to be any rules for incoming arresting officers. Where to put their weapons, how arrestees are supposed to be handcuffed (front/back), what is to be done if a weapon or drugs are found on the arrestee?

2. There was a pat search rule, but it was not known or being followed.

3. Drawers and cupboards which had locks on them were not locked.

4. Inmate/arrestees food was left out/not refrigerated.

5. The AED unit was in a closet.

6. It seemed that sworn staff were completing booking input processing with the computer system. These staff did not seem to have direct contact with arrestees. Could non-sworn staff provide these services?

7. Deputies were wearing coats because they were cold due to air-conditioning. An inmate asked for a blanket, but the sergeant said “no”. This seemed inappropriate as the female inmate had been sitting since 3:30 a.m. and it was 7:15 a.m. Was this really a security issue?

8. There was an inmate who was clearly homeless. He was dirty and smelled. He asked to take a shower which was apparently available in booking. It was denied. It seemed that it would be safer for staff and the inmate, if he cleaned himself and was given clean clothes.

**Intake Process (Recommendations)**

There are many items that need attention at Intake/Booking as follows:

1. A thorough cleaning is required that involves the removal of existing wax and floor/cleaning sanitation before re-wax. Cells
need to be sanitized, re-painted, etc. Clutter needs to be removed, drawers cleaned out and locked, and food distribution assessed.

2. The law enforcement intake process needs review to include specific rules for acceptance of arrestees. Additionally, most jails now require that the arresting officer provide specific written information about any medical/mental health issues that occurred at the time of arrest (i.e., taser use, baton, diabetes symptoms, etc.) Further, most jails have a RN assess the arrestee before acceptance. There is a room immediately adjacent to the transfer of the arrestee area that could be remodeled to provide this service.

3. There seems to be need for sensitivity training for this staff. This is where the first time offender and the long time recidivist comes in direct contact with the jail. The "open booking approach" is the proper model, but now staff needs to work to recognize the immediate needs of arrestees/inmates for their wellbeing, as well as the inmate. (Note: As noted above, CIT programs for the booking staff would also be of value.)

4. Relative to the procedures, rules, process and post orders in booking, the staff recommended that the leadership, in cooperation with the officers actually doing the job, review, update and practice what is expected.

**Release Processing (Observations)**

Recent case decisions seem to indicate that jails “should” attempt to allow inmate release within 6 hours from notice of release (i.e., bond submittal). However, discussion with release personnel indicated that this goal was not being achieved. (Note: It was said, though, that once the new inmate computer system is in place, this time frame should be reduced.)

In addition, the following was noted:
1. It was said that Thursday has an increased number of releases, but no increased staff which extends release delays.

2. It was said that the court process is not automated and the jail must wait for paperwork to be physically brought back before a releasee can begin the process of release. It is then sent to the administrative area for coordination with the jail file.

3. It was said that “until admin finishes”, the release staff is not noticed of the name of a released inmate. It is after that, that they begin to gather money, property, clothing and the inmate. However, the Release Officer does not act until he has several possible released inmates (I saw 6) and has typed a list to send to the different areas.

4. Once everything for all the listed inmates has become available, then the release process actually is initiated. (Note: Some releases (i.e., the mentally ill are not released at night). Although this has some practical basis, I must wonder what happens if the inmate releasee becomes ill while waiting for release. Is Risk Management aware? Do the courts agree?)

Release Processing (Recommendation)

First, the faster the jail knows that an inmate is available for release the faster the individual can be processed. As such, if an inmate is sentenced to “time served”, why can’t the court officer call or email the administrative office to start the process. With this, why can’t property, money, clothing, be sent to the release area quickly, and then have it available immediately when the inmate returns from court.

Second, is there a reason the mentally ill cannot be processed first so they can be released during the daylight?

Third, is there a better process than waiting to have a list of releases before starting the process? Why not move more quickly, even one at a time. The longer releases are held the more difficulties are possible.
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Relative to these possible actions, it seems that a staff committee of all the involved parties is needed to assess this (flow chart) and determine where expediting the process is possible.

Inmate Housing Supervision (Observations)

The supervision model used by the SC Jail is designed around the 3rd generation concept called “direct supervision”. This model is recognized as the best practice in inmate management and has proven to be the best in providing staff and inmate safety and security.

