MICHIGAN

OFFICE OF THE AUDITOR GENERAL

AUDIT REPORT

PERFORMANCE AUDIT
OF THE

ST. LOUIS CORRECTIONAL FACILITY

DEPARTMENT OF CORRECTIONS

September 2011

THOMAS H. MCTAVISH, C.P.A.
AUDITOR GENERAL

471-0249-11

The auditor general shall conduct post audits of financial transactions and accounts of the state and of all branches, departments, offices, boards, commissions, agencies, authorities and institutions of the state established by this constitution or by law, and performance post audits thereof.

– Article IV, Section 53 of the Michigan Constitution

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REPORT SUMMARY

Performance Audit

St. Louis Correctional Facility

Department of Corrections

Report Number:
471-0249-11

Released:
September 2011

The St. Louis Correctional Facility, opened in 1999, is located in St. Louis, Michigan, on 67 acres north of M-46. The Facility has the capacity to house 1,176 security level IV male prisoners. The Department of Corrections' (DOC's) mission is to create a safer Michigan through effective offender management and supervision in its facilities while holding offenders accountable and promoting their success. Through its facilities, DOC provides supervision of offenders and protects the public by providing a secure, safe, and humane environment for staff and prisoners.

Audit Objective:

To assess the effectiveness of DOC's efforts to comply with selected policies and procedures related to safety and security at the St. Louis Correctional Facility.

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Audit Conclusion:

We concluded that DOC's efforts to comply with selected policies and procedures related to safety and security at the St. Louis Correctional Facility were moderately effective. We noted 10 reportable conditions (Findings 1 through 10).

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Noteworthy Accomplishments:

The Adaptive Skills Residential Program (ASRP) at the St. Louis Correctional Facility is a specialized program for prisoners who are impaired in their adaptive behavior due to a low level of psychological, social, and occupational functioning. ASRP treats a prisoner's biological signs and symptoms while addressing an individual's psychological state and related social factors. Since its inception at the Facility, ASRP has shown positive results. The Facility indicated that critical incidents related to prisoners in the program decreased from 83 for the period June 1, 2009 through May 31, 2010 to 62 for the period June 1, 2010 through May 31, 2011 and misconducts for the same prisoners dropped from 39 in August 2010 to 10 in June 2011.

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Reportable Conditions:

The Facility did not always maintain proper controls over weapons stored in its arsenal (Finding 1).

The Facility did not rescind DOC weapons permits as required by DOC policy. Also, the Facility did not ensure that all officers who were provided handguns possessed a current DOC weapons permit. (Finding 2)

The Facility did not ensure that its officers performed and documented all required prisoner shakedowns and area searches (Finding 3).

The Facility did not ensure that it performed and documented all required employee shakedowns (Finding 4).

The Facility did not document that it completed all scheduled preventive maintenance tasks on a timely basis. Also, DOC did not ensure that its Micro Main system operated as intended to support an effective and efficient maintenance program. (Finding 5)

The Facility did not ensure that it conducted and documented all required radio checks (Finding 6).

The Facility did not ensure that all officers assigned to a self-contained breathing apparatus (SCBA) squad were properly trained and qualified in the use of SCBA equipment. Also, the Facility did not always assign the minimum number of SCBA-certified officers to SCBA squads. In addition, the Facility did not properly complete or document all required SCBA inspections. (Finding 7)

The Facility did not ensure that all training qualification and certification information used or available for making assignment decisions was accurate (Finding 8).

The Facility did not propose corrective action plans or identify completion dates for all instances of noncompliance identified by its weekly and monthly inspections. Also, DOC's regional operation did not document that it completed all required fire safety inspections. (Finding 9)

The Facility did not complete all required security monitoring exercises (Finding 10).

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Agency Response:

Our audit report contains 10 findings and 15 corresponding recommendations. DOC's preliminary response indicates that the Facility agrees with all the recommendations and has complied with them.

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A copy of the full report can be obtained by calling 517.334.8050 or by visiting our Web site at: http://audgen.michigan.gov

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AUDITOR GENERAL

September 29, 2011

Mr. Daniel H. Heyns, Director
Department of Corrections
Grandview Plaza Building
Lansing, Michigan

Dear Mr. Heyns:

This is our report on the performance audit of the St. Louis Correctional Facility, Department of Corrections.

This report contains our report summary; description of agency; audit objective, scope, and methodology and agency responses; comment, findings, recommendations, and agency preliminary responses; and a glossary of acronyms and terms.

The agency preliminary responses were taken from the agency's responses subsequent to our audit fieldwork. The *Michigan Compiled Laws* and administrative procedures require that the audited agency develop a plan to address the audit recommendations and submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

We appreciate the courtesy and cooperation extended to us during this audit.

