Memorandum

To: John Rees, Commissioner

From: Patti R. Webb, Warden

Date: October 4, 2004

Subject: Critical Incident Review

Re: Lee Adjustment Center

Ms. Georgia Dunn, Mr. Don Bottom, and myself were directed to review the Critical Incident that occurred at Lee Adjustment Center on September 14, 2004. We agreed on two days, September 27th and 28th. We met at Natural Bridge Lodge on Wednesday, September 26, 2004 to review a tape and what reports we had been given. We decided to take a tour of the facility and talk to staff and inmates.

On September 27, we went to the facility and met with Archie Moore, Internal Affairs and Donna Stivers, Associate Warden. We completed the tour of the yard, North Dorm, and the area destroyed by the fire on this day and began talking to staff. Ms. Melanie Turner, CCA Regional Incident Commander, was at the facility, thus allowing us to discuss the situation with her. Vermont also had representatives present; however, they were not there for investigative purposes but to ensure the Vermont inmates' needs were being met.

During our discussions with staff we discovered an underlying theme. Numerous changes had been made during the past six months when LAC began receiving Vermont inmates. Such changes included control movement, scheduling of activities, and feeding. Containment fences had been erected to assist with movement. These changes were from the corporate office.

The number of Vermont inmates was originally only 200; however, in June or July this number increased an additional 200 due to a problem at Marion Adjustment Center with Vermont inmates. Two hundred Kentucky inmates were removed from LAC in order to accommodate the additional Vermont population. The total population for LAC included approximately 400

Kentucky and 400 Vermont inmates. There does not appear to be a problem between the two groups of inmates.

During the past three months, Mr. Eckman implemented several additional operational changes. These changes included canteen schedules, mass punishment, and rumors regarding state pay. These changes were not made known to the Corporate Office.

There also seemed to be some concern regarding Mr. Randy Eckman's lack of communicating with staff and inmates. It appears he would tell them what changes he wanted; however, he did not offer reasons as to why. Staff as a rule do not like changes, and by not discussing them with staff to explain the ultimate goal, the staff were not given the opportunity to "buy into" the program. They, in turn, vented their frustration to and around inmates. The inmates and staff were only "feeding" off each other and adding to the dissention.

The inmates we talked to also voiced much of the same concerns offered by the staff. The underlying themes again were changes and failure to communicate. They stressed there was no problem between Vermont and Kentucky inmates. Kentucky inmates were upset that Vermont inmates did not have to pay the $2.00 co-pay for medical. This too caused unrest because of a failure of the Administration to communicate the difference of the two state systems.

The staff and the majority of the inmates did not appear to know the incident was going to occur on this particular evening. They did have rumors of a sit-down strike, which was to have occurred three months ago. They placed two inmates in segregation for investigation. There was not enough evidence and ultimately the inmates were released. Since that time morale continued to decline among both staff and inmates. The top administrative staff attempted to discuss issues with Mr. Eckman; however, they found it very difficult to persuade him to change his mind. Some staff we interviewed was not comfortable nor felt confident enough to express their opinion to Mr. Eckman.

A few inmates were aware of what was to occur on the day the incident took place. However, it was not known institution wide. The Psychologist did report to the Officer in medical that she had been told something was going to happen that night. She informed the Officer as she was leaving at approximately 6:30 p.m. It was unclear as to whether or not the staff member informed the Shift Captain. It seems there had been grumbling for some time about something going to happen with nothing occurring. Staff may have gotten complacent.

One staff member, who went on vacation after the incident, returned to work during our investigation. He informed Internal Affairs that he had reported to the Captain his observations of two inmates on the recreation field during the past month or so. It appeared to him the two inmates were controlling various possible illegal activities. The two inmates always had several inmates around them with groups of inmates coming and going. The Captain did not report this information to Internal Affairs. These two inmates were immediately placed in administrative segregation. This leads us to believe the communication problem may also have been occurring further down the chain of command.

PROBLEMS

1. Lack of communication to both staff and inmates to explain changes.

2. Lack of communication up and down the chain of command.

3. Failure of the containment fences to control location of inmates.
   - Containment fences on the recreation yard and around dorms did not contain the inmates.
   - The fences were "peeled up" from the bottom and gates were doubled in two to make battering rams. This has been corrected.

4. Changes in recreation times
   - It appears Mr. Eckman would periodically change the yard time and each time a change was made, it resulted in less recreation time.
   - Two dorms were allowed to go to the yard area, and one dorm was scheduled for the gym on a rotating basis.
   - It should be noted the recreation yard is small and to allow 800 inmates in this area at one time would be impossible to control and supervise, thus creating a dangerous situation.
   - Control movement to recreation was monitored and access was given to the inmates every 15 minutes. However, with count and meal schedules, less time for recreational activity was the result.

5. Inmate Canteen
   - Complaints from inmates and staff regarding posting of state pay, money orders, and refunds in a timely manner.
     - One staff stated he went to the fiscal office to inquire about a refund and money order for an inmate and found money transactions dated six months prior had not been posted.
   - Canteen manager resigned.
     - This individual has not been replaced and her duties were given to the individual who posts the monies to the account.
   - Reduction in selection of products
     - The canteen list was reduced from approximately four pages to one. Examples are reducing from four selections of different shampoos down to two choices.
   - Items removed from canteen list: ice cream, chewing gum, and baby oil.
   - Reduction in hours
     - Went from two times per week, open window, to one time per week package. Inmates must submit a written order two days in advance and are allowed to go to the canteen one time per week to pick up their order. No substitutions are made. This also creates problems when money is not posted in a timely manner.
   - Aspirin
     - Sold in packages of two for $.26. Bottles of generic aspirin of 100 tablets are cheaper when doing the math.

