Arizona Department of Corrections

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JANICE K. BREWER
GOVERNOR

CHARLES L. RYAN
DIRECTOR

December 29, 2010

Odie Washington, Senior Vice President
Management & Training Corporation
500 North Marketplace Drive
Centerville, Utah 84014

RE: Contract AD9-010-A3, Kingman 3400 Beds

Dear Mr. Washington:

As discussed during our meeting on December 21, 2010, this letter is intended to document the status of our contract in light of those corrective actions taken and those still required, subsequent to the tragic and avoidable escapes from the Hualapai unit, Arizona State Prison (ASP)-Kingman on July 30, 2010.

As I have shared with you consistently throughout this ordeal, I am evaluating all of the available information from Arizona Department of Corrections (ADC) staff, the ADC Annual and automated "Green, Amber, Red" Inspections (conducted on November 15-19, 2010 by 9 ADC subject matter experts) recently completed at your facilities at Kingman, our letters, your responses, and my personal observations. I also reiterated that I would consider the report which Management and Training Corporation (MTC) contracted for with the Nakamoto Group (conducted on December 15-17, 2010 by Mark Saunders, Mike Randall, Larry Norris and Steve Huffman).

This letter is intended to document and outline the history of our interactions since the escapes, the activities that are ongoing and the necessary curative actions required from MTC at Kingman in order to determine that your operations are compliant with ADC policy (the only standard that has been utilized throughout this process) and for me to determine that I have enough confidence in your responsiveness and operations to continue the contract.

I have been transparent and extremely communicative with you, as you acknowledged during our brief telephonic conversation on November 22nd. I acknowledge that you have effected some corrective action and some improvements; however, I also refer to our communications with you regarding chronic operational deficiencies which have been unaddressed or inadequately addressed over the past 5 months. I acknowledge your stated observation that there is a tougher monitoring process in place; as is to be expected in the wake of an incident of this magnitude. I affirm for you that MTC is not being held to a higher standard than any other ADC prison or ADC contracted facility. I am looking for sustained and systemic improvements in your operation that will support independent compliance with ADC policy and contract requirements.

History of Significant Events at ASP-Kingman:

Subsequent to the escapes on July 30, 2010, part of the review of the Kingman facility and ADC's contract monitoring of that facility included a review of all of the reported significant incidents. What we discovered was that from 2005 forward, there were 13 instances of large groups of inmates refusing directives and/or chasing MTC staff off the yard. Contrary to your statement during a meeting on December 21, 2010, this is not simply a matter of instances typical in the operation of prisons; rather, this is a pattern of unacceptable inmate behavior, in which large inmate groupings of hundreds of inmates react to dissatisfaction with MTC operations, endemic inmate idleness or other triggers.

Specific to the post-escape reviews, you were provided with the following written reports/communications (with MTC responses listed):

- August 12, 2010 – An extensive Security Assessment conducted by 6 ADC subject matter experts on August 4–6, 2010.
- August 17, 2010 – MTC's Memorandum/corrective action plan to the assessment, noted above.
- September 1, 2010 – An out-briefing provided to MTC staff regarding the findings of the inspection conducted August 30 through September 1 by Division Director Patton, Contracts Administrator Profiri and Contract Monitor Sullivan.
- September 7, 2010 – ADC's requirement from MTC regarding a corrective action plan.
- September 9, 2010 – MTC's submission of a corrective action plan to ADC.
- November 1, 2010 – ADC's notice to MTC which included 9 outstanding deficiencies that remained uncorrected, as well as an additional 24 deficiencies identified at both Kingman units (Hualapai and Cerbat). This letter included concerns regarding the large inmate demonstrations on the Cerbat unit on October 17, 2010, followed by a larger inmate demonstration of the entire yard at Hualapai on October 18, 2010. In both cases there were similar concerns by the inmate population regarding food service issues left unaddressed by your staff. It also was becoming apparent that ADC contract monitor staff was being deferred to by MTC staff seeking leadership and direction.
- November 2010 – ADC received an undated and unattributed "response" to the above letter via e-mail from Administrator Sternes.
- November 15 – 19, 2010 – ADC provided MTC with daily out-briefings of the ASP-Kingman Site Inspection, Annual Inspections Report and ADC DO 703 GAR Automated Inspections Report, which included the electronic notifications of all GAR Findings.
- December 7, 2010 – MTC's corrective action plan to the GAR findings from Administrator Sternes.
- December 27, 2010 – MTC was issued a response to Administrator Sternes authored by Mr. Profiri which responded to MTC's corrective action plan, requested additional information regarding proposed actions, and cited corrective actions that have not, in fact, taken place.