Michigan Auditor General

AUDITOR GENERAL

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ST. LOUIS CORRECTIONAL FACILITY
DEPARTMENT OF CORRECTIONS

GLOSSARY

Description of Agency

The St. Louis Correctional Facility, opened in 1999, is located in St. Louis, Michigan, on 67 acres north of M-46 in Gratiot County. The Facility houses security level IV* male prisoners.

The Facility has seven separate housing units: five that house general population prisoners, one that serves as a segregation unit, and one that is an adaptive skills residential program unit. The Facility's perimeter is surrounded by two fences with razor-ribbon wire on the side and top of the outer fence. The inner fence is equipped with a detection device and has a row of razor-ribbon wire affixed to the top. The perimeter is also monitored by an electronic detection system and is patrolled by an armed vehicle 24 hours per day. The Facility has armed gun towers to complement its other security measures.

The Department of Corrections' (DOC's) mission* is to create a safer Michigan through effective offender management and supervision in its facilities while holding offenders accountable and promoting their success. Through its facilities, DOC provides supervision of offenders and protects the public by providing a secure, safe, and humane environment for staff and prisoners.

The Facility offers academic programs to provide for adult basic education through the completion of a General Educational Development (GED) certification. Also, the Facility offers services including substance abuse treatment, Violence Prevention Programming, and Thinking for Change programming to help prepare prisoners for release and to improve their decision-making abilities. In addition, the Facility offers special education services, general and law library services, religious services, recreational programs, and vocational training in custodial maintenance technology.

For fiscal year 2010-11, the Facility's General Fund appropriation was $32.1 million to support 325.3 full-time equated positions. As of July 31, 2011, the Facility had 317 employees supported by its appropriations and 49 employees supported by other DOC's appropriations. At the time, the Facility housed 1,154 prisoners. The Facility has the capacity to house 1,176 prisoners.

* *See glossary at end of report for definition.*

Audit Objective

The objective of our performance audit* of the St. Louis Correctional Facility, Department of Corrections (DOC), was to assess the effectiveness* of DOC's efforts to comply with selected policies and procedures related to safety and security at the St. Louis Correctional Facility.

Audit Scope

Our audit scope was to examine the program and other records of the St. Louis Correctional Facility. We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusion based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusion based on our audit objective. Our audit procedures, performed from May through July 2011, generally covered the period October 1, 2009 through July 31, 2011.

Audit Methodology

To establish our audit objective and to gain an understanding of the Facility's activities, we conducted a preliminary review of the Facility's operations. This included discussions with various staff regarding their functions and responsibilities; observations; and examination of program records, policy directives, and Facility operating procedures. Also, we reviewed the warden's monthly reports to the DOC director, critical incident reports, self-audits*, and the Facility's most recent accreditation review.

To assess the effectiveness of DOC's efforts to comply with selected policies and procedures related to safety and security at the Facility, we reviewed procedures and examined records related to arsenal inventories and operations; firearm certifications and weapons permits; radio checks; preventive maintenance; prisoner, visitor, and

* *See glossary at end of report for definition.*

employee shakedowns*; cell searches* and area searches*; security monitoring exercises*; fire safety; and self-contained breathing apparatus* (SCBA). In addition, we inventoried critical tools* and dangerous tools* on a test basis.

When selecting activities or programs for audit, we use an approach based on assessment of risk and opportunity for improvement. Accordingly, we focus our audit efforts on activities or programs having the greatest probability for needing improvement as identified through a preliminary review. Our limited audit resources are used, by design, to identify where and how improvements can be made. Consequently, we prepare our performance audit reports on an exception basis. To the extent practical, we add balance to our audit reports by presenting noteworthy accomplishments for exemplary achievements identified during our audit.

Agency Responses

Our audit report contains 10 findings and 15 corresponding recommendations. DOC's preliminary response indicates that the Facility agrees with all the recommendations and has complied with them.

The agency preliminary response that follows each recommendation in our report was taken from the agency's written comments and oral discussion subsequent to our audit fieldwork. Section 18.1462 of the *Michigan Compiled Laws* and the State of Michigan Financial Management Guide (Part VII, Chapter 4, Section 100) require DOC to develop a plan to address the audit recommendations and to submit it within 60 days after release of the audit report to the Office of Internal Audit Services, State Budget Office. Within 30 days of receipt, the Office of Internal Audit Services is required to review the plan and either accept the plan as final or contact the agency to take additional steps to finalize the plan.

* *See glossary at end of report for definition.*

COMMENT, FINDINGS, RECOMMENDATIONS, AND AGENCY PRELIMINARY RESPONSES

SAFETY AND SECURITY

COMMENT

Background: The St. Louis Correctional Facility operates under policy directives and operating procedures established by the Department of Corrections (DOC) in addition to operating procedures developed by the Facility. These policy directives and operating procedures were designed to have a positive impact on the safety and security of the Facility as well as to help ensure that prisoners receive proper care and services. The policies and procedures address many aspects of the Facility's operations, including key, tool, and firearm security; prisoner, employee, visitor, and housing unit searches; gate manifests; prisoner counts; radio checks; security monitoring exercises; metal detector calibration; electronic perimeter tests; sanitation and food service inspections; preventive maintenance; and fire safety. Although compliance with these policies and procedures contributes to a safe and secure facility, the nature of the prison population and environment is unpredictable and inherently dangerous. Therefore, compliance with the policies and procedures will not entirely eliminate the safety and security risks.