The concept involves eight principles (or nine if one uses the AJA model) and involves staff empowerment and much more. However, unless somehow it was missed, we could not find this concept, “direct supervision”, in the staff and/or supervisor training. If this is the design, shouldn’t it be an integral part of the initial, as well as in-service and promotional training plans?

Given this, it seems that some of our observations mitigate against the inmate direct supervision model actually being used, as follows:

1. The staff uses “red tape” on the floor to prevent inmates from accessing staff. This also tends to make staff believe they should not inter mix with inmates on the floor.
2. Rather than having a great deal of “out of cell time”, there seemed to be extensive periods of lock downs.
3. Staff seemed to direct inmates to submit grievances, rather than attempting to resolve issues, before they become grievances.
4. The Inmate Handbook states: The Snohomish County Jail (SCJ) is a “Direct Supervision Facility”. This means there is a Correctional Deputy who manages each housing unit, or module, who directly supervises your activities. Check with the module deputy regarding release dates, filling out of “kites” (jail request forms), visitation, and module rules...
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If the staff are not trained in this model, how can they be expected to follow it?

Inmate Supervision (Recommendation)

1. NIC provides “Training for Trainers” in direct supervision. SCJ should take advantage as there is only a minimal cost.

2. NIC provides a manual for jail leadership in “DS” which has a checklist for the elements of a successful “DS” jail. The Bureau Chief and the Major should access this and use it to assess the jail’s present level of DS operations.

3. A retraining for all staff needs to be conducted in “DS” and impediments (like red tape on floors) needs to be removed.

4. Several jails have provided a card for all staff to carry that shows the Principles of Direct Supervision and each staff member must be able to repeat them.

Food Services (Observations)

Of all the items of importance in a jail’s operations, food services is a significant one (usually third after safety/security and medical). The SCJ has a contract service under Aramark (4/1/13 - 3/31/18). This is a $7.0 million contract which is designed around a 2800 calorie per day meal plan, over a 4 week schedule, for the general population inmate. It also includes “Special Diets” (i.e., therapeutic diet meals prescribed by the medical staff (up to 15% of inmates). The per meal cost is expected to be 92¢. Aramark also oversees an inmate work program entitled “In 2 Work”, however the details of this were not ascertained.

Relative to direct observations, the following was noted:

1. The Aramark Menu Manual was dated 2007 and seemingly designed around the Scientific Food Nutritional Standard of the 1990’s. This was changed in 2009.
2. The contract states that:
   - Food must taste good;
   - Food must be served properly to enhance inmate acceptance;
   - Have "cooks occasionally (must) go to housing modules to observe serving and note any problems."

   It was unclear how this was audited.

3. The inmates complained about portions (which is very much expected), but also about blandness. (Note: Usually, such contracts require salt/pepper to be part of each meal in order to meet nutritional standards. It was not provided and, therefore, were nutritional standard (2800 calories) being met?)

4. The food service area was presentable, but does need more detailed attention to sanitation. The hood over the ovens, behind the ovens, and the dish washing area needs a deep cleaning. Wet pans are stacked and need to be placed on their side to adequately dry and not hold water. There appeared to be papers and trash behind the heating units and the copper piping was dirty.

5. When examining the food storage areas, it was discovered that some stock was dated and some was not. It is important to date all food items received that are stored in the refrigerator, the freezer, and dry stores to ensure that food is not kept too long and that the stock is rotated to ensure quality and safety.

6. Food temperatures are taken and monitored when the food is being prepared and while it is being placed into the individual trays. However, it is not taken when being served to the inmates.

7. There were 3 days of meals on hand in the freezer for testing purposes should there be a food problem in the jail.

8. The inmate lunch meal was consumed on the 21st of August and was of sufficient quality. The quantity could not be ascertained because an item listed on the menu was not available. (Note: It was said that the same meal served to the inmates was available "free" to staff in the staff break area. It did not seem the same. Specifically, the meal called for juice which was not provided.)
9. There is a single inmate worker who oversees the “Special Diets” (Therapeutic Meals). He seems to do a conscientious job and was well versed in the process. (Note: However, a cardiac meal was observed and it seemed extremely high is sodium and carbohydrates. It included “Dorito” type chips, rice and an orange? Is there a process for medical to actually review the meals to insure they meet standards?)

