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Carl Reynolds

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# Effective Self-Monitoring of Correctional Conditions

Carl Reynolds\*

## I. Introduction

In 1972, Texas Department of Corrections (TDC) “inmate David Ruiz filed a hand-written lawsuit against [TDC], which was destined to become the most far-reaching prison conditions litigation in American history.”<sup>1</sup> Pre-Ruiz<sup>2</sup> TDC was largely unaccountable; it was invisible to the general public and even to the rest of the state government. One of the many profound changes to TDC’s successor agency, as a result of the *Ruiz* litigation, is a high degree of visibility, accountability and, concomitantly, fairly sophisticated methods of internal monitoring for accountability. This article is intended to highlight those methods, demonstrating how one professionally-operated prison system detects and addresses problems and risks.

## II. Effective Self-Monitoring

### A. Introduction

The Texas Department of Criminal Justice (TDCJ) was formed by the Texas legislature in 1990 to consolidate prison operations with parole processing and supervision,<sup>3</sup> and the

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\* Carl Reynolds is General Counsel for the Texas Department of Criminal Justice. Prior to that he served as the Executive Director of the Texas Punishment Standards Commission, which rewrote the Texas Penal Code and led to the creation of the state jail system, he also served as the Texas legislative staff architect of the Prison Management Act of 1987. Mr. Reynolds is a graduate of the University of Cincinnati and the Lyndon B. Johnson School of Public Affairs; he received his J.D. from the University of Texas School of Law.

1. *The Final Chapters of the Ruiz Case*, CRIM. JUST. CONNECTIONS (Tex. Dep’t of Criminal Justice, Huntsville, Tex.), Sept.-Oct. 2002, at [http://www.tdcj.state.tx.us/mediasvc/connections/SeptOct2002/agency2\\_v10no1.html](http://www.tdcj.state.tx.us/mediasvc/connections/SeptOct2002/agency2_v10no1.html) (last visited Aug. 22, 2004).

2. *Ruiz v. Estelle*, 161 F.3d 814 (5th Cir. 1998).

3. Leaving release and revocation decisions to a separate Board of Pardons and Paroles. See TEX. GOV’T CODE ANN. §§ 508.031 to -.080 (Vernon 2002).

state's component of community corrections.<sup>4</sup> After a decade of rapid expansion and increasingly positive adjustments to the consolidation, TDCJ in 2003 is a strong and stable bureaucracy of about 39,000 employees,<sup>5</sup> responsible for 150,000 inmates<sup>6</sup> and 80,000 parolees.<sup>7</sup> Within the bureaucracy correctional institutions are run as para-military command structures with a high reliance on two systems: conformance with policies that are carefully prepared and periodically revised, and the sound discretion of unit wardens. Those systems are complemented by an array of methods; what auditors refer to as "internal control:" monitoring, risk assessment, communication, training and other "control activities" that help ensure that management directives are carried out.<sup>8</sup>

TDCJ's internal control systems range from immediate notification of incidents to longer-range, more strategic information gathering to inform the agency's leadership. The following systems, which predate the end of *Ruiz* but have continued to advance, are discussed in greater detail in this section:

- Emergency Action Center Daily Reports & Monthly Select Statistics
- Serious Incident Reviews
- Operational Review & Risk Management
- Grievance Review
- Use of Force Review
- Medical Monitoring
- Internal Affairs/Inspector General
- Internal Audits
- Policy Preparation

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4. Setting standards for receipt of state aid to local probation departments. See generally TEX. GOV'T CODE ANN. §§ 509.001 to -.015 (Vernon 2002).

5. Approximately 1,000 fewer than before the 2003 legislature. See TEX. DEPT OF CRIMINAL JUSTICE, ANNUAL REVIEW 2003 7, 49 (2004), available at <http://www.tdcj.state.tx.us/publications/annual-report/annualreview2003.pdf> [hereinafter ANNUAL REVIEW 2003].

6. *Id.* at 23.

7. *Id.* at 67.

8. See generally *id.* at 55.

B. *Emergency Action Center Daily Reports & Monthly Select Statistics*

The Emergency Action Center (EAC) operates 24/7 and is responsible for receiving all reports of serious or unusual incidents, making proper notifications and compiling information for agency decision-makers.<sup>9</sup> TDCJ policy details the operation and reporting procedures of EAC.<sup>10</sup> It includes a list of “reportable serious or unusual incidents”<sup>11</sup> that require an “administrative review,” which is a detailed report prepared by the unit warden to the appropriate regional director and includes:

- A review of the circumstances of the incident;
- The name(s) of the person(s) involved;
- Events leading up to and following the incident;
- A consideration of whether the actions taken were consistent with agency policies and procedures;
- A review of whether lesser alternative means of managing the situation were available;
- An identification of actions, if any, that could be taken to avoid future incidents of a similar nature and identification of training needs;
- A determination of whether substandard employee conduct was a factor in the incident;
- Corrective action taken; and
- Escape information.<sup>12</sup>

The policy also includes a list of other incidents for which administrative review is optional, including such things as accidental injuries, property damage, use of chemical agents and arrest of an inmate’s visitor.<sup>13</sup> The mandatory list of reportable incidents includes:

- Any reported incident the executive director deems appropriate for administrative review;
- Accidental death;

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9. See generally Texas Department of Criminal Justice, Executive Services, at <http://www.tdcj.state.tx.us/executive/exec-svcs.htm#EAC> (last visited Aug. 23, 2004).

10. TEX. DEP’T OF CRIMINAL JUSTICE, ADMINISTRATIVE DIRECTIVE AD-02.15 (May 2003) (on file with author).

11. *Id.* at 11.

12. *Id.* at 13.

13. *Id.* at 11.