Audit Objective: To assess the effectiveness of DOC's efforts to comply with selected policies and procedures related to safety and security at the St. Louis Correctional Facility.

Audit Conclusion: We concluded that DOC's efforts to comply with selected policies and procedures related to safety and security at the St. Louis Correctional Facility were moderately effective. We noted 10 reportable conditions* related to arsenal, weapons permits, prisoner and area shakedowns, employee shakedowns, maintenance, radio checks, self-contained breathing apparatus (SCBA), reliability of training qualification and certification information, fire safety, and security monitoring exercises (Findings 1 through 10).

Noteworthy Accomplishments: The Adaptive Skills Residential Program (ASRP) at the St. Louis Correctional Facility is a specialized program for prisoners who are impaired in their adaptive behavior due to a low level of psychological, social, and occupational functioning. The ASRP interdisciplinary treatment team uses a bio-psychosocial rehabilitation model to treat the prisoners. This model, which has

** See glossary at end of report for definition.*

been in place since June 2009, treats a prisoner's biological signs and symptoms while addressing an individual's psychological state, their feelings and beliefs about an illness, and related social factors, such as their relationship with families and the larger community. The maximum number of prisoners who can be involved in this program is 120. Since its inception at the Facility, ASRP has shown positive results. The Facility indicated that critical incidents related to prisoners in the program decreased from 83 for the period June 1, 2009 through May 31, 2010 to 62 for the period June 1, 2010 through May 31, 2011 and misconducts for the same prisoners dropped from 39 in August 2010 to 10 in June 2011.

FINDING

1. Arsenal

   The Facility did not always maintain proper controls over weapons stored in its arsenal. As a result, the Facility could not ensure that arsenal weapons were issued only to qualified individuals, were properly stored, and were properly accounted for.

   We reviewed master weapons inventory records and conducted physical inventories of select arsenal weapons on May 10, 2011 and July 12, 2011. Our review disclosed:

   a. The Facility did not always properly issue weapons from its arsenal:

      (1) The Facility allowed officers assigned to its perimeter security vehicle to transfer possession of a Facility-issued handgun outside of the arsenal during shift changes. As a result, we identified two officers who did not have a valid DOC weapons permit in their possession while carrying a handgun. We determined that one of the officer's training qualification to use a handgun had expired (see Finding 2), and the other officer had to retrieve his weapons permit from his personal vehicle when stopped and asked to produce it.

      DOC policy directive 03.03.100 specifies that employees shall not possess a handgun on duty unless the officer is properly authorized and has a valid DOC weapons permit. Facility operating procedure 03.03.100 further requires that the DOC weapons permit be verified and in the officer's possession before being issued a handgun.

(2) The Facility issued weapons from the arsenal without a proper weapon and restraint authorization record. We reviewed shotgun training records from July 1, 2010 through June 30, 2011 and noted that, in 34 (51.5%) of 66 instances, shotguns had been issued from the arsenal without a weapon and restraint authorization record. Also, we reviewed weapon and restraint authorization records issued from July 1, 2010 through June 30, 2011 and noted that 46 (13.7%) of the 335 records reviewed were incomplete.

Facility operating procedure 03.03.100 requires that the weapon and restraint authorization form be completed for any arsenal equipment issued and that the form be retained for one year and stored in chronological order in the arsenal.

b. The Facility did not ensure that all weapons were properly stored. We noted that one handgun stored in the arsenal had a round loaded in the chamber, three handguns did not have magazines locked into their magazine wells, two rifles were not stored as indicated on the master weapons inventory record, and one handgun was not appropriately tagged as defective.

Facility operating procedure 04.04.100 requires DOC-issued firearms to be maintained in a clean and service-ready condition and that handguns have their slides closed, chambers empty, and magazines loaded to capacity and locked into the magazine well. It also requires that weapons be placed in the proper storage area within the arsenal and that defective equipment be removed from the designated area and appropriately tagged to ensure that it is not issued until repaired.

c. The Facility did not ensure that the master weapons inventory record posted in the arsenal was accurate. An accurate master weapons inventory record is essential to properly account for the weapons stored in the arsenal.

Our May 10, 2011 arsenal inventory review noted that the master weapons inventory record posted in the arsenal was dated June 24, 2010 and did not identify 16 shotguns physically located in the Facility's arsenal. Further review

determined that this master weapons inventory record appeared to have been posted in the arsenal since June 24, 2010 even though the record maintained on the Facility's computer network had been updated on September 19, 2010.