10. The food service manager (Greg Chinn), seemed well versed on the operation and the delivery of meals to include therapeutic and faith based diets. However, a concern was raised as to the ability of Captain Bly, with his other duties, to be able to effectively monitor the contract.

Food Services (Recommendations)

Although there is no direct reason to suspect that the 2800 calorie diet (4 week) plan is not being met, it seems it needs auditing. Specifically, the calorie count was verbalized by the contract vendor, but it is recommended that a third party, such as the public health department, be utilized to verify the actual calories for a meal, a day, and for an entire week. Given the observation of the “Cardiac Meal”, this assessment should also include a review by medical and public health of the “Special Diets”.

Other thoughts include:

1. The menu manual needs to be updated to 2009 Standards and annually co-signed by the medical director, bureau chief, etc. along with the nutritionist.

2. Food temperatures should be taken upon delivery in the inmate housing areas to ensure the delivery temperature is acceptable.

3. The SCJ just installed a new $250,000 scullery (tray washing) machine. The inmates placing the trays in it seemingly were using a great deal of force to do so. Do they need training on how to use?
4. There is an officer assigned to the kitchen to oversee the safety and security of operation. Given the observation of unclean pipes, clutter behind heating units, etc. does he not have a responsibility to ensure cleanliness, portion review, inmate training, etc. What has been his training? Has he read the contract?

5. On page A–3 of the contract, “Cooks” are supposed to go to housing modules and “observe the serving process”. Is this done and documented?

6. On page A–2 it states that sack lunches are to be sent “To the booking area for inmates who have not yet been moved to a housing module...” This was not observed and needs to be audited.

Administrative Segregation (Observations)

After the Prison Rape Elimination Action (PREA), the next area that is believed to be gaining the attention of the correctional oversight advocates is the “Administrative Segregation” areas of jails. Given this, we examined the “Ad Seg” area of the jail and observed the following:

1. Upon entering the area, there was a room housing 2 inmates that appeared to be totally closed off from direct observation. We had never seen such a place in jails and, as such, could only wonder how safe it was. (Note: The staff seemed to work well with it, but it was unusual. Also, it was interesting that management staff did not know how to access it?)

2. There was a recreation area for these inmates, but it was unclear how often they got to use it. If they got to use it, basketball hoops were available, but no basketballs.

3. The control room was small and cluttered. In it, there was an emergency response bag, but its contents were apparently not monitored and/or inventoried.
4. The windows of the control booth and those windows adjacent were covered with taped on notices. How could staff see out of them to observe inmates?

5. Upon testing the inmate phones, it seemed that they did not work without a loud buzzing. Does staff test these and take corrective action?

6. It was unclear how often each “Ad Seg Inmate” was assessed by classification to determine if they were eligible to return to general population?

7. It appeared that reading materials were available to inmates, but only in English. Is there a need for Spanish books?

Administrative Segregation (Recommendations)

Given that this “could become” the next area of serious outside review, the following recommendations should be considered.

1. If the SCJ does not have a continuous 30 day review of each person in Ad Seg, this needs to be addressed. It might even be appropriate to create a weekly Ad Seg Inmate Status Review Committee.

2. Since inmate medical attention, upon entering Ad Seg, is important, does SCJ have a medical review of every inmate before they are sent to Ad Seg.

3. Recreation is an important element as well. SCJ should consider building walls in the recreation area so more inmates could have recreational opportunities at once (i.e., 2 walls, 3 inmates). (Note: Inmates should be given something to do – basketballs?)

Training (Observations)

It was said that “new recruit” training involves the following:
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- SCJ on-site 2 week orientation;
- Then 1 week transition to the State Academy;
- Upon that, a 4 week “Problem Based Learning Academy”;
- 6 week FTO program follows

(and)

- Then 9 months of probation.

Thereafter, staff have annual AED/CPR “online” training, 1 hour firearm training (for 50% of staff) and annual 45 minutes defensive tactics class.
Upon promotion, sergeants receive a 40 hour class and 6 weeks of FTO. Lieutenants receive 40 hours and 3 weeks FTO. It was said that there is no other training in a deputy’s career that is mandated. (Note: I am aware that there needs to be PREA training by December, 2013?)

