



PERFORMANCE AUDIT REPORT

**Department of Corrections:
Reviewing Allegations of Staff Misconduct**

**A Report to the Legislative Post Audit Committee
By the Legislative Division of Post Audit
State of Kansas
January 2010**

Legislative Post Audit Committee

Legislative Division of Post Audit

THE LEGISLATIVE POST Audit Committee and its audit agency, the Legislative Division of Post Audit, are the audit arm of Kansas government. The programs and activities of State government now cost about \$13 billion a year. As legislators and administrators try increasingly to allocate tax dollars effectively and make government work more efficiently, they need information to evaluate the work of governmental agencies. The audit work performed by Legislative Post Audit helps provide that information.

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January 22, 2010

To: Members, Legislative Post Audit Committee

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This report contains the findings, conclusions, and recommendations from our completed performance audit, *Department of Corrections: Reviewing Allegations of Staff Misconduct*.

The report includes several recommendations for the Legislature to amend State law to require individuals convicted for sexual misconduct to register as a sex offender, and toughen the penalties for both sexual misconduct and trafficking in contraband. Other recommendations are directed to the Secretary of Corrections to improve management information about staff involved in undue familiarity—including sexual misconduct—and trafficking in contraband, and to further review Topeka Correctional Facility to ensure the female inmates are protected.

We would be happy to discuss these recommendations or any other items in the report with any legislative committees, individual legislators, or other State officials.

Barbara J. Hinton
Legislative Post Auditor

READER'S GUIDE

<i>The Big Picture</i>		<i>The Details</i>	
Audit Highlights	The highlights sheet, inserted in each report, provides an overview of the audit's key findings	"At-a-Glance Box"	Used to describe key aspects of the audited agency; generally appears in the first few pages of the main report
Conclusions and Recommendations	Located at the end of the audit questions, or at the end of the report	Side Headings	Point out key issues and findings
Agency Response	Included as the last Appendix in the report	Charts, Tables, and Graphs	Visually help tell the story of what we found
Table of Contents, and lists of figures and appendices	Lets the reader quickly locate key parts of the report	Narrative Text Boxes	Highlight interesting information or provide detailed examples

This audit was conducted by Lynn Retz, Allan Foster, and Lindsey Rousseau. Chris Clarke was the audit manager. If you need any additional information about the audit's findings, please contact Lynn Retz at the Division's offices.

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Department of Corrections: Reviewing Allegations of Staff Misconduct

The Department of Corrections operates eight correctional facilities across the State to provide safe and secure institutional care for male and female felons committed to the custody of the Secretary of Corrections. Currently, seven of the eight correctional facilities house male inmates; one correctional facility houses only female inmates.

Over the last few years, there have been three highly publicized incidents occurring at three different correctional facilities—Lansing, El Dorado, and Topeka. Two of these incidents involved inmate escapes with the help of people associated with the correctional facilities. The third incident involved an inmate getting pregnant after having sexual relations with a correctional employee. These three incidents have caused legislators to question whether the State is doing enough to prevent misconduct by correctional employees.

This performance audit answers the following question:

What happened in the Lansing, El Dorado and Topeka cases and what were the contributing factors?

For reporting purposes, we amended the original audit question to address how these three incidents occurred. Specifically, we focused on contributing factors of staff undue familiarity with inmates, sexual misconduct, and trafficking in contraband.

To answer this question, we visited Lansing, Topeka, and El Dorado Correctional Facilities. We gathered information about all three facilities, including budget and staff levels, and allegations of staff misconduct. We reviewed a summary provided by each of these facilities of investigations conducted on staff misconduct for a period of five years. We also reviewed the investigative files and Serious Incident Review Board documents for the two escapes, personnel files, and routine reports regarding complaints and grievances.

In addition, we interviewed Department of Corrections' officials and correctional facility staff, and reviewed Prison Rape Elimination Act reporting information, training materials, and information provided to inmates about their rights to be free from sexual violations while in prison.

We also reviewed correctional facility policies and procedures, best practices, the Department of Corrections' policies and procedures, Kansas Administrative Regulations, and Kansas statutes related to staff trafficking and sexual misconduct. We compared Kansas' statutory penalties for staff sexual misconduct to the penalties in 49 other states.

A copy of the scope statement for this audit approved by the Legislative Post Audit Committee is included in Appendix A.

We conducted this performance audit in accordance with generally accepted government auditing standards with certain exceptions. Specifically, because of time constraints, we did limited testing of the investigation summaries provided by the three facilities. At Topeka Correctional Facility, we randomly checked the information provided against selected investigative files and personnel records.

We compared the investigative data against the disciplinary data provided by each of the three facilities and found discrepancies in the Topeka Correctional Facility disciplinary database and the investigative data. Those discrepancies included incidents of undue familiarity being included in the disciplinary database, but not appearing in the investigative data. Also, the disciplinary database included inaccurate information on recommended and final disciplinary actions for employees. We didn't do any testwork to verify the findings or determinations of the investigative files.

The standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. Although our review found errors in our limited testwork, it's unlikely that the extent of errors is so grossly or systematically wrong as to affect our findings and conclusions. Still, the reader should consider the information from the Department of Corrections in Question 1 as a reasonable estimate, not as absolute fact.

Except for the limitations described above, we think the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Our findings begin on page 9, following a brief overview of the Department of Corrections and the correctional facilities.

Overview of the Department of Corrections and Correctional Facilities

The Department of Corrections Is Responsible For More Than 8,600 Inmates in Eight Facilities Across The State

The Department maintains eight facilities across Kansas. Seven facilities house only males; all female inmates are housed at the Topeka Correctional Facility. In total, the eight facilities have the capacity to house 8,880 inmates Statewide. As of December 1, 2009, the inmate population was 8,683, or 98% of capacity.

The wardens at each facility are hired by, and serve at the direction of the Secretary of Corrections. Each facility hires administrators, support staff, and correctional officers who are responsible for the daily supervision and management of the inmates. In addition, each facility has its own in-house investigation staff to look into allegations of staff or inmate misconduct.

Of the 2,727 Department of Corrections' facility employees, approximately 71% are uniformed staff (corrections officers). In addition to those employees, the Department contracts with outside firms to provide health professionals and food-service workers.

Figure OV-1 provides a snapshot of the eight facilities' fiscal year 2010 budgets, full-time-equivalent positions, inmate populations as of December 1, 2009, and inmate population capacity. The Department of Corrections also houses 110 inmates in other facilities. Those numbers also are reflected in **Figure OV-1**.

Figure OV-1 shows that on average the facilities are at 98% capacity.

Figure OV-1 Correctional Facility Data, Fiscal Year 2010					
Correctional Facility	FY 2010 Budget	FTE Positions	Population as of 12/1/09	Inmate Capacity as of 12/1/09	% of Capacity
El Dorado	\$ 23,721,659	429	1,216	1,178	103% (b)
Ellsworth	\$ 12,820,512	222	817	832	98%
Hutchinson	\$ 29,525,854	515	1,781	1,768	101% (b)
Lansing	\$ 37,917,849	685	2,350	2,365	99%
Larned Mental Health Facility	\$ 10,015,884	186	356	368	97%
Norton	\$ 13,627,996	235	705	707	100%
Topeka (all female inmates)	\$ 13,827,203	253	567	727	78%
Winfield	\$ 12,847,286	202	781	804	97%
Other Facilities (a)	n/a	n/a	110	131	84%
Total	\$ 154,304,243	2,727	8,683	8,880	98%

(a) These facilities house inmates the Department of Corrections is responsible for, and include Larned State Hospital, county jails, and out-of-state placements.
 (b) Reasons for exceeding capacity include: infirmary and segregation beds, transition of inmates between facilities, and double-bunked cells.
 Source: Unaudited data from the Department of Corrections and Department officials.

The Three Incidents We Reviewed Involved Staff Undue Familiarity, Sexual Misconduct, And Trafficking in Contraband

In conducting this audit, we reviewed the investigative reports and other files for three incidents that occurred in recent years at Lansing, El Dorado, and Topeka Correctional Facilities. Those incidents can be summarized briefly as follows:

- In February 2006, an inmate escaped from Lansing Correctional Facility while hiding in the vehicle of a long-time volunteer for the Safe Harbor Dog Program.
- In October 2007, two inmates escaped from the El Dorado Correctional Facility with the help of a former corrections officer who, among other things, provided them with guns and bolt cutters.
- In November 2007, officials at the Topeka Correctional Facility were tipped off that an inmate who'd been participating in the Facility's plumbing/maintenance program was pregnant. As part of that program, inmates would respond to service calls with maintenance staff, one of whom had had sexual relations with this inmate.

All three incidents involved staff misconduct stemming from undue familiarity with inmates, sexual relationships with inmates, or trafficking in contraband. More detailed information about each case is presented in Question 1.

Staff Misconduct Can Have Severe Implications For Other Staff, Inmates And the Facility

Correctional facility staff are supposed to fulfill the Department's mission to safely contain and supervise the inmates committed to the custody of the Secretary of Corrections. Staff misconduct can compromise the security of both staff and inmates, and can undermine staff authority, such as:

- **Undue Familiarity:** Conversation, contact, or personal or business dealings between an employee and offender under the supervision of the Secretary of Corrections which is unnecessary, not a part of the employee's duties, and related to a personal relationship or purpose rather than a legitimate correctional purpose. Undue familiarity includes horseplay, betting, trading, dealing, socializing, family contact unrelated to the employee's duties, sharing or giving food, delivering or intending to deliver contraband, personal conversation, exchanging correspondence, sexual misconduct, or in any other manner developing a relationship with an offender that's inappropriate. A similar prohibition restricts inmates from initiating an unduly familiar relationship with staff.
- **Sexual Misconduct:** Sexual behavior that is directed by an employee toward an offender under the supervision of the Department of Corrections. Sexual misconduct includes acts or attempts to commit acts of sexual abuse, sexual contact, sexual assault, unlawful sexual relations, and sexual harassment. It also includes conversations or correspondence that demonstrate or suggest a romantic or intimate relationship between an offender and the employee. Whether or not the inmate consents or initiates the behavior is irrelevant in determining if sexual misconduct has occurred.