- Accidental injury requiring treatment beyond first aid to any staff/offender to be admitted to a hospital;
- Accident involving a State vehicle which results in damage to non-TDCJ property or resulting in serious injury;
- Alleged sexual assault;
- Assault to an offender resulting in serious injury;
- Assault to staff resulting in serious injury;
- Body cavity search;
- Disturbance involving seven (7) or more offenders;
- Employee death;
- Employee/Offender occupational-related illness;
- Environmental threat;
- Escape (including attempted escape, walk-aways and failure to return from emergency absence);
- Fire which results in injury requiring treatment beyond first aid or property is damaged to the extent that it can no longer be used for its intended function;
- Homicide;
- Hostage situation;
- Offender death (except natural cause attended death);
- Suicide;
- Unit/Facility lockdown (including annual shakedowns).<sup>14</sup>

EAC daily reports are a key way in which TDCJ managers maintain vigilance concerning the events at over 100 secure facilities. It is common for one or two events listed in a daily report to prompt inquiries from agency leadership in Huntsville to the appropriate warden or regional director. For example, the August 21, 2003 EAC report of activity for the previous day listed fifty-five incidents, including seven uses of chemical agents, five offender injuries, four instances of tobacco possession and so on.<sup>15</sup> The Institutional Division deputy director sent two faxes to regional directors directing them to respond regarding their review of:

[T]wo instances on one unit of inmates using slingshots to shoot pieces of metal at staff, one of which resulted in an extensive use of chemical agents in a dayroom; and a different unit's use of chemical agents to address what was believed to be a fight in the

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14. *Id.*

15. TEX. DEP'T OF CRIMINAL JUSTICE, EMERGENCY ACTION CENTER, DAILY REPORT 1 (Aug. 21, 2003) (on file with author).

gymnasium, then believed to be mere horseplay between the two inmates, and ultimately determined to be in fact a fight.<sup>16</sup>

These are in the larger context of the deputy director's current focus on the issue of striking a balance in the use of chemical agents prior to the use of a team of staff.

Serious and unusual incidents reported to EAC, as well as information surrounding major uses of force, form the basis for monthly "select statistics" reports. All incidents are catalogued by categories, as described above,<sup>17</sup> in comparison to recent months and the reports provide yearly totals for incidents by category and yearly ratios of incidents per 10,000 inmates. More detail is provided regarding staff assaults—by inmate custody, location on the unit and race of participants. The report also includes monthly data by unit for uses of force, additional detail on usage of chemical agents and ongoing unit lockdowns.<sup>18</sup> The content of the report has evolved over time as management has determined areas of unit operations that need to be monitored.

### C. *Serious Incident Reviews*

Former TDC Director Ray Procnier organized the first "serious incident review" in early 1985 following an inmate-on-inmate homicide at the Ramsey II Unit.<sup>19</sup> At its inception such a review was to be organized by the director and conducted by internal affairs and security operations staff, in an effort to maintain an independent evaluation to determine if staff negligence was a causative factor. Criminal investigations into these incidents were addressed by law enforcement in the local jurisdiction.<sup>20</sup>

The reviews have recently evolved into more of a "peer evaluation," still organized by a director, but conducted by regional

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16. Facsimile from Douglas Dretke, Institutional Division Deputy Director, Texas Department of Criminal Justice (DATE) (on file with the author).

17. See *supra* note 14 and accompanying text.

18. See, e.g., TEX. DEP'T OF CRIMINAL JUSTICE, EMERGENCY ACTION CENTER, SELECT STATISTICS (Aug. 2004) (on file with the author).

19. See Mary C. Bounds, *Lock-down Affects 17,000 Emergency Measure Continues at Texas Prison*, DALLAS MORNING NEWS, Sept. 11, 1985, at 18A.

20. See TEX. DEP'T CRIMINAL JUSTICE., ADMINISTRATIVE BULLETIN, AB 85-28 (Feb. 1985) (the original policy establishing the "Serious Incident Review Board") (on file with author).

director/warden teams, a representative from the Office of the Inspector General (OIG) and complemented by staff with functional area expertise as needed.<sup>21</sup> Findings and recommendations are made for areas of inquiry, such as the appropriateness of the classification of the inmates involved, the staffing strength and pattern, adherence to policies and the adequacy of reaction to the incident. The warden of the affected unit is required to respond within thirty days, and a follow-up review is conducted within ninety days of the incident to ensure that recommendations and corrective actions were implemented.<sup>22</sup>

#### D. *Operational Review & Risk Management*

The TDCJ Director of the Administrative Review and Risk Management Division maintains an extensive program for periodic operational review of each correctional institution, which encompasses operational adherence to agency policies across a comprehensive gamut of functional areas. Under the agency's current organizational structure these areas are grouped as follows:

- Administrative Review and Risk Management (includes offender grievance, offender property, offender management, use of force and risk management issues);
- Business and Finance (includes agribusiness, environmental affairs, maintenance and prison industries issues);
- Human Resources;
- Operations (includes classification, visitation, offender protection, correctional training and support functions such as food, laundry and supplies);
- Programs and Services (includes schools, religious programs, access to courts, offender discipline and correspondence);
- Security Operations (includes staffing and armory).<sup>23</sup>

The operational review program is currently under significant renovation. "Enhanced" operational review will demand that the functional area proponents—the subject matter ex-

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21. See TEX. DEP'T CRIMINAL JUSTICE, ADMINISTRATIVE DIRECTIVE AD-02.17 (May 2003) (on file with author).

22. *Id.* at 3.