Training (Recommendations)

Given that Florida requires 22 weeks of training in an Academy and certification subsequent to a “300 question test”, it is difficult to not judge the Washington program as deficient. This is especially so when there seems to be no training in “Direct Supervision” and little relative to the mentally ill in jails. Even so, it is recommended that SCJ seriously examine the State Academy curriculum to insure it is really addressing the needs of SCJ and/or assess the SCJ orientation, FTO, and probationary period to insure it provides the necessary training experiences.

It should be noted that NIC and AJA provide some excellent training opportunities at small cost. Specifically, the Executive Leadership Academy at Sam Houston University should be considered for the leadership team, along with other NIC programs.  (Note: Also NIC supports regional training, if SCSO would sponsor it.)

Inmate/Staff Comments (Observations)

Relative to inmates, the following was noted:
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1. During the course of the operational assessment, several inmates were interviewed and/or talked with about the conditions of confinement, security staff, medical services, and any comments they felt we and the leadership needed to know. The inmates did not complain about the staff. They overwhelmingly felt the staff were doing their jobs and cared about their welfare. Several inmates did voice concerns about their medical treatment and one stated that the most frequent response was to “drink more water and submit a kite.”

2. There was concern about food service. They felt that the portions were too small and that they did not get a variety of meals or condiments. This is a very common complaint when interviewing inmates, but as stated earlier, the leadership needs to have a third party review the meals, calorie counts, and portion control.

3. Inmates were very vocal about the inconsistency between shifts. Once comment was “we know what this officer expects and the next officer operates differently”. The inconsistency between shifts was evident when talking to inmates and staff. This is a challenge and must be addressed. As stated in the out brief, the leadership needs to direct the middle managers (Lieutenants) to communicate and ensure that all shifts operate within the parameters. They need to understand that the officers and inmates need consistency in the daily operation.

Relative to staff, the following was noted:

1. The staff of the facility was impressive and presented a positive image of this facility. Most were polite and answered questions and professionally voiced concerns. They are concerned and hopeful that the new administration will move the operation in the right direction. They are, for the most part, optimistic that the new Sheriff will do good things.

2. Most officers feel the initial training was sufficient for the job. They feel that training after that is basically non-existent. They would like to see more practical application when it comes to unarmed self-defense instead of just 45 minutes annually which is
believed to not be realistic. The armed officers would like more range time and the ability to get practice ammo. They would like to see more practical application when it comes to training and less computer based training. Also, several officers verbalized that they would like more training designed for their specialty, not just the generic training all officers receive.

3. The consensus was that there is little to no communication between the line staff, the lieutenant level, and the leadership of the organization. They stated that they do not see their supervisor much, but several did comment that they had seen the new Sheriff and did feel good about that. The most verbalized complaint was the inconsistency between shifts. Each supervisor does things differently and they felt that wasn’t fair for the officers or inmate population. The comment was made by several staff that the new Chief was easy to talk to and they hoped he would be accessible and in the facility more often.

4. Officers overwhelmingly did not like the way they had to search for and try to find the documentation that they are required to know and review to do their duties. They felt that trying to find the policies and post orders was cumbersome and confusing.

5. The officers felt that the communication and relationship they had with the inmates was good. They did not feel threatened by the inmates and felt that most officers would respond when needed.

6. The majority of the officers felt that promotions were who you know, not what you know. They would like to have and see a fair promotional system for all ranks.

7. Several officers stated that they would like to see the leadership in the facility more and show they care for correctional staff like they do the law enforcement side. The uniforms were only an issue for about half of the staff interviewed. However, they would like to ensure that the officers in the jail have the same pay and benefits as the road officers.
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It is only recommended that SCJ leadership, as well as the Sheriff assess
the above comments and take action as may be deemed appropriate.
However, it is suspected that much of this has to do with providing good
communication with staff which presently seems to need significant
improvement.

General Observations and Recommendations
(No Particular Order)

1. It seemed that Inmate Programs were extremely limited due to
recent budget cuts. Clearly, this is an important area of concern in
an effort to reduce recidivism. It is believed that expansion of
services might be possible with improved connections with social
services organizations, as well as, non-profits like domestic
violence programs. (Note: It is recognized that, in times like the
present, this will be difficult.)

2. It was noted that the SCJ has several very large contracts like food
services, commissary and medical. To closely monitor these will
take some significant attention, and to give these to the
Administrative Captain along with other duties, will be most
challenging. (Note: It is recommended that these be delegated to
others or a contract monitor position be specifically created.)