Ongoing Compliance Activities:

As I acknowledged following the July 30, 2010 escape, the ADC contract monitor and his administrator were not performing their duties adequately, which resulted in me taking immediate corrective action. All ADC contract monitors are now selected from a pool of candidates that are experienced Deputy Wardens. Additionally, the contract team members have expanded responsibilities to ensure that they are all contributing to contract monitoring on an ongoing basis.

To supplement that, I have dispatched various teams of employees to conduct reviews, assessments or inspections (to all facilities). You have been notified of each of these initiatives for Kingman. I have personally toured your facilities on a number of occasions at Kingman, along with other executive staff, and have observed evidence supporting the issues of non-compliance discovered by various teams. Additionally, I have repeatedly raised concerns about the extremely high level of inmate idleness (directly to MTC staff on-site), which is a precursor to inmate management problems leading to groupings and disturbances.

The sum of ADC's concerns, observations and reports to MTC lead me to believe that you have instituted a number of the physical plant improvements during the preceding 3-5 months, not the least of which was the perimeter alarm system which has been dysfunctional or unreliable for the better part of 2 ½ years.

However, MTC Kingman has not effected sustained systemic operational improvements. It is apparent that your staff are deferring to ADC employees for leadership in incident management, as well as waiting for ADC staff to point out problems and prescribe corrective action before acting upon that direction. The following examples are illustrative of these points:

- MTC staff was unable to identify the name of your complex administrator, as recently as the night of October 17, 2010, during a disturbance.
- MTC staff could not find the phone numbers for the Mohave County Sheriff's Office and did not have the presence of mind to dial 911, leaving ADC staff to make the contact on that same night.

- When advised about the escape response protocol cards, ADC monitors asked MTC perimeter patrol officers to see a copy, which could not be produced and of which they were unaware, as recently as December 16, 2010. This is in spite of ADC having provided post orders on December 10, at the request of MTC.
- When challenged to describe what use of force actions they would take in the event of an escape, responses were incorrect (one MTC employee responded that he would shoot at the inmate "if he were coming at me", but would "shoot in the dirt, if he were running away from me"), also on December 16, 2010.
- We discovered inmate unescorted access to no-man's land, which is still a routine activity, on December 15, 2010.
- The ladder that the Nakamoto report indicated was found in the sallyport was indicative of a chronic problem that ADC had previously directed to be corrected.
- There are myriad chronic tool and key control issues that your staff report as corrected, but my staff continually discover.
- Inmate movement during count time, as well as failure to control movement and prevent inmate access to unauthorized housing units, is a chronic problem discovered as recently as December 15, 2010.
- As recently as mid-December, ADC monitors continue to find footprints in no-man's land unreported and unaddressed by your staff.
- Security device inspections are still not reported or corrected in a timely manner; for example, during the week of December 6th, the Cerbat North Yard gate was malfunctioning and would not open. Repairs did not occur for 3 days, despite MTC's stated timeline of 24 hours for security device repairs.
- Post order corrective additions were not made as of December 16th for Main Control and North Yard Officer responsible for Zone Alarm Testing, despite MTC reports that this has taken place.
- Joe Profiri, Administrator of Contract Beds, provided Administrator Sternes with a follow-up response on December 27, 2010.