6. Disciplinary Process
   - Restrictions in canteen up to 90 days
   - Mass punishment of entire wing in a dorm when one bed area found dirty or cluttered. No one was allowed to go out of the wing until the problem was corrected. Area inspections had been occurring at 8:00 a.m.; however, on Monday, September 13th, this was changed to 7:00 a.m. per Mr. Eckman. Staff were informed of the change on Friday; however, the memo to the inmate population explaining the change did not get posted until Monday afternoon, September 13th.
   - Ice scoop found inside the ice machine. Ice machine locked for one week.
   - Alleged gambling at pool tables. Pool tables were off limits to the entire population for weeks.

7. Visitation
   - Nine tables were removed from visitation area.

8. State Pay reduction
   - Staff had been told by Mr. Eckman he was not going to pay a daily wage when the inmates only worked one or two hours per day. He was going to divide the daily wage by hours actually worked. Staff had been talking about this, thus inmates overheard. This was to be implemented October 1, 2004.

9. Lack of information on Vermont Inmates
   - The entire inmate file was not forwarded from Vermont. The facility had contacted CCA; however, the issue was not resolved. There were times when the Vermont inmates were actually maximum custody.

10. Staff unprepared for Vermont
    - The majority of Vermont inmates are sex offenders and are prescribed psychotropic medication. Sex offenders have a history of behavior problems, and the vast number left staff unprepared.

11. Number of SORT members
    - At the time of the critical incident the number of SORT members were approximately seven. It is my understanding recruitment is now occurring. LAC does have a signed, written agreement that assistance from Eastern Kentucky Correctional Complex CERT will be provided.

12. Lack of staff qualified to use firearms
    - Mr. Eckman did not allow all staff to be re-certified annually on firearms. When the incident occurred, only a select few who reported to the institution were qualified to utilize firearms and gas.

13. Lack of Inmate Programming
    - Due to additional operational duties given to staff, several programs had been suspended due to lack of time. Vermont requires all their inmates to participate in a cognitive-type

program. This is a part of CCA's contract. This program is available only to Vermont inmates.

- The religious program was weakened when the Chaplain resigned and is now dependent upon volunteers. It is unclear if anyone has been given the responsibility of ensuring consistency with the volunteers.
- Parenting, Anger Management, AA, and NA programs were discontinued when the staff assigned to these programs was given the responsibility of the Institutional Parole Officer and Pre-release.

14. State Monitor
    - It appears no one has been monitoring the facility due to promotions, re-organization, or activation for military duty. This position may not have prevented this incident if what we were told concerning Mr. Eckman's management style is true.

15. Administrative Staff
    - The administrative staff did not feel comfortable reporting what they saw as potential problems with operational decisions to anyone in CCA or the State of Kentucky.

16. Master Picture Count Book
    - The facility had a difficult time clearing count the next day due to inmates refusing to give staff their names. The inmates were dislocated from their original dorm due to the fire and a picture ID book was not available. They do have the pictures on a computer; however, all equipment was damaged, network lines burned, and electricity was off.

RECOMMENDATIONS

- Open the lines of communications with staff and inmates.
- Changes should be gradual with time given to both staff and inmates to ask questions and prepare.
- Stop mass punishment for the small problems.
- Qualify all security and select program staff with firearms annually.
- Post money to accounts in a timely manner.
- Increase canteen list, review procedure, and schedule to determine if additional day at the canteen is feasible.
- Review present count and feeding schedules to determine if recreation time can be extended.
- Place security cameras with recording capability at various locations throughout the institution. There are numerous blind spots created by the physical design of the facility.
- Monitor adjustment process in relation to loss of privileges.
- State monitor to visit a minimum of one time per week.
- Expanded programming by hiring additional staff or increased utilization of unit staff.
- Unit staff follow up on inmate requests or questions.
- Review visitation area and schedule to increase the area or additional days to ensure Kentucky and Vermont inmates are treated fairly and consistently.
- Master photo ID book (hard copy).

- Obtain the information concerning Vermont inmates and provide staff training on dealing with behavior-problem inmates.

CONCLUSION

It is the opinion of the Review Committee this incident was created by lack of communication up and down the chain of command and too many changes within a short period of time. Several things were taken from the inmates and nothing was given to them in return. A few staff attempted to explain other options to Mr. Eckman; however, his strict management style did not offer any leniency. Staff should not be inhibited to offer their opinions and report to supervisors what they see occurring.

The tension of the institution had been gradually increasing during the past few months. Morale of both staff and inmates had been decreasing. When the five or so inmates began their destruction, this is all that was needed to get the other inmates to join. It is our opinion the institution and the majority of the inmates were unaware of what was about to happen. If, in fact, the inmates who began the series of events knew what they were going to do, it was not well planned. They may have known they were going to do something, but not to what extent. It is our opinion the incident grew into something larger than the original inmates had intended.

Associate Warden Donna Stivers and her staff are to be commended for their outstanding performance. Ms. Stivers was at the facility when it began. Her quick action and direction to her staff prevented the loss of life and serious injury. She and her staff implemented and carried out the Emergency Plan. The staff regained control of the situation within a few hours, knowing they were seriously outnumbered. As a result of their actions and professionalism, the facility is operational today.

skm

c: File