3. The Inmate Welfare Fund provides services for the “benefit of the
inmates”. However, there does not seem to be an annual budget
overseen by an Inmate Welfare Committee. As such, there is not an
inventory of IWF items prepared and monitored for games, sports
equipment, etc. (Note: This is the inmate’s money and Sheriffs
have been seriously examined for a failure to address this closely.)

4. Above “Key Control” was mentioned, but needs to be reviewed.
Overall, keys were checked out to individuals that are not employed
by the Sheriff’s Office, therefore they are not issued key tags or
“chits”. Any and all individuals that are permitted to work in the
facility and can possess facility keys should be issued key tags, so
that the control room operators, and leadership, know where all keys are at any given time.

5. The staff dining area is accessible from the main hallway and is where staff can purchase food from the contract vendor and also consume meals brought in. The area is well lit and has two walls of windows which is a great atmosphere for a lunch or break area. There are also free meals for the staff if they desire to consume the “inmate” meal. This meal is on a separate steam table and is not displayed in a way that the staff would consider or be motivated to eat it. It was also discovered when comparing the displayed food items with the daily menu that the entire meal was not available.

6. The video visitation process is not only a great security tool; it saves manpower and reduces the introduction of contraband into the facility. We walked through the area adjacent to the lobby where family and friends come to have a video visit with the incarcerated. There was an officer logging individuals in and directing traffic in the area. There are lockers for visitors and several were damaged or had no doors. There is also a walk through metal detector that was not being utilized. It is recommended that the area be brought up to an acceptable level of sanitation, repair, and security.

7. The administrative areas of the facility are functional, but lack any personality. There is not much in the way of decorations that may lend to a better, more professional working atmosphere. The main hallway has a cabinet with openings in it for officers to store their items while at work. This area looks un–kept and it would be recommended that a locker room or an area off of the beaten path be utilized for this purpose. This area also needs to be maintained on a daily basis to ensure the area instills a positive and professional correctional attitude and environment.

8. It is clear that morbidity reviews are not conducted within an acceptable time frame after an inmate death. With the concern over the recent and past number of inmate deaths, this review would establish data that could be used to identify areas that may
or may not be a concern. The deaths in the past few years were reviewed and no trend was identified by the consultants. However, it is very important to put a review process in place to include:

- A review in 72 hours including medical, mental health staff, custody, legal, investigators, medical examiners, and risk management.

- If there is any “issue that surfaces” calling for action, an implementation program needs to be immediately reviewed for initiation (and that action absolutely documented).

- Upon final results of the Medical Examiner’s Office (Coroner), all the parties should be brought back together to conduct a follow up review and take further action, if deemed necessary. A final report should be prepared, probably by jail staff consolidating all the information together.

- **Special Note:** Be sure the event is overseen by criminal homicide investigators that have had training in in-custody deaths, so all the necessary evidence, photos, video shots, inmate phone records, etc. are preserved.

9. Relative to inmate recreation, the housing areas have attached recreation yards, but no basketballs to utilize the basketball goals installed in these areas. There is no requirement to have them, but this is an excellent way for inmates to burn off energy, stay fit and have less aggression towards the staff. Further noted, was that the inmates can buy playing cards from the commissary and some games are available from the housing officer. However, the games themselves are in bad shape and it is recommended that the facility purchase and have on hand board games for the inmate population. Any activity that keeps the inmates busy is a great way to reduce negative interaction between inmates and staff.

**Special Note:** There is a rule that prevents released inmates from “giving” decks of cards they have purchased to remaining inmates. There are some security concerns that support this, but if staff do not have games to “give to inmates”, this rule needs reconsideration.
10. Relative to the movement of inmates from their housing unit to the court through the tunnel, we walked with transport officers through the process. Although it has already been raised above relative to the firearm process, once the officers and inmates arrive at the court house, they must use an elevator also utilized by the public. This is not the best situation for moving inmates and needs to be revisited to see if there is a better solution. Also when maximum security inmates are moved to the court, the inmate is secured in a cell with a bolt and padlock. Unfortunately, it is difficult to see and monitor this inmate. There needs to be more observation capability of the inmate and a better security procedure.

11. Pest Control (insects and rodents) is a concern in jail operations, especially if the jail is located near water, but there was no evidence of any in the facility. The individual in the kitchen and housing units were questioned about the presence of pests and no one indicated a problem. There is a pest control contractor who apparently visits the facility on a regular basis. (Note: It was noted though that there were rodent traps in the loading dock area that appeared very old and dirty. It seemed that these had not been visited by the vendor in some time.)