Nakamoto Report and Findings:

I reviewed and have considered the Nakamoto report, received from you on December 27, 2010. It clearly reflects a contracted assessment based on limited parameters or research, as many conclusions are unsupported by factual data. Rather than critique or respond to the entire document, I will refer to a few of the citations:

- Escape Incident Reparation - ADC concurs with these reparations, as the majority of them were identified during the August 4 - 6, 2010 ADC Security Assessment, to include the physical plant improvements, the addition of the static/stationary posts, the revisions to the post orders and tool control modifications.
- Emergency Plans - The escape response plan is an after-the-fact development, and did not exist prior to the escape.
- Entrance/Exit Point Security - The recommendation and commentary by the Nakamoto Team Leader about "utilizing an actual inmate(s) in determining if any vulnerability exists in the exit identification process" is an irresponsible tactic in challenging a security practice. To do what was suggested by the Team Leader would jeopardize the safety of the inmate and the ultimate security of the facility. Switching identification cards with staff would serve the same purpose.
- Inmate Disciplinary System - Arizona Revised Statutes require ADC to maintain control of the inmate disciplinary system. The report does not indicate that Nakamoto was aware of this fact.
- Local Support Agency Agreements - The Nakamoto Group identifies that MTC has no agreements with local support agencies regarding emergencies, which raises the question; why has MTC not done this in the six (6) years that MTC Kingman Private Prison has existed?
    - Nakamoto's contention is that "the facility could have permeated the surrounding areas with staff standing vigil to detect the missing inmates; however the local law enforcement inexplicably prohibited this activity. Strategically placed staff could have changed the entire course of the incident, very likely ending the incident the night it started, based on the lack of cover in the terrain surrounding the facility."
    - The escape occurred between 2000 and 2010 hours. Mohave County Sheriff was initially contacted by MTC at 2219 hours. ADC was initially contacted at 2337 hours. MTC had not practiced escape response drills and over two hours elapsed before any outside agency was notified of the escape. Though ADC has not heard of this request or denial previously, it is implausible that establishing escape posts in the immediate vicinity more than two hours after the escape would have had any impact on the course of events. Additionally, the lack of escape response plans/training, and mutual aid agreements with local law enforcement inhibited the productive communication between MTC and law enforcement responders. It appears the Nakamoto's Team did not thoroughly read the ADC investigation to ascertain the facts.

- Inmate Classification - Although the Nakamoto Team conveys a finding that the population of inmates housed at the facility is appropriate for a medium security prison, the Team Leader goes on to question the validity of the instrument. The generalization that questions the 'gang classification procedure' requiring a 'long-term process for mitigation' is without foundation. Again, statutorily, inmate classification is an ADC responsibility.
- No where in the Nakamoto Report is found a discussion about the level of idleness and inactivity throughout the populations in both Hualapai and Cerbat. Pro-social engagement in work and programs is a basic requirement of sound correctional practice.

Required Cure Actions:

Based on what we have been providing MTC verbally and in writing, I can reiterate that I am looking for sustained, systemic operational improvements, in order to gain confidence in MTC's ability to operate the Kingman facility in compliance with ADC policy and the contract. Physical plant improvements alone are insufficient. MTC needs to implement a training program for your staff, as well as to demonstrate that corrective action has been taken and been institutionalized in a systemic manner to the daily operations.

