

Arizona Department of Corrections



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CHARLES L. RYAN
DIRECTOR

December 29, 2010

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

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

Dear Mr. Washington:

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

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

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

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

History of Significant Events at ASP-Kingman:

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

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

Nakamoto Report and Findings:

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

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

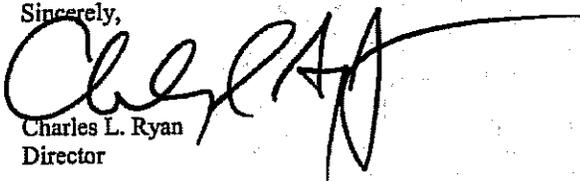
This letter shall also serve as a demand for written assurance in accordance with section 8.1, Right to Assurance, Uniform Terms and Conditions, that it is MTC's intent to perform and comply with all provisions of the contract. Specifically that MTC will complete all deficiencies as documented and as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

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

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

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

Sincerely,



Charles L. Ryan
Director

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

Attachment: Required Cure Actions, Detail

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

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