12. It was observed that inmates are issued individualized inmate property boxes at booking which are designed to maintain all of an inmate’s personal property, uniform, clothing, and commissary. After reviewing what an inmate is allowed to possess, there is no way all of the authorized items, if purchased and maintained, will fit. It is recommended that additional or larger containers be provided, so the inmates can be within the published guidelines.

13. Regarding “Shift Briefings” it was noted that they are conducted via a conference call. The conference call is to half of the staff (one building’s employees) and then another conference call to the second building’s employees. When asked why this is conducted in this manner, the lieutenant stated that the buildings were on two different phone systems. It is recommended that a system be implemented so that all officers receive one shift
briefing from the lieutenant. This not only saves time, but ensures the same information is passed to all officers.

14. It was noted that there were buckets with flex cuffs in the evacuation stairwell. It was said that these were to cuff inmates as they exited during a major event (fire). It was our opinion that this concept is neither workable nor reasonable and would result in a significant delay. It is suggested that this plan be thoroughly reviewed and a new approach, absent cuffing, be implemented.

15. In observing the laundry operations, there seemed to be a significant number of possibly old and frayed sheets. A concern was raised as to the inventory control process, the actual types of sheets purchased and their expected useful life, and the removal process when they become tattered. Possibly an assessment of this would be worthwhile.

16. In assessing the inmate grievance procedure, it was noted that there was a chart of grievances by category and shift (enclosed). However, in talking to shift supervisors, they said they had never seen the chart. They indicated that, if they had, they might be able to address concerns before they became grievances. This chart needs to be shared.

17. In examining the Inmate Welfare Fund (see other notes above), it did not appear that there was an annual budget prepared or an IWF Committee was in place headed by the Bureau Chief that chaired such a committee. Further, it was unclear whether an annual inventory was conducted of games, etc. nor what was the usage plan for replacement of old games, etc. It seemed that this is an area for consideration.

18. Regarding “legal mail”, it is required that it be opened “in front of the inmate” so that it might be checked for contraband. However, at SCJ legal mail is also monitored as it “leaves the jail”. It is logged out and a daily list is maintained. When questioned as to why, the staff person said that, in the last 5 years, there has been one investigation of this which apparently lead to the discovery of a
person, who was not a lawyer receiving said mail.  *(Note: It seems that such a logging system may not be worthy of such attention?)*

19. In looking at Inmate Programs, there is a weekly “Hispanic Bible Study”. However, we were told there were insufficient Spanish speaking inmates to require the Inmate Handbook or reading materials/forms to be in Spanish. Given the DOJ Limited English Proficiency (LEP) rules, this may need to be reviewed.

It was also noted that there is a “Female Victim (Domestic Violence Program); however, no program for males as either victim or perpetrator. I did talk to two inmates that were in custody purportedly for domestic violence charges. Should there be program equity?

20. In observing the video court operation, a couple of items surfaced including:

- There are many inmates in the court room (possibly 30 or more). There are just a couple of doors to the outside. Have there been any mock hostage events tested in this location?

- The cleanliness of this area also seemed deficient (an odor was evident in the court room area). How often is it cleaned? This is an area where outsiders (Public Defenders) visit the jail daily. What is their impression?

- There is no “privacy” between the inmate and the judge. Could the operation be restricted so the video unit was placed where “other inmates” would not directly view what is happening?

21. Inmate personal property is placed in a bag upon inventory and receipt completion. Many jails have now gone to a shrink wrap system which is overseen by a camera that takes a photo of the property for staff and the inmate. The photo is the receipt for the inmate and a separate paper receipt is not created. This may be worthy of consideration.

22. The Work Release Center was visited to review its operation. The facility encompasses Work Release, Electronic Home
Monitoring, Department of Corrections Females on Work Release, Minimum Security Residents, and External Work Crews that go into the community on a daily basis. The operation was explained as the tour progressed.

The facility could be neater and cleaner by utilizing the individuals living there. They have a cleanup each afternoon, but they need to do some deep and continual cleaning. Some areas of the facility are cluttered, and several offices have boxes stacked and papers taped to the windows and walls. This is not what is expected in a professional environment.