Facility operating procedure 04.04.100 requires that each shift assign a supervisor to perform a daily inventory of the arsenal and that the arsenal sergeant perform weekly and monthly inventories, immediately reporting any discrepancies to the assistant deputy warden of custody.

d. The Facility did not ensure that the master weapons inventory record was properly maintained, updated, and secured:

(1) The Facility's master weapons inventory record was maintained and updated by the arsenal sergeant. The arsenal sergeant is responsible for the operation, cleanliness, and good order of the arsenal, including issuing and receiving equipment. To ensure proper control over the arsenal's physical inventory, the master weapons inventory record should be maintained and updated by someone other than the arsenal sergeant, with a revised copy provided to the arsenal sergeant as necessary.

(2) The Facility's master weapons inventory record was maintained in a file stored on the Facility's computer network and was accessible by multiple individuals. To ensure the integrity of the master weapons inventory record, access to the file should be limited to the individual responsible for updating the record and the file should be protected to prevent unauthorized changes.

RECOMMENDATION

We recommend that the Facility maintain proper controls over weapons stored in its arsenal.

AGENCY PRELIMINARY RESPONSE

The Facility agrees with the recommendation and informed us that it has complied. The Facility indicated that staff members assigned to the perimeter security vehicle are now required to retrieve their personal equipment from the arsenal instead of exchanging equipment on the assignment. The Facility also indicated that the

arsenal sergeant is ensuring that both the individual's weapons permit and driver's license are checked at the time of issue and that all weapons instructors complete a weapon and restraint authorization record for all weapons taken to the range for training purposes. The Facility informed us that the arsenal sergeant has since sent weapons storage instructions to all of the custody supervisors as a reminder and that each locker in the arsenal now has storage instructions for each of the weapons fastened to the door of the locker for easy reference for staff returning weapons. The Facility also informed us that hardware was added to each locker enabling the arsenal sergeant to separately seal each individual locker to help ensure that weapons are not inadvertently returned to the wrong locker. The Facility indicated that it has instructed the arsenal sergeant to verify that all inventory lists in the arsenal contain the same revision dates to ensure that all inventory sheets are updated at the same time. The Facility also indicated that it had assigned the assistant deputy warden of custody to maintain the arsenal master inventory lists and that this is the only individual with access to the electronically stored file.

FINDING

2. Weapons Permits

The Facility did not rescind DOC weapons permits as required by DOC policy. Also, the Facility did not ensure that all officers who were provided handguns possessed a current DOC weapons permit. As a result, the Facility placed staff in a position to possess weapons they should not have had access to.

Our review of the Facility's critical incident reports, shift assignments, and firearm training records and procedures disclosed:

a. The Facility did not properly rescind the DOC weapons permits of two officers who were convicted of domestic violence. Also, the Facility assigned one of these two officers to clean weapons in the arsenal after the officer's conviction. DOC policy directive 03.03.100 requires that the DOC weapons permit be rescinded for a domestic violence conviction and that employees not be issued or allowed to possess a weapon or ammunition if convicted of a domestic violence crime.

b. The Facility did not rescind the DOC weapons permits of, and subsequently assigned handguns to, two officers whose training qualifications to use a handgun had expired. DOC policy directive 03.03.100 states that a DOC weapons permit will be rescinded immediately when an employee does not successfully complete annual requalification requirements.

RECOMMENDATIONS

We recommend that the Facility rescind DOC weapons permits as required by DOC policy.

We also recommend that the Facility ensure that all officers who are provided handguns possess a current DOC weapons permit.

AGENCY PRELIMINARY RESPONSE

The Facility agrees with the recommendations and informed us that it has complied. The Facility indicated that it now understands that it needs to rescind the permits even when the courts have given permission for officers to possess weapons during the course of their official duties and that it needs to maintain documentation showing that permits have been rescinded. The Facility informed us that it has made changes in how it schedules individuals to work in armed positions. Specifically, the Facility indicated that all three shifts are required to place the weapons qualification dates on the schedule next to the individuals' names. Also, the Facility indicated that the daily reconciliation packet must include a statement showing that all qualification dates were verified by the scheduling supervisor and shift commander. In addition, the Facility indicated that it has changed the format of the master weapons list to make it easier to determine if an individual's qualification has expired or been rescinded.

FINDING

3. Prisoner and Area Shakedowns

The Facility did not ensure that its officers performed and documented all required prisoner shakedowns and area searches. As a result, the Facility was less likely to detect and confiscate contraband that could compromise the safety and security of staff and prisoners.

DOC policy directive 04.04.110 requires each non-housing unit corrections officer who has direct prisoner contact to conduct pat-down searches* or clothed-body searches* of at least five randomly selected prisoners per shift. The policy directive also requires that on first and second shifts, each housing unit officer will conduct at least three randomly selected cell searches per shift and record them in the appropriate logbook. Facility operating procedure 04.04.110 requires each housing unit officer on third shift to conduct at least three common area/room searches and record them in the appropriate logbook.