You will find the following areas of concern, identified in our initial inspection and/or the letters of September 4 and November 1, 2010, remain incompletely addressed, unaddressed or uncorrected, as of the November 15, 2010 inspection (further discussed in the attachment, with noted and expected cure time frames):

Inmate identification card compliance
Staff communication with inmates
Command staff communication with line staff
Inmate housing compliance
Staff training
Perimeter sand condition
Perimeter alarm response
Perimeter security challenges
Perimeter post order revisions
Perimeter lighting
No man's land access/storage
Count procedures
Inmate controlled movement
Ingress: personal property/staff protocols
Pat searches
Key control
Service journals
Inmate population training
Facility security: unauthorized metal
Sweat lodge security enhancements
Fence tie accountability
Detention training
Tool control: general/yard
Awning security enhancements
Security device tracking and corrective action
Kitchen protocols
Fire detection system
Weapons storage
Weapon munitions
Weapon accountability
Inmate Programs

I expect that you will provide me with a proposed corrective action plan for all of the outstanding deficiencies prior to January 10, 2011. Although you are afforded 30, 60, or 90 days to complete corrective action, it is my expectation that you will begin corrective action on all identified items immediately. Corrective action on all items must be ongoing throughout the 90 day cure period, and you must regularly (daily, weekly, monthly) demonstrate to our contract monitor(s) and staff that corrective action is ongoing and being completed throughout the 90 day cure period.

Additionally, I expect that your complex administrator will schedule time with the ADC contract monitor and contract administrator to demonstrate to them that corrective action has actually taken place. I also expect that when confirmation has been made that acceptable corrective action has been completed, I receive regular written updates at 30 day intervals of those corrective actions and systemic change implementation. However, the cure period will not exceed 90 days.

In closing, I reiterate there have been improvements; however, I retain serious concerns about myriad chronic operational deficiencies, as well as discrepancies between what you report as having been accomplished compared with what my staff is observing. I expect MTC employees, supervisors and administrators to take responsibility for the operation of your institution, as well as to effect proactive corrective actions, demonstrating these to the monitors as they are accomplished and institutionalized.

This letter shall also serve as a demand for written assurance in accordance with section 8.1, Right to Assurance, Uniform Terms and Conditions, that it is MTC's intent to perform and comply with all provisions of the contract. Specifically that MTC will complete all deficiencies as documented and as identified in this letter within a 90 day time frame.

Accordingly, MTC has ten (10) days from the date of this letter to respond to the demand for assurance and ninety (90) days to complete all noted and documented deficiencies.

Failure to provide written assurance of intent to perform within ten (10) days and failure to cure all deficiencies noted within ninety (90) days will be the basis for termination of your contract with the Department.

I will continue to communicate openly with you about the issues we observe and I will remain transparent in my expectations. I must be assured that this letter of assurance is fulfilled before I can have the confidence necessary to increase the population or continue our contractual relationship.

Sincerely,

Charles L. Ryan
Director

cc: Charles Flanagan, Deputy Director
Robert Patton, Division Director
Mike Kearns, Division Director
Karyn Klausner, General Counsel
Joe Profiri, Contracts Administrator
Denel Pickering, Procurement Officer