However, the officers working at the facility were knowledgeable, professional, and enthusiastic about the program. They were concerned about the staff though, because when there are five officers assigned, in most cases, one is reassigned to the jail. They would prefer to have their own staffing to be able to conduct their daily operation and have time to do inspections, searches and ensure individuals are doing what they are supposed to be doing. They would also prefer that their supervisor be responsible for all shifts and not transfer the responsibility to the jail supervisor after hours.

They also mentioned that they do not have the staffing ability to do job checks to ensure individuals are at the job site as required. There is a big concern about those individuals working for “family” and actually not working at all. The program needs to have set procedures and staff to ensure the program is legitimate and that individuals are at their assigned places of work. If not, they pose a huge liability for the agency.

23. There is apparently a plan/program to update the jail technology system. However, there seemed to be a lot of “rumors” about what this actually entails, its timeline, etc. Which goes back to one of the most important topics noted – Communication.

It seems that this program is very positive for the organization, and yet, little is known. It is suggested that this be shared with staff and have them engage in the process.
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Obviously, much of the above General Comments are just quick perceptions. However, it is recommended they be considered as deemed appropriate.
Future Thoughts and Considerations

There seems to be several future opportunities that might facilitate a smoother and more efficient criminal justice system operation for the Snohomish County Corrections Bureau. It is recommended that each be considered as may be deemed appropriate.

A. It seems that a Criminal Justice Coordinating Council (CJCC) would be of value. This brings all the participants of the system together, in a collaborative manner, to address issues of mutual concern. NIC has a model plan that should be examined, and we believe, the Sheriff should take the lead in this.

A first topic might be the process of releasing the mentally ill back into the community. What is the best practice?

B. It seems clear that the staff desires to be “in the know”. The best known model for this is to truly use “Management by Walking Around”. Management must do more of this and determine better ways of communicating with all staff.

C. Many jails have moved to a 12 hour shift model. It can reduce overall staffing costs, reduces sick leave, and seems to improve morale. As there may be some resistance, it might be worth considering the placement one jail on 12 hour shifts and the other on 8’s.

D. Some jails have created “Honor Dorms” where inmates, by good behavior, make their way there. These dorms have the use of inmate purchased radios, and TV’s with headsets (Wi-Fi connected) so there is no noise. They have coffee availability, popcorn, and vending machines. They can purchase I-Pads and movies for personal use. SCJ might want to consider such a program.

E. It was noticed that there are many paper logs in use. For as little as $25,000 Miami Dade purchased a wand system that allows staff to track their observations without multiple logs and in real time. Staff has been very receptive.
F. And finally, it is recommended that the SCCB consider the process of accreditation, via, at least, the “Core Jail Standards”, as well as the NCCHC for medical standards. These are time tested guidelines which will assist in developing professional operations and policies. (Note: This is not an absolute endorsement on accreditation, just a good reference source.)
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Conclusion

The Snohomish County Jail has had a unique history given its Sheriff’s oversight, to county operated, and back to Sheriff. Given that the most recent return was in 2009, it seems that a full transition remains incomplete. This has created some anomalies that tend to adversely affect operations like the chain of command, uniform differences, and Guild (union) concerns. However, the recent change to Sheriff Trenary seems to have been a positive step towards bringing the Sheriff’s Office and the Corrections Bureau together.

It is our hope that this operational assessment will serve as a catalyst to bring positive and functional environmental changes into the organization, its structure, its operation, and its culture. Our review is not intended to cast aspersions on any areas, but rather to offer observations, thoughts, and recommendations for making the operations better. As such, it was clear that all persons with whom we spoke were as eager as we are to improve the Snohomish County Jail for the future.

Given this, it is critical that a top priority be the immediate development of policy, procedure, and post orders. This is absolutely necessary to reasonably expect staff to responsibly deal with inmates in a consistent and systematic manner. Within this, better communication, improved technology, expanded supervisory, management, and administrative oversights, and just “walking around” will do much to improve the culture and general operations of the jail.

We sincerely appreciate the opportunity to share our thoughts. We thank all for the courtesy we were shown and Sheriff Trenary and his entire staff for the honest, forthright, and professional approach that was given to us during our technical assistance action. We wish the best for Snohomish County Sheriff’s Office and the Snohomish County Jail both now and into the future.

TPR/JF/sl

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