23. See TEX. DEP'T OF CRIMINAL JUSTICE, ADMINISTRATIVE DIRECTIVE AD-02.92 (July 2001) (currently under revision) (on file with author); see also TEX. DEP'T OF CRIMINAL JUSTICE, UNIT OPERATIONAL REVIEW MANUAL (2000) (currently under revision) (on file with author).

perts—identify their most critical—high impact—issues, where units will be required to evidence 100% compliance, and other policy issues for which a compliance score will be calculated. Currently a full blown operational review is conducted on a unit every two years and unit-level operational reviews are conducted monthly in some functional areas by a “Unit Operational Review Sergeant.”<sup>24</sup>

The Risk Management Division is involved in a variety of monitoring activities, most of which have internal control functions.<sup>25</sup> Occupational safety and health is the primary function, and ongoing inspections, training and coordination support this comprehensive effort. All staff and inmate accidents and injuries are investigated and tracked to provide direction for prevention and remediation. Additionally, independent State Office of Risk Management<sup>26</sup> and state fire marshal inspectors routinely visit TDCJ facilities and provide their perspective to the Risk Management Division. Inmates submit their safety concerns to Unit Risk Management Coordinators for review.<sup>27</sup> In addition, Americans with Disabilities Act compliance is under the purview of the Risk Management Division.<sup>28</sup> Each facility is required to conduct an annual assessment in this regard, and facilitate accommodations for disabled offenders.

### E. Grievance Review

The mission of the Offender Grievance Program<sup>29</sup> is to enhance the lines of communication between staff and offenders by providing a resource within the TDCJ for hearing and resolv-

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24. See TEX. DEP'T OF CRIMINAL JUSTICE, SECURITY MEMORANDUM SM-01.23 (June 2002) (on file with author).

25. See generally Texas Department of Criminal Justice, Administrative Review and Risk Management Division, at <http://www.tdcj.state.tx.us/adminrvw/adminrvw-riskmgt.htm> (last visited Aug. 23, 2004); see also ANNUAL REVIEW 2003, *supra* note 5, at 64-65.

26. See generally State Office of Risk Management, at <http://www.sorm.state.tx.us> (last visited Aug. 23, 2004).

27. See generally Texas Department of Criminal Justice, Administrative Review and Risk Management Division, Offender Grievance Program, at <http://www.tdcj.state.tx.us/adminrvw/adminrvw-offgrvpgm.htm> (last visited Aug. 23, 2004); see also ANNUAL REVIEW 2003, *supra* note 5, at 65.

28. See ANNUAL REVIEW 2003, *supra* note 5, at 65.

29. Also under the gamut of the Administrative Review and Risk Management Division. See *id.* at 64.



ing concerns of offenders affecting the institutional environment. The current offender grievance process facilitates problem resolution on two levels. Step I allows a warden the opportunity to resolve issues at the unit level and Step II affords the offender an opportunity to appeal the warden's decision. Step II grievances are sent off the unit to the Central Grievance Office, in Huntsville, Texas, for review and processing by administrative staff not under the control or authority of the warden.<sup>30</sup> Once this two-step process is completed, the offender's administrative remedies within TDCJ have been exhausted.

Texas Board of Criminal Justice policy governs the Offender Grievance Program, and the Offender Grievance Operations Manual provides direction in the processing of grievances by grievance staff.<sup>31</sup> A centralized database of each grievance filed by an offender is maintained within the TDCJ mainframe computer system (known as the GR00 Grievance Case Tracking System) to track grievances and identify trends.

Through comprehensive, detailed statistical reports generated quarterly and annually, agency managers are provided the information necessary to project trends in order to make sound correctional decisions. In addition to statistical reports, a monthly "exceptions report" is compiled and distributed to agency leaders, which highlights not only trends and issues, but also any corrective action taken to resolve those issues. During fiscal year 2002, Texas offenders at 118 facilities filed a combined 212,329 Step I and Step II grievances, representing only a slight increase from the previous fiscal year. Approximately 21% of all Step I Grievances were appealed to the second step, suggesting that problem resolution is occurring at the unit level.<sup>32</sup>

An effective grievance program extends far beyond the staff of the grievance department. It involves an ongoing commit-

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30. See generally *id.*

31. See TEX. BD. OF CRIMINAL JUSTICE, POLICY DIRECTIVE 03.77 (May 2002) (on file with author); see also TEX. DEP'T OF CRIMINAL JUSTICE, ADMINISTRATIVE DIRECTIVE AD-03.82 (May 2002) (on file with author); TEX. DEP'T OF CRIMINAL JUSTICE, OFFENDER GRIEVANCE OPERATIONS MANUAL (Apr. 2004).

32. TEX. DEP'T OF CRIMINAL JUSTICE, ANNUAL REVIEW 2002 52 (2003), available at <http://www.tdcj.state.tx.us/publications/annual-report/annualreview2002.pdf>.

ment by both staff and offenders at every facility to solve problems. The grievance program also provides a variety of supportive and protective functions by giving the offender an alternative to confrontation and aggression. The program offers the offender a less formal alternative to litigation, but is also a necessary prerequisite to litigation. Grievances, when taken collectively, provide a wealth of insight into the daily operations of each facility that is necessary to maintain a safe and secure environment for staff and offenders. Grievances are self-monitoring tools, which help reduce the need for external monitoring, such as the judicial monitoring that TDCJ experienced in the past.

#### F. *Use of Force Review*

TDCJ employs a multi-tiered accountability system for the use of force on offenders and holds staff responsible both for procedural compliance and performance.<sup>33</sup> This, along with relatively strict limits on the use of offensive tools and strict guidelines contained in the TDCJ Use of Force Plan,<sup>34</sup> ensures the success of the program as a whole.