Attachment: Required Cure Actions, Detail

ITEM	ISSUE	CURE	TIMEFRAME
Inmate identification card compliance	Inmates continuously observed not in compliance with required wearing of ID Cards	Consistent and sustained enforcement of DO 704	30 Days
Staff communication with inmates	Poor communication routinely reported by inmate population which have contributed to inmate groupings	Adhere to provision outlined in DO 916, specifically Community Forums/Meetings	30 Days
Command staff communication with line staff	Briefings are not occurring for all staff, "phone tree" briefings occur intermittently and are not available to all staff	Conduct briefings wherein all posting personnel are in attendance, ensure facility administration regularly visit posts and shift commanders visit posts daily. Maintain running operational logs at all posts.	30 Days
Inmate housing compliance	Inmate housing areas continuously observed to contain unauthorized items and excess hobby craft and inmates observed laying in bed under sheets and blankets past 07:30 HRS.	Consistent and sustained enforcement of DO 704. Conduct search operations consistent with DO 708 and complete quarterly facility searches. Searches are to be conducted as often as necessary to control contraband.	30 Days
Staff training	Assigned perimeter officers remain unfamiliar with proper escape response/use of force protocols. No training program for Case Managers.	Develop a formal training program related to escape response procedures/use of force, inclusive of drills/exercises and train all personnel. Develop formal training program for Case Managers.	60 Days
Perimeter condition	Dirt piles in no man's land, excess weed growth in inner perimeter, inner perimeter hard packed and perimeter soil erosion observed.	Remove/spread dirt piles in no man's land, remove all weed growth in inner perimeter, soften soil within inner perimeter to aid in track identification and ensure constant maintenance of soil erosion on inner/outer perimeter.	30 Days
Perimeter alarm response	Relevant Post Orders are not inclusive of perimeter response protocols.	Rewrite relevant Post Orders to include language specific to perimeter alarm response protocols.	30 Days
Perimeter security challenges	Security challenge tracks on outer perimeter routinely missed by assigned Perimeter Patrol Officers.	Institute training protocols regarding perimeter soil anomaly identification, conduct and track self assessment security challenges of posted perimeter personnel and ensure proper use of assigned equipment (handheld spotlights) in evaluating perimeter.	30 Days
Perimeter post order revisions	Perimeter Post Orders contain no information regarding escape response protocols.	Re-write Post Orders to include specific language regarding escape response protocols.	30 Days
Perimeter lighting	Perimeter Lighting in Zone 9 was observed malfunctioning.	Include and document serviceability of perimeter lighting/zone alarm lights during zone alarm testing.	30 Days
No man's land access/storage	Inmates continue to be observed unescorted in no man's land. Ice freezers are stored in no man's land.	Restrict all unescorted inmate movement within no man's land. Develop written protocols, with respect to accessing ice freezers stored in no man's land, wherein staff do not carry keys to access the gates to these freezers, thus accessing no man's land and restricts no man's land gate access in any event when inmates are present.	30 Days

Count procedures	External inmate movement not entered into AIMS. No procedure in place for "red lining of beds," Proper signatures missing on Out Count Forms, Shift Commander not consistently clearing count, and signing count sheets, rather cleared by Accountability Officer. Shift Commanders inconsistent.	Train and ensure staff is completing count procedures in accordance with DO 701 – Inmate Accountability.	60 Days
Inmate controlled movement	Inmates observed secured in run(s) not assigned to them after meal turn outs and requesting release from respective run(s) at count time in order to return to assigned run(s). Uncontrolled inmate movement occurring during inmate counts.	Properly control inmate movement through direct observation and enforcement actions. Institute count announcement to population 10 minutes prior to count and enforce no inmate movement during counts.	60 Days
Ingress: personal property/staff protocols	Staff food items and property entering the facility are not consistently inspected. Increased rate of occurrence during high traffic periods/shift change.	Ensure proper staffing/controls are in place with special attention to high traffic periods and ensure proper screening procedures of personnel, food and property entering the facility occur at all times.	30 Days
Pat searches	Random pat searching seldom observed.	Ensure completion of random pat searches with emphasis on turn outs and turn ins.	30 Days
Key control	Emergency Keys stored at complex were only labeled as "D," with no additional designation or number. Exterior/yard gates are not labeled with a specific color code for Emergency Key use. Hot Box(es) contained key sets in excess of the number of hooks available in the box.	Review key control systems and ensure compliance with Department Order 702 – Key Control. Develop Emergency Key diagrams identifying Emergency Key access locations.	60 Days
Service journals	Officers are not consistently in with logging Security Device Inspections on their daily post logs/journals.	Ensure shift supervisors are visiting all posts during the course of their shift to review logs/journals for completeness and accuracy. Facility Administration should also complete routine reviews.	60 Days
Inmate population training	Lack of consistent enforcement of DO 704 – Inmate Regulations.	Sustained and consistent enforcement of D.O. 704, which will train inmates to largely self-comply.	60 Days
Facility security: unauthorized metal	Hanging metal file folders within units.	All hanging metal file folders need to be removed.	30 Days
Sweat lodge security enhancements	Though enhancements are complete for Hualapai Sweat Lodge, Cerbat remains without a Sweat Lodge.	Complete construction of Sweat Lodge at Cerbat and ensure proper security enhancements are in place, commensurate to its location.	60 Days
Fence tie accountability	Fence ties at base of Hualapai Detention enclosure, officer's station in detention and property storage enclosure in detention need to be properly marked.	Properly mark fence ties. Additionally, ensure fence ties associated with the new "slow down fence" are properly marked as they are placed.	30 Days
Detention training	Assigned staff are routinely observed not wearing personal protection equipment and have been observed opening doors without a second officer present.	Conduct remedial training of officers assigned to detention regarding proper detention protocols and ensure Post Order is inclusive of requirements associated with Detention.	30 Days