We reviewed documentation of prisoner shakedowns for the period March 22, 2011 through March 31, 2011 and May 5, 2011 through May 9, 2011. We also reviewed documentation of cell searches for March 2011 and May 2011. Our review disclosed:

a. Non-housing unit corrections officers did not document whether they performed 427 (14.2%) of the 3,005 required prisoner shakedowns.

b. Housing unit officers on third shift did not perform any of the required 744 area searches.

RECOMMENDATION

We recommend that the Facility ensure that its officers perform and document all required prisoner shakedowns and area searches.

AGENCY PRELIMINARY RESPONSE

The Facility agrees with the recommendation and informed us that it has complied. The Facility indicated that shift commanders are monitoring shakedown and search documentation for each officer on a daily basis to ensure that all required shakedowns and searches are performed and documented. The Facility also indicated that it changed the format of the reports in which shift commanders document shakedowns. In addition, the Facility indicated that the assistant deputy warden of custody will perform random audits of shakedown reports to ensure that the numbers reported in the monthly report are accurate.

** See glossary at end of report for definition.*

FINDING

4. Employee Shakedowns

The Facility did not ensure that it performed and documented all required employee shakedowns. Conducting employee shakedowns improves the likelihood of detecting and confiscating contraband and improves the safety and security of staff and prisoners. Documentation provides assurance that all required shakedowns were performed.

Facility operating procedure 04.04.110, Section K requires that each shift perform daily random (periodic, unannounced) shakedowns of all employees entering and exiting the secured area. Shift command will designate when the random shakedowns will occur.

We reviewed Facility records for March 15, 2011 through March 18, 2011 and April 1, 2011 through April 30, 2011. For the periods reviewed, the Facility could not provide documentation that it had performed any employee shakedowns during 38 (37.3%) of 102 shifts. Our review disclosed that the Facility seldom conducted employee shakedowns of third shift (11 p.m. to 7 a.m.) employees. Third shift completed only 5 (14.7%) of the required 34 shakedowns. Twenty-nine (76.3%) of the 38 exceptions noted occurred on third shift. The third shift captain stated that he was not aware that employee shakedowns had to be conducted on a daily basis.

RECOMMENDATION

We recommend that the Facility ensure that it performs and documents all required employee shakedowns.

AGENCY PRELIMINARY RESPONSE

The Facility agrees with the recommendation and informed us that it has complied. The Facility indicated that it has discussed employee shakedown requirements with all the supervisors on third shift. The Facility also indicated that shift commanders will closely monitor employee shakedowns to ensure compliance on all three shifts. In addition, the Facility indicated that it does require all employees to successfully pass through the walkthrough metal detector when entering the Facility and that anyone who fails to successfully pass through the walkthrough metal detector is pat searched.

FINDING

5. Maintenance

The Facility did not document that it completed all scheduled preventive maintenance tasks on a timely basis. Also, DOC did not ensure that its Micro Main system operated as intended to support an effective and efficient maintenance program.

A preventive maintenance plan is designed to ensure the most economical use of all equipment and to ensure that all equipment will operate effectively during emergency situations. Maintenance inspections and the completion of preventive maintenance tasks conducted in accordance with a scheduled preventive maintenance plan may identify potential safety and security hazards. Documented completion of scheduled maintenance and repairs is necessary to provide assurance that the risk of system or equipment failure is minimized.

We reviewed the documentation of 17 monthly preventive maintenance tasks for the period January 2011 through April 2011 and the 14 annual preventive maintenance tasks that were scheduled to be completed during fiscal year 2009-10. Also, we discussed maintenance activities with Facility staff. In addition, we discussed technical support concerns with the Facility and DOC's northern regional office. Our review disclosed:

a. The Facility did not have documentation that it had completed 42 (61.8%) of the 68 scheduled monthly preventive maintenance tasks. Also, the Facility did not have documentation that it had completed 8 (57.1%) of the 14 scheduled annual preventive maintenance tasks. The Facility stated that it believes that some of these inspections were completed but, because of problems with maintenance software (part b.), the Facility was not able to provide documentation to support this claim.

b. Maintenance software did not operate as intended to run an effective and efficient maintenance program. The Facility utilized DOC's Micro Main system to schedule and document all maintenance activities (both preventive maintenance tasks and repair requests). In January 2010, the Facility informed DOC that the repair request portion of the software was not functioning correctly and, in April 2010, the Facility informed DOC that the

preventive maintenance portion of the software was not functioning correctly. Despite the Facility's requests for a timely resolution, these problems persisted until January 2011 for the preventive maintenance portion and April 2011 for repair request portion. In the interim, the Facility used e-mails to notify the maintenance department of problems and printed e-mails to document the scheduling and completion of the requested work. The Facility informed us that tracking e-mails proved to be a burdensome, administrative problem for which it did not have the administrative support to handle. As a result, all preventive maintenance requests may not have been documented, unnecessary paperwork was created, and the Facility's ability to electronically and efficiently track the completion of preventive maintenance orders was lost.