The process begins at the unit level, with forms that lend themselves to data gathering and detailed statements from all participants in a use of force incident. The shift supervisor gathers all documents and statements before the end of the shift, and reviews the use of force for procedural compliance and performance. She then turns the use of force packet over to the unit's use of force coordinator, who reviews the paperwork and associated photographs and video for procedural compliance. Either the shift supervisor or the use of force coordinator may cause further inquiry into the nature and facts of the use of force and add additional documentation to the packet. After the use of force packet clears the initial levels, unit administration (usually the unit major and assistant warden) reviews the

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33. See generally Texas Department of Criminal Justice, Administrative Review and Risk Management Division, Monitoring & Standards—Administrative Monitor for Use of Force (UOF), at <http://www.tdcj.state.tx.us/adminrvw/adminrvw-useforce.htm> (last visited Aug. 23, 2004).

34. TEX. DEPT OF CRIMINAL JUSTICE, USE OF FORCE PLAN (May 2003) (on file with author) [hereinafter USE OF FORCE PLAN]; see also 37 TEX. ADMIN. CODE § 97.23 (West 2003).

paperwork and photographs, watches any related videotape and decides whether to address questions through a fact finding inquiry, conduct an employee disciplinary hearing or to approve the paperwork and pass it off of the unit for second-level review.<sup>35</sup> Unit level administration pays particular attention to certain red-flag issues, and is more likely to conduct a fact finding inquiry if certain injuries occur or an inmate is “taken down” while in handcuffs. Unit administration has shown an express willingness to hold its staff accountable for violating use of force procedures and standards of performance.<sup>36</sup>

In order to supplement and encourage unit level accountability, the second and third tier reviews closely examine the use of force packets coming off of state and privately-operated units. TDCJ’s six regional directors and a private facility monitor are responsible for the second tier review process. They also review the video tapes and paperwork and question the units frequently about the statements and facts contained in the use of force packets. If any concerns are identified at the regional review level, the use of force packet may be returned with a request that a specific violation be addressed or a fact finding inquiry be conducted.<sup>37</sup> The third tier review takes place at the executive director’s level and may also involve questioning or a return of the use of force packet to the unit.<sup>38</sup> Finally, the use of force packet receives a review by the legal department and is sent to records retention in the OIG. On those occasions when the use of force documentation does not “add up,” staff at any of the review levels may request the incident be investigated by the OIG.

The OIG, which has a separate reporting authority, accepts referrals for investigations into allegedly unreported uses of force and, in fact, any referral by any party that an improper use of force may have occurred.<sup>39</sup> The OIG helps to keep the system honest by performing its own investigations and draw-

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35. Interview with Sharon Felfe Howell, Director of Preventive Law, Texas Department of Criminal Justice, Office of the General Counsel (Oct. 2003).

36. *Id.*

37. *Id.*

38. *Id.*

39. See generally Texas Department of Criminal Justice, Office of the Inspector General, at <http://www.tdcj.state.tx.us/inspector.general/inspector.gnl-home.htm> (last visited Aug. 23, 2004) [hereinafter Office of the Inspector General].

ing its own conclusions, without the influence from security or administrative review personnel. If the OIG concludes that an improper use of force has occurred, the use of force is referred to the director of the prison system for appropriate action.

TDCJ upper-level administration tracks unit by unit statistics on the use of force every month. When spikes or other trends in the use of force are observed, units may be called and held accountable for those trends. While very often spikes and other trends may have perfectly legitimate causes, the interaction between the units and the upper-level administration keeps both sides of the equation aware of the importance of accountability and of the process as a whole.

### G. *Medical Monitoring*

Under state law, inmate health care is provided by medical schools in Texas, while TDCJ maintains a Health Services Division with responsibility for monitoring.<sup>40</sup> The Health Services Division has implemented a comprehensive program that targets problem identification and resolution. The major components of this program are described below.

#### *Operational Review Audits*

The Health Services operational review audit tools address processes identified by the National Commission on Correctional Health Care (NCHC), the ACA, TDCJ directives and TDCJ Health Services policies and procedures. These audits are performed every three years and are scheduled to be approximately eighteen months after the previous ACA or NCHC audit.<sup>41</sup>

#### *Patient Liaison and Offender Grievance Reports*

Statistics concerning the rates of complaint submission relating to health care received through the Patient Liaison and Offender Grievance Programs are reviewed and reported to the Correctional Managed Health Care Committee quarterly.

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40. See TEX. GOV'T CODE ANN. §§ 501.131 to .152 (Vernon 2004); see also ANNUAL REVIEW 2003, *supra* note 5, at 35.

41. Interview with Marjorie Pulvino, R.N., Ph.D., Director of Administration, Texas Department of Criminal Justice Health Services Division (Oct. 2003).

These reports address the nature and number of complaints for each unit, university provider and private facility. Issues regarding specific health care personnel or quality of health care are referred to the appropriate university or private provider for resolution.<sup>42</sup>

Registered nurses provide clinical guidance to each investigator in the Patient Liaison and Offender Grievance Programs. If an issue is considered an emergency it is brought to the attention of the TDCJ Health Services Division Director immediately for action. Corrective action requests are reviewed by a physician/midlevel practitioner prior to being distributed. Corrective action responses are reviewed by registered nurses and, if found to be inadequate, are referred back to a physician/midlevel practitioner.<sup>43</sup>

*Department of Professional Standards Quality Control Committee*

The Department of Professional Standards Quality Control Committee meets monthly to review the performance standards of the Patient Liaison and Offender Grievance investigators. It tracks investigations to be certain that both the investigators and the quality assurance staff of the universities are complying with required timeframes for responding to health-related concerns and inquiries.<sup>44</sup>

*Utilization Review Monitoring*

Each month, the office of the Health Services liaison audits the medical records of 10% of the inmate patients discharged from hospitals and infirmaries. The records are audited to determine the percentage of discharged patients who required re-admission to an inpatient facility within seven days, or who did not have sufficient discharge documentation accompanying them to their new facility.<sup>45</sup>

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42. *Id.*

43. *Id.*

44. See generally Texas Department of Criminal Justice, Health Services Division, Department of Professional Standards, at <http://www.tdcj.state.tx.us/health/health-adminsvcs.htm#Clinical%20Issues> (last visited Aug. 23, 2004).