Tool control:	Tools not properly shadowed. Tool check out forms not maintained in unit for 30 days. Inaccurate inventory of Main Control tool box at Hualapai Unit. A tool box located in Cerbat's WBE area was listed on Cerbat Tool Inventory, but is stored at Complex. Institutional Order 712 regarding tools references restricted products, but does not address Tools. Master Tool Inventories not in place. Inmates in Cerbat WBE area were observed using Class A tools without supervision. Proper tool check in and out protocols not occurring with Class B tools (Spade shovels and wheel barrows). Tool Inventories did not match check out log. Inconsistent accounting of tools begin/ending of shift.	Ensure compliance with Department Order 712 in all tool storage areas and tool use protocols.	30 Days
Awning security enhancements	Awnings in inmate accessible areas lend themselves to potential breach points.	Add razor wire at buildings roof line in all areas where awnings are present in inmate accessible areas.	60 Days
Security device tracking and corrective action	Journal entries annotating Security Device Inspections are inconsistent. Security Device tracking and logging is inconsistent and items remain open for extended periods. As exemplified the week of 12/06/2010 when a malfunction security gate at Cerbat unit was not repaired for 3 days.	Security Device Inspections accountability, malfunction tracking and repair needs to be complied with in accordance with Department Order 703.	30 Days
Kitchen protocols	Food service not consistently adhering to food safety, health, sanitation and security requirements.	Food Service shall comply with Department Order 912 and all security, health and safety standards.	30 Days
Fire detection system	Fire detection and suppression system in trouble/silence mode.	Fire detection and suppression system needs to be repaired and/or properly maintained via preventive maintenance practices.	60 Days
Weapons storage	Staff not logging seals at beginning and ending of shift. Information reports/journal entries are not occurring at time of seal breakage.	Facility needs to comply with requirements outlined in Department Order 716.	60 Days
Weapon munitions	Damaged and potentially inoperable ammunition was discovered in service on perimeter patrol posts.	Weapons and munitions exchanges need to occur in accordance with Department Order 716.	30 Days
Weapon accountability	Inventories found to be inaccurate regarding weapons and munitions present (14 foggers not on inventory and one CS grenade). No evidence of monthly inventories occurring by Chief of Security. Proper form utilization for signing out weapons not in place.	Facility needs to accurately account for all weapons and munitions in accordance with Department Order 716.	30 Days

Inmate Programs	Inmate Idleness - 50% of facility's inmate population is unemployed; 176 seats are available in Academic and Career Technical Education classes at Cerbat Unit with over 700 inmates' eligible but unassigned; 20 seats are available in the DUI/Substance Abuse Treatment Program at Cerbat Unit with over 700 inmates' eligible but unassigned; 12 seats are available in Academic Programs at Hualapai Unit with over 600 hundred inmates' eligible but unassigned; 39 seats are available in the DUI/Substance Abuse Treatment Program at Hualapai Unit with over 450 inmates' eligible but unassigned; No Career Technical Education classes are available at Hualapai Unit. Unit.	75% of population shall be engaged in work or programming activities.	90 Days