RECOMMENDATIONS

We recommend that the Facility document its completion of all scheduled preventive maintenance tasks on a timely basis.

We also recommend that DOC ensure that its Micro Main system operates as intended to support an effective and efficient maintenance program.

AGENCY PRELIMINARY RESPONSE

The Facility agrees with the recommendations and informed us that it has complied. The Facility indicated that DOC's Micro Main system is currently working properly and that maintenance staff are using it to document completion of all scheduled preventive maintenance tasks.

FINDING

6. Radio Checks

The Facility did not ensure that it conducted and documented all required radio checks. Periodic contact with corrections officers ensures that radio equipment is in working order and helps ensure the safety of the officers and prisoners.

Facility operating procedure 04.04.100G requires the Facility to conduct and log status checks of single staff assignments on an hourly basis during daylight hours and every 30 minutes during hours of darkness. The operating procedure further

requires the Facility to conduct a radio check of each radio at the beginning and end of first and second shifts and at the beginning of third shift and hourly thereafter.

Our review of radio check records for the periods December 14, 2010 through December 20, 2010, February 14, 2011 through February 18, 2011, and March 1, 2011 through March 7, 2011 disclosed that the Facility did not document that it conducted 248 (40.8%) of the 608 required radio checks.

RECOMMENDATION

We recommend that the Facility ensure that it conducts and documents all required radio checks.

AGENCY PRELIMINARY RESPONSE

The Facility agrees with the recommendation and informed us that it has complied. The Facility indicated that it implemented additional measures to ensure that radio checks are recorded in the appropriate logbook. The Facility specified that it created a checklist, that the radio checks are now only conducted by the monitoring room officer in the control center, that shift commanders review and retain the appropriate radio check sheets for each shift, and that the assistant deputy warden of custody will randomly review the sheets for compliance.

FINDING

7. Self-Contained Breathing Apparatus (SCBA)

The Facility did not ensure that all officers assigned to a SCBA squad were properly trained and qualified in the use of SCBA equipment. Also, the Facility did not always assign the minimum number of SCBA-certified officers to SCBA squads. In addition, the Facility did not properly complete or document all required SCBA inspections. As a result, the Facility did not have assurance that adequate safety precautions existed in the event of a prison disturbance or fire.

We inspected SCBA equipment records for January 2011 through May 2011, reviewed SCBA qualification records as of May 16, 2011, and analyzed staff shift assignments for the period May 1, 2011 through May 8, 2011. Our review disclosed:

a. The Facility assigned 9 officers to SCBA squads whose semiannual SCBA qualifications had lapsed. We determined that 2 (22.2%) of these officers had not been trained in more than 5 years and that 5 (55.6%) of these officers had not been trained in more than a year.

   Facility operating procedure 04.03.120M requires that SCBA equipment only be used by staff who have successfully completed DOC's SCBA training and continually demonstrate proficiency in its use. The procedure also requires that all SCBA-certified staff be recertified semiannually, including proficiency testing and annual face piece fit testing.

b. The Facility assigned only 4 officers to SCBA squads for 3 (12.5%) of 24 shifts reviewed. The Facility's fire safety operation plan requires at least 5 SCBA team members per shift.

c. The Facility had not tested SCBA air regulators on any of the 12 SCBA air packs since 2007. Facility operating procedure 04.03.120M requires that SCBA air packs be flow tested every two years. Also, we noted that the Facility did not document that all weekly and monthly inspections were completed for any of the Facility's 12 SCBA units maintained at the Facility. Facility records indicated that the Facility did not complete 238 (94.4%) of the 252 required weekly inspections and 39 (65.0%) of the 60 required monthly inspections. The Facility's fire safety operation plan requires that weekly and monthly SCBA equipment inspections be documented on the SCBA inspection record (CAX-435).

RECOMMENDATIONS

We recommend that the Facility ensure that all officers assigned to a SCBA squad are properly trained and qualified in the use of SCBA equipment.

We also recommend that the Facility always assign the minimum number of SCBA-certified officers to SCBA squads.

We further recommend that the Facility properly complete and document all required SCBA inspections.

AGENCY PRELIMINARY RESPONSE

The Facility agrees with the recommendations and informed us that it has complied. The Facility indicated that it has since provided training to appropriate custody staff, including proficiency testing. The Facility also indicated that shift commanders on all three shifts are now ensuring that only qualified staff are assigned to SCBA squads and that each SCBA squad now has the required minimum number of qualified staff. In addition, the Facility indicated that it had the SCBA equipment flow tested on August 5, 2011 and that it now assigns qualified staff to complete and document all required SCBA inspections. The Facility further indicated that it is also taking steps to evaluate whether SCBA is needed within the Facility given the Facility's physical plant design.