45. See *supra* note 42.

*Mental Health Monitoring of Administrative Segregation Offenders*

The Health Services Division contracts with a master's level psychologist to visit each facility with administrative segregation (ad/seg) inmates twice a year. During these visits the psychologist interviews mental health, medical and security staff to identify ad/seg inmates who have been noticed to have behaviors that might indicate mental illness. He visits each ad/seg cell, views each inmate and interviews those inmates who have been identified as having potential mental health problems, or ones that he determines require further evaluation. After the interview, if he believes the inmate requires further evaluation, he makes a referral to the mental health staff. A report of the results of each referral is requested.<sup>46</sup> Some inmates request mental health services (e.g. anger management training, stress management, etc.) during the interview with the Health Services auditor. Those requests are also forwarded to the mental health staff.

*Monitoring Consolidation Committee*

All Health Services auditors and clinical staff meet monthly. At that time, the results of each operational review audit performed that month are reviewed. In addition, a summary of statistics from the Patient Liaison and Offender Grievance Programs are presented for each unit that received an operational review audit. The results of any additional audits of those units performed by Health Services quality improvement nurses or statistics reported to the quality improvement nurses are also presented to the committee. Based on all of these reports, the committee determines whether any additional actions are needed. Additional actions may include continued monitoring of the unit by the appropriate quality improvement nurse, provision of training to unit staff or special follow-up audits addressing identified problem areas. If after the above actions have been taken, the unit continues to be out of compliance, the Health Services Division Director may contact the corresponding medical director. If the issue remains

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46. *Id.*

unresolved, the division director can submit the issue to the Correctional Managed Health Care Committee for resolution.<sup>47</sup>

#### *Quality Assurance Committee*

All clinical staff of the Health Services Division meet monthly to report and discuss any quality of care issues that have been identified during the month. These issues may be identified during a medical record review as part of an audit, when units request assistance with health-related inmate reassignments, by a quality improvement nurse, during an ad/seg mental health audit, during a patient liaison or grievance investigation, or from information provided by an outside party. Identified issues are discussed, and if they are found to be accurate and significant, the committee recommends actions to resolve the issue. These issues are followed by the committee until they are resolved.<sup>48</sup>

#### *Mortality Committee*

The Mortality Committee is comprised of nurses, physicians, midlevel practitioners and psychologists from both university health care providers and the TDCJ Health Services Division; a dentist would be added if the death was related to a dental issue.<sup>49</sup> The health records of each inmate who died while in TDCJ custody are completely reviewed by an appropriately credentialed clinical staff member. A summary of the review is presented to the committee, and the committee makes a decision as to whether the health care provided was appropriate. If the health care is not deemed appropriate, the case is referred to the corresponding peer review committee for clinical issues or to the corresponding utilization review committee for process issues.<sup>50</sup>

#### H. *Internal Affairs / Inspector General*

The Office of Inspector General, formally known as Internal Affairs, has its origins in the *Ruiz* litigation's focus on inves-

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47. *Id.*

48. *Id.*

49. *Id.*

50. *Id.*

tigating staff harassment, retaliation and use of force.<sup>51</sup> OIG investigators are certified peace officers operating under the commissioning authority of the TDCJ Executive Director, and the Inspector General is hired and controlled by the Board of Criminal Justice, to maintain investigatory independence from the prison system's chain of command.<sup>52</sup> OIG investigates alleged crimes by both inmates and employees and is still requested to investigate some uses of force incidents, although they no longer review every use of force report. In the last decade, OIG has also evolved into the primary liaison between external law enforcement agencies and TDCJ when there are criminal connections from within prison to the free world.<sup>53</sup>

### I. *Internal Audit*

Under Texas law, agencies must maintain an office of internal audit with a direct reporting relationship to the governing board, independent of the executive director or other chain of command.<sup>54</sup> The Internal Audit Division of TDCJ furnishes independent analyses and recommendations concerning the adequacy and effectiveness of the agency's systems of internal control policies and the quality of performance in carrying out assigned responsibilities.<sup>55</sup>

### J. *Policy Preparation*

TDCJ is a gigantic bureaucracy that necessarily relies upon guiding staff through the development and periodic review of multiple layers of policy that are built upon the higher-level policies represented in statutes and case law. That reliance is exemplified by the citations to policy in this paper.<sup>56</sup> Board rules, board policies, executive directives, personnel directives and administrative directives all have applicability across the agency. There are also several operational plans, such as the classifica-

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51. Office of the Inspector General, *supra* note 40.

52. See TEX. BD. OF CRIMINAL JUSTICE, POLICY BP-01.07 (July 2003) (Inspector General policy statement) (on file with author).

53. See generally Office of the Inspector General, *supra* note 40.

54. See TEX. GOV'T CODE ANN. §§ 2102.01 to -.014 (Vernon 2004).

55. See TEX GOV'T CODE ANN. § 493.0052 (Vernon 2004); see also Texas Department of Criminal Justice, Internal Audit Division, at [http://www.tdcj.state.tx.us/internal.audit/internal\\_audit\\_home.htm](http://www.tdcj.state.tx.us/internal.audit/internal_audit_home.htm) (last visited Aug. 23, 2004).

56. See *supra* notes 10, 20-21, 23-24, 32.



tion plan, visitation plan, use of force plan, administrative segregation plan, death row plan and security threat group plan. For security operations, the agency maintains very specific post orders detailing the duties for specific positions on units, and a series of security memorandums for procedures such as the use of telephones on units, counts, perimeter security and so on.<sup>57</sup>

During the second half of the *Ruiz* era, certain policies affecting inmates were, by stipulation, only to be amended with the approval of the governing Board of Criminal Justice: the definition of "sensitive information" that inmates should not have about other inmates, rules for discipline of inmates, policies governing the use of force, chemical agents, investigating uses of force, disciplining staff for uses of force, policies governing access to courts and investigations of retaliation for such access.<sup>58</sup> When *Ruiz* came to a close in 2002, the Board of Criminal Justice adopted amendments to the policy governing their responsibilities, not to eliminate these required reviews, but to accept the staff's suggestion that they add to the list the offender visitation rules and the correspondence rules.<sup>59</sup> This underscores the agency and board's commitment to maintaining visibility and accountability of these important policies.

### III. National Institute of Corrections Reviews

TDCJ maintains a credo of maximum possible openness to the public, including families of the incarcerated, as the strongest bulwark against unconstitutional conditions. This mentality was reinforced in the final discussions with plaintiffs' counsel in *Ruiz*, who challenged TDCJ to actively exercise its responsibility to maintain constitutional standards and sound correctional practices in the absence of court and counsel oversight.<sup>60</sup> The first response, of course, is that TDCJ needs to do

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57. See generally ANNUAL REVIEW 2003, *supra* note 5, at 23-25.

58. TEX. BD. OF CRIMINAL JUSTICE, POLICY DIRECTIVE 01.01 (1999) (on file with author).

59. TEX. BD. OF CRIMINAL JUSTICE, POLICY DIRECTIVE 01.01 (July 2003) (on file with author); see also TEX. DEP'T OF CRIMINAL JUSTICE, OFFENDER RULES AND REGULATIONS FOR VISITATION (2002), available at <http://www.tdcj.state.tx.us/publications/id/visitation.PDF>; TEX. DEP'T OF CRIMINAL JUSTICE, OFFENDER HANDBOOK 71-108 (2003), available at <http://www.tdcj.state.tx.us/publications/id/offender-handbook-2003.PDF>.

60. See *supra* note 36.

what any prison system not under court order does, or should do. In the case of TDCJ, continue current practice in the areas of internal monitoring and compliance. The second response is that it makes sense to seek advice from outside sources, and TDCJ agreed with plaintiffs' counsel to do so. This is really nothing new—TDCJ has often sought advice and training from the National Institute of Corrections (NIC), the ACA, and others, as situations warranted over the years. The difference now is that the agency no longer has to ensure compliance with court orders as it takes the advice or examines its systems. TDCJ now needs only to ensure that its practices make sound correctional sense and comply with constitutional mandates.

TDCJ has two recent experiences working with the NIC on technical assistance projects—one regarding ad/seg and the treatment of mentally ill offenders housed in ad/seg<sup>61</sup> and the other regarding the use of force within TDCJ.<sup>62</sup> Long term, each technical assistance project involves two consultants from other states going to eight different prison units in the five different TDCJ regions, visiting with staff and offenders, touring the units and reviewing paperwork and processes in place at each unit. So that the consultants could have a context for their visits, they were provided with relevant policies and statistics kept by the agency, as well as with examples of paperwork they could expect to see during their visits. The consultants were asked not to evaluate agency policies, which had already been determined to be sound, but to evaluate the way those policies and procedures are implemented at the unit level.

TDCJ and NIC had no template or guidelines for how these visits were supposed to be done; this is the first time in the United States that the NIC has provided assistance to help a prison system look for problems proactively rather than in response to an identified set of circumstances. The lack of guidance caused some difficulty, but also yielded the freedom to respond to many issues in a way that made sense, given all of the information, rather than leading to a programmed response.

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61. See generally NAT'L INST. OF CORR., U.S. DEP'T OF JUSTICE, REVALIDATING EXTERNAL PRISON CLASSIFICATION SYSTEMS: THE EXPERIENCE OF TEN STATES AND MODEL FOR CLASSIFICATION REFORM (2002), available at <http://www.nicic.org/pubs/2002/017382.pdf>

62. See *supra* note 36.

Most importantly, the lack of a given set of guidelines resulted in a great deal of dialogue between the consultants and TDCJ.

### *Use of Force*

The NIC made arrangements for TDCJ to be provided with two very competent consultants, Gene Atherton, the Assistant Director of Prison Operations for the western region of Colorado and the co-author of *Use of Force: Current Practice and Policy*,<sup>63</sup> and Jeff Wells, the security chief of a supermax facility in the Maryland Division of Correction. To date, both consultants have toured two maximum security prison units, and one consultant has toured another two such units. They have reviewed the use of force paperwork, interviewed officers and offenders and produced two reports.<sup>64</sup> As the two consultants moved through TDCJ headquarters during one of their visits, they were able to visit in an informal group setting with all senior administrative personnel in the agency responsible for training, reviewing, monitoring, assisting and administering the use of force in TDCJ. TDCJ also provided the consultants with a list of overriding concerns regarding use of force held by the *Ruiz* plaintiffs' attorneys from their experience with the system a year prior to the visits by the consultants.

The consultants found some problems at the various units they visited, but also found that the problems had been appropriately addressed at the unit level. More importantly, they made a number of findings validating the systems TDCJ has in place to govern the use of force in its prisons. They found that TDCJ probably prepares more extensive paperwork on its uses of force than any other state in the United States. They found that TDCJ has a tremendous amount of administrative control over the use of force. They also found that TDCJ's emphasis on verbal intervention prior to the use of force, and the written ac-

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63. CRAIG HEMMENS & EUGENE ATHERTON, *USE OF FORCE: CURRENT PRACTICE AND POLICY* (1999).