FINDING

8. Reliability of Training Qualification and Certification Information

The Facility did not ensure that all training qualification and certification information used or available for making assignment decisions was accurate. As a result, shift management could not rely on the training qualification or weapons certification information provided to them.

The Training Automated Documentation System (TADS) is a DOC system intended to be used by facilities to record training qualification and certification information provided to their staff. The employee emergency mobilization certifications report, generated from TADS, is used to manually develop a facility's master weapons list, which a facility uses to verify whether an officer is qualified to use weapons or equipment prior to issuing them to the officer.

DOC operating procedure 02.05.100-B requires that training data entries be audited by someone other than the person entering the information to ensure that the data was entered correctly.

Our review of TADS reports, the master weapons list dated May 4, 2011, and shift assignment sheets disclosed:

a. The Facility did not ensure that all officers' weapons qualification information contained on the master weapons list was complete. The master weapons list did not identify shotgun expiration dates for 28 (10.9%) of the 256 officers listed and did not identify handgun expiration dates for 4 (20.0%) and rifle expirations dates for 5 (25.0%) of the 20 squad leaders identified. As a result, the Facility could have assigned officers to positions requiring the use of weapons or equipment that they were not qualified to use.

b. The Facility did not ensure that DOC weapons permit information documented in TADS was correct. The Facility used this information as a means for determining which weapons and equipment an officer was qualified to use and which positions officers could be assigned to. We determined that the Facility incorrectly entered certification information for all 95 officers with DOC weapons permits. As a result, the Facility had limited assurance that TADS data was accurate. As noted in Finding 2, at least one officer's training record indicated a current DOC weapons permit even though the officer's weapons permit had expired.

c. The Facility did not ensure that all officers' information related to their SCBA qualification was accurate. We noted that 13 officers' SCBA training records reflected inaccurate expiration dates on the employee emergency mobilization certifications report and the master weapons list. We also noted that 19 officers' SCBA training expiration dates documented on the shift assignment sheets varied from their official training record.

RECOMMENDATION

We recommend that the Facility ensure that all training qualification and certification information used or available for making assignment decisions is accurate.

AGENCY PRELIMINARY RESPONSE

The Facility agrees with the recommendation and informed us that it has complied. The Facility indicated that the human resource developer is now typing the word "expired" or "rescinded" in the qualification date box on the master weapons list. The Facility also indicated that it is now properly entering weapons permit information into TADS.

FINDING

9. Fire Safety

The Facility did not propose corrective action plans or identify completion dates for all instances of noncompliance identified by its weekly and monthly inspections. Also, DOC's regional operation did not document that it completed all required fire safety inspections.

The completion and proper documentation of all required fire safety inspections would assist the Facility in identifying fire safety deficiencies to reduce the potential for loss of life, personal injury, or property damage that may result from fires, explosions, and related incidents.

We reviewed the Facility's fire safety operations and processes, its 14 weekly fire safety reports completed for the week of March 20, 2011, and its 6 monthly fire safety inspections reports completed for December 2010 through May 2011. Our review disclosed:

a. The Facility did not document a corrective action plan for any of the 4 noncompliance issues identified in the 14 weekly fire safety reports that we reviewed. Also, the Facility did not document a corrective action plan for 2 (11.1%) of the 18 noncompliance issues identified in the 5 monthly fire safety inspections that we reviewed. In addition, the Facility did not document a completion date for 9 (50.0%) of the 18 items even though 4 (22.2%) of the 18 items were repeated, despite having a previously dated plan of corrective action.

   DOC policy directive 04.03.120 requires that all deficiencies cited during fire safety inspections have a corrective action plan, with an acceptable

completion date, documented on the fire/safety deficiencies plan of correction form for all deficiencies cited which cannot be corrected immediately.

b. DOC's regional operation in Kincheloe did not have documentation that it completed 1 (16.7%) of the 6 monthly fire safety inspections and did not accurately complete 4 (66.7%) of the remaining monthly fire safety inspection reports. Monthly inspection reports submitted for December 2010 and February 2011 through April 2011 indicated that SCBA equipment had been inspected in compliance with DOC policy. However, our review disclosed that none of the SCBA air packs had been flow tested since 2007 and that monthly inspections of the SCBA equipment had not been completed or documented (see Finding 7).

   DOC policy directive 04.03.120 requires that the Facility fire inspector shall conduct a monthly comprehensive and thorough fire safety inspection of all areas within the Facility, including ensuring that all testing and maintenance of equipment has been completed and reported on the monthly fire safety inspection checklist.

RECOMMENDATIONS

We recommend that the Facility propose corrective action plans and identify completion dates for all instances of noncompliance identified by its weekly and monthly inspections.