64. See NAT'L INST. OF CORR., TECHNICAL ASSISTANCE SERVICE, *USE OF FORCE PROJECT CONSULTANT REPORT, TEXAS DEPARTMENT OF CRIMINAL JUSTICE, POLUNSKY UNIT AND GIB LEWIS UNIT* (Dec. 2002) (on file with author) [hereinafter *CONSULTANT REPORT II*]; see also NAT'L INST. OF CORR., TECHNICAL ASSISTANCE SERVICE, *USE OF FORCE PROJECT CONSULTANT REPORT—PHASE II, TEXAS DEPARTMENT OF CRIMINAL JUSTICE, ROBERTSON UNIT AND SMITH UNIT* (May 2003) (on file with author).

countability used by some units for that verbal intervention, was impressive enough for both consultants to consider bringing it back to their own states.<sup>65</sup> Many other states have more and different kinds of chemical agents and other intervention devices, including the use of dogs, than TDCJ. However, after a great deal of internal discussion regarding the reports and advice given by the consultants, TDCJ is content that it takes the approach that works for it and does not anticipate expanding TDCJ's arsenal or including other, more drastic approaches to the use of force in the foreseeable future. TDCJ continues to focus on offender management through communication with offenders and staff to the extent possible. After four site visits and an overview of the systems TDCJ has in place at the system level and the unit level, the consultants offered the following conclusion:

The consultants were impressed with the high quality of current TDCJ systems for managing use of force and feel that all the basic elements required for success in a correctional use of force program are in place. However, it is also generally understood in all jurisdictions that there is normally a high frequency of disturbing and challenging experiences between inmates and staff in high security confinement. It is truly one of the greatest challenges to correctional officers to remain composed and professional under those circumstances. The consultants agree with one of the staff interviewed in this experience. He described the animosity that normally exists, and expressed concern that should any of the administrative controls be reduced or eliminated that they could easily descend to conditions where excessive force is used. For that reason we urge the TDCJ to remain on course and vigilant in carefully managing the use of force.<sup>66</sup>

### *Administrative Segregation*

The site visits for the ad/seg technical assistance project were managed a bit differently than for the use of force project. NIC provided two consultants, Mary West, the former Deputy Director from the state of Colorado, who also has a doctorate in psychology, and Todd Ishee, the warden of a supermax facility currently under a highly restrictive court order from the state of

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65. See CONSULTANT REPORT I, *supra* note 64, at 17; see also *supra* note 35.

66. CONSULTANT REPORT I, *supra* note 64, at 17.

Ohio.<sup>67</sup> They came to Texas and visited eight units housing significant numbers of ad/seg and close custody offenders in the five regions in TDCJ over a period of two weeks. TDCJ designated units around the system that would give the consultants the broadest perspective of unit types in which offenders in ad/seg and close custody would be housed. Those units also included units experiencing some of the most severe staffing shortages in TDCJ. Because of the way health care is delivered to offenders in TDCJ, the agency provided the consultants with an overview of the managed care system in use prior to their visits. At each unit, the consultants visited with security staff, the responsible psychotherapist, other health care staff and offenders.

The consultants were routinely impressed with the level of communication between security and mental health staff at all of the units. They were particularly impressed with one large unit, where a mental health staff member conducted rounds throughout all of ad/seg three times per week. The consultants stated in their report: "The inmates know her and she believes that this is a very beneficial practice as the inmates know they have consistent access to the mental health staff."<sup>68</sup> At most units, complete mental health rounds are conducted in ad/seg every ninety days.<sup>69</sup> This is a systemic improvement that did not exist during the time when *Ruiz* was being actively litigated, and it helps to catch those offenders with mental health needs who might otherwise fall through the cracks. However, the consultants pointed out that the standard of care in most other correctional environments includes complete mental health rounds once per week, despite ACA standards. Therefore, the consultants recommended that we utilize mental health rounds once per week in ad/seg.<sup>70</sup> This recommendation was passed on to the agency's health care providers and has already been implemented.

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67. See *Austin v. Wilkinson*, 189 F. Supp. 2d 719 (N.D. Ohio 2002), *aff'd in part, rev'd in part* by 372 F.3d 346 (6th Cir. 2004).

68. NAT'L INST. OF CORRS., TECHNICAL ASSISTANCE REPORT, PROJECT NO. 2003P1028, OFFENDER MENTAL ILLNESS AND ADMINISTRATIVE SEGREGATION IN THE TEXAS DEPARTMENT OF CRIMINAL JUSTICE 6 (Mar. 2003) (on file with author).

69. *Id.* at 12.

70. *Id.* at 15.

The consultants were also concerned with offender idleness in both ad/seg and close custody offender cellblocks. They recommended that we add more in-cell programming designed for self-improvement and assistance in transitioning to a lower custody status.<sup>71</sup> The consultants were informed about the federal grant being implemented at one unit where certain ad/seg offenders will receive interactive video instruction to help prepare them for release from prison directly from ad/seg.<sup>72</sup> The consultants also were informed of the various in-cell anger management packets utilized by mental health staff for ad/seg offenders<sup>73</sup> and of another program at an East Texas unit where mentally-ill, but medication compliant offenders, are assisted in making a transition from ad/seg to a lower custody status.<sup>74</sup> TDCJ has also taken steps to reduce the idleness of close custody offenders despite some severe staffing shortages.<sup>75</sup> Part of that problem has been taken care of by the current economy—staffing is much closer to optimal at this point—and wardens otherwise have devoted more resources to ensuring those offenders regularly get out of their cells to work and recreation.

#### IV. Future Enhancements

For such a large enterprise, TDCJ is a fairly dynamic “learning” organization. We certainly never intend to claim victory and stand pat on the internal control systems existing at a single point in time. For example, TDCJ’s participation and interaction in the NIC consultant project has been extremely beneficial and we look forward to continuing similar programs in the future. We may also encourage more of our professionals to become involved in such endeavors for other states, as that pro-

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71. *Id.*

72. *Pre-release Program First of Its Kind in the Nation: SVORI Aims to Lower Recidivism Among TDCJ Segregation Offenders*, CRIM. JUST. CONNECTIONS (Tex. Dep’t of Criminal Justice, Huntsville, Tex.), May-June 2004, at [http://www.tdcj.state.tx.us/mediasvc/connections/MayJune2004/agency\\_v11no5.html](http://www.tdcj.state.tx.us/mediasvc/connections/MayJune2004/agency_v11no5.html) (Aug. 22, 2004).

73. *See id.*

74. *See generally* Texas Department of Criminal Justice, Rehabilitation and Reentry Programs Division, Serious and Violent Offender Reentry Initiative Program (SVORI), at <http://www.tdcj.state.tx.us/pgm&svcs/pgms&svcs-serious-offender-pgm.htm> (last visited Aug. 23, 2004).

75. *See supra* note 36.

cess entails benefits to the state in which the consultants work as well as to the state or county that they visit.

In the near future, the agency plans to combine the monthly select statistics data<sup>76</sup> with other important indicators of unit level activity which are currently collected but in separate reports, such as employee sick leave, overtime and inmate grievances. This will provide management with a more comprehensive single source of information, for a holistic view of unit dynamics and an opportunity to detect trends and spikes or dips that suggest a need for explanation.

TDCJ's current organizational structure contains "compliance" or monitoring components in several different areas of the agency. To a large degree, this decentralized approach provides appropriate checks and balances, or complies with applicable law in the case of the Internal Audit Division. The OIG reports to the governing board; the Administrative Review and Risk Management Division report to the executive director, independent of the Correctional Institutions Division that is the subject of the grievance, operational and use of force reviews; and the Health Services Division conducts its monitoring activity under the aegis of licensed health care providers who are qualified to understand the subject matter at hand. One issue the agency may continue to examine, however, is the extent to which some consolidation of monitoring and compliance functions could enhance the impact of those activities.

Finally, there are a number of parts and pieces of TDCJ that bear on the topic of internal control through effective self-monitoring and that are subject to continual improvement, but which were not discussed in this paper. For example, the TDCJ Ombudsman program, under the Administrative Review and Risk Management Division, uses an Ombudsman Case Tracking System to log in every inquiry received by source, issue and outcome, and uses the same issue and outcome codes as the Offender Grievance Program, so they can track trends and alert administration when there appears to be a problem somewhere.<sup>77</sup> Other examples are: the training program, a primary

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76. See *supra* Part II.B.

77. See Texas Department of Criminal Justice, Administrative Review and Risk Management, TDCJ Ombudsman Program, at <http://www.tdcj.state.tx.us/adminrvw/adminrvw-ombud.htm> (last visited Aug. 23, 2004).

vehicle in any organization for conveying the requirements of policy to staff; the Advisory Council on Ethics, composed of a cross section of TDCJ staff volunteers; and the Research, Evaluation and Development Group, whose mission is be “[p]urveyors of education, knowledge and information to improve system operations.”<sup>78</sup>

## V. Conclusion

The June 2002 conclusion of thirty years of litigation in *Ruiz* was a major landmark. For new Texas Department of Criminal Justice Executive Director Gary Johnson and his leadership team, the end of court intervention marked the beginning of even more challenging work. “The end of *Ruiz* place[d] total responsibility for Texas prisons back in the hands of the executive and legislative branches of [the Texas] government . . . .”<sup>79</sup> For the prior six years the state of Texas had,

[T]aken the legal[ ] . . . position that Judge Justice was exceeding his authority under the 1996 Prison Litigation Reform Act. Time after time, the judge’s rulings on that law were reversed, both directly by the 5th Circuit and indirectly by the U.S. Supreme Court. But setting aside the ultimate probability that the State would prevail under the law,<sup>80</sup> it remained, and still remains, crucially “important to recognize the continuing moral lesson that Judge Justice’s findings held for the State.”<sup>81</sup>

In the final throes of the litigation, Judge Justice,

[F]ocused on the fundamental challenges that face every correctional facility in this country. First, the physical safety of every offender, from excessive uses of force by staff and the predatory behavior of other inmates. Second, the mental and physical safety of those . . . inmates whose aggressive conduct in prison

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78. Texas Department of Criminal Justice, Executive Administrative Services, Research, Evaluation and Development (RED) Group, at <http://www.tdcj.state.tx.us/red/red-home.htm#Mission> (last visited Aug. 23, 2004).

79. *The Post-Ruiz Era—The Moral Imperative: Ruiz Returns Responsibility to Texas Prison System*, CRIM. JUST. CONNECTIONS (Tex. Dep’t of Criminal Justice, Huntsville, Tex.), Sept.-Oct. 2002, at [http://www.tdcj.state.tx.us/mediasvc/connections/SeptOct2002/agency\\_v10no1.html](http://www.tdcj.state.tx.us/mediasvc/connections/SeptOct2002/agency_v10no1.html) (last visited Aug. 22, 2004).

80. *Id.*

81. *Id.*



results in a trip downward to the most restrictive conditions possible.<sup>82</sup>

Administrative segregation, what I call “the prison system’s prison system.”

Judge Justice reminded us again of the frail humanity of the people whom society and the criminal justice process condemn to multi-year imprisonment. “The leadership of the Texas Department of Criminal Justice is committed to the core moral importance of those lessons, and to action that demonstrates the opposite of the ‘deliberate indifference’ standard that defines unconstitutional prison conditions.”<sup>83</sup>

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82. *Id.*

83. *Id.*