We also recommend that DOC's regional operation document that it completed all required fire safety inspections.

AGENCY PRELIMINARY RESPONSE

The Facility and the regional operation in Kincheloe agree with the recommendations and informed us that they have complied. The Facility indicated that it has assigned the warden's administrative assistant to ensure that corrective action plans are documented for any noncompliance issues identified in fire safety reports and that timely corrective action is taken and documented. The Facility also indicated that the regional office in Kincheloe confirmed that the missing monthly inspection was completed but not documented because of a medical issue. In addition, the Facility indicated that the regional office will remind the

regional fire inspectors to ensure during monthly inspections that Facility staff have conducted required SCBA inspections. Further, as noted in Finding 7, the Facility indicated that it had the SCBA equipment flow tested on August 5, 2011 and that it now assigns qualified staff to complete and document all required SCBA inspections.

FINDING

10. Security Monitoring Exercises (SMEs)

The Facility did not complete all required SMEs. Performing the required SMEs helps ensure that custody staff are adequately trained in critical security measures.

SMEs are developed to test the effectiveness of established procedures and the alertness of staff by simulating the condition, behavior, or emergency that the procedures were designed to prevent or control. Facility operating procedure 04.04.100D requires SMEs to be conducted as designated by the assistance deputy warden of custody. For the months of January, February, and March 2011, the assistance deputy warden of custody designated 252 SMEs to be conducted.

Our review of the SME forms for the months of January 2011 through March 2011 disclosed that the Facility did not complete 23 (9.1%) of the 252 required SMEs.

RECOMMENDATION

We recommend that the Facility complete all required SMEs.

AGENCY PRELIMINARY RESPONSE

The Facility agrees with the recommendation and informed us that it has complied. The Facility indicated that it immediately brought third shift into compliance with the frequency rates on all SMEs. The Facility informed us that it has developed and implemented a spreadsheet that identifies the various SME requirements and their completion. The Facility indicated that the spreadsheet has been added to the documents submitted with the monthly report.

GLOSSARY

area search	The act of searching common areas of the prison for contraband.
ASRP	Adaptive Skills Residential Program.
cell search	The act of going through a prisoner's cell and belongings looking for contraband.
clothed-body search	A thorough manual and visual inspection of all body surfaces, hair, clothing, wigs, briefcases, prostheses, and similar items and visual inspection of the mouth, ears, and nasal cavity. The only clothing items that may be required to be removed are outerwear (e.g., coats, jackets, and hats), shoes, and socks; however, all items shall be removed from pockets.
critical tool	An item designated specifically for use by employees only or for use or handling by prisoners while under direct employee supervision. Critical tools are to be stored only in a secure area and accounted for at all times.
dangerous tool	An item that may be used or handled by prisoners while under indirect employee supervision. Dangerous tools are to be stored only in a secure area and accounted for at all times.
DOC	Department of Corrections.
effectiveness	Success in achieving mission and goals.
level IV	A security classification assigned to a facility or a prisoner. The facility has close security, including a full security perimeter with double fences, concertina wire, and a perimeter detection system with gun towers. These facilities

	house prisoners who have a sentence of more than 60 months, who can generally be managed in the general population of prisons, and who have not shown a tendency to escape.
mission	The main purpose of a program or an agency or the reason that the program or agency was established.
pat-down search	A brief manual and visual inspection of body surfaces, clothing, briefcases, and similar items. The only clothing items that may be required to be removed are outerwear (e.g., coats, jackets, and hats) and shoes; however, all items shall be removed from pockets.
performance audit	An economy and efficiency audit or a program audit that is designed to provide an independent assessment of the performance of a governmental entity, program, activity, or function to improve program operations, to facilitate decision making by parties responsible for overseeing or initiating corrective action, and to improve public accountability.
reportable condition	A matter that, in the auditor's judgment, falls within any of the following categories: an opportunity for improvement within the context of the audit objectives; a deficiency in internal control that is significant within the context of the objectives of the audit; all instances of fraud; illegal acts unless they are inconsequential within the context of the audit objectives; significant violations of provisions of contracts or grant agreements; and significant abuse that has occurred or is likely to have occurred.
security monitoring exercise (SME)	A systemic method of safely and effectively testing and monitoring security standards of a facility to enable staff to have an opportunity to practice the standards under controlled conditions.

self-audit	An audit performed by facility staff that enables management and staff to ensure that an operational unit complies with policy directives and takes proactive steps to correct any noncompliance. Performing self-audits is intended to maximize safe and efficient operations by DOC.
self-contained breathing apparatus (SCBA)	An atmosphere-supplying respirator for which the breathing air source is designed to be carried by the user.
shakedowns	The act of searching a prisoner, an employee, or a visitor to ensure that he/she does not have any contraband in his/her possession.
TADS	Training Automated Documentation System.

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