- **Contraband**: Any item that has not been approved for introduction into a correctional facility by law, regulation, policy, or otherwise specifically authorized by the warden, per K.A.R. 44-2-103. Pursuant to the administrative regulation and departmental policies, contraband would include, but is not limited to: guns, knives, ammunition, escape paraphernalia, narcotics, cell phones, tobacco, intoxicants, and currency.

Department and facility officials told us most instances of trafficking in contraband, sexual interactions, and even escapes begin with undue familiarity. As such, Department officials noted that instances and allegations of undue familiarity need to be quickly stifled. Department policies state that Department officials “**absolutely forbid** acts of undue familiarity, including sexual misconduct with offenders” (emphasis added). Those policies also state that Department officials will investigate and take necessary action to prevent undue familiarity.

Undue familiarity can range from casual conversation all the way to sexual misconduct. As a result, not all cases of undue familiarity will result in the employee being terminated. Officials told us, for cases of undue familiarity, they have to weigh the action against the employee’s work history to try to determine whether the action would “compromise” the employee’s ability to perform his or her job effectively, and whether the action potentially puts the entire facility at risk.

Undue familiarity can lead to the following:

- **Sexual misconduct** Because the Department is charged with the care of inmates, taking advantage of an inmate can never be tolerated. Although some inmates and staff claim their relationships are consensual, the literature we reviewed and correctional facility officials we talked with stressed that, because employees are in a position of power, a sexual relationship should never be viewed as consensual.

For sexual misconduct, the Department and facilities have a zero tolerance policy. If sexual misconduct is substantiated, the employee is terminated. See the profile box on page 6 for more information about the Prison Rape Elimination Act, a federal law passed in 2003 that’s designed to help prevent prison rape.

- **Contraband** Even seemingly harmless contraband items can have severe consequences. Because tobacco is not an illegal substance outside a correctional facility, there’s little appreciation for the implications of tobacco inside a correctional facility. Once smuggled in by a staff member, for example, tobacco becomes a commodity for the inmate. Moreover, because the inmate could report staff for trafficking contraband, the inmate gains some control over the staff member.

Prison Rape Elimination Act Is a Federal Law That's Designed To Raise Awareness of and Prevent Rape in Prison

The Prison Rape Elimination Act (PREA) of 2003 focused on curbing prison rape through a “zero-tolerance” policy. One of the main purposes of the PREA was to increase available data and information on the number of incidents of prison rape. The intent was to improve the management and administration of the facilities and reduce prison rape by increasing correctional employees’ awareness.

The law requires the Bureau of Justice Statistics to conduct a comprehensive statistical review and analyze the effects of prison rape on the population and the facilities. The data would give indications of the prevalence of rape inside the prison, and the analysis was to provide positive ways to reduce the number of incidents. The Act covers the entire spectrum of sexual violence, from sexual harassment to rape. It focuses on both inmate-on-inmate and staff-on-inmate sexual misconduct. For the purposes of this report, we focused only on staff-on-inmate sexual misconduct.

The Prison Rape Elimination Act of 2003 requires correctional facilities to take specific actions intended to prevent and reduce sexual violations in prisons. These requirements include reporting inmate-on-inmate and staff-on-inmate sexual misconduct allegations in the prison environment. Facilities also must report the outcome of investigations into such allegations. Correctional facilities also are required to provide inmates with information about their rights to be left alone and not to be subject to sexual violations, including sexual harassment.

The Department of Corrections has prepared a Prison Rape Elimination Act brochure for inmates and also one for staff, which provides specific information about the inmate’s rights, reporting opportunities, and medical and counseling information. The Department also has developed a Prison Rape Elimination Act video for inmates to view in which the Secretary provides information about the inmates’ rights. More information about the reporting and video can be found on page 33 and 34.

Similarly, inmates having cell phones may initially appear harmless. However, cell phones can be used for gang activity, drug transactions, planning escapes, and other illegal activities. Like tobacco, cell phones and other contraband can lead to an officer being compromised and losing the balance of power. This places both the officer and the facility at risk. The Department has established a policy of graduated sanctions for these infractions, as described in the profile box on page 7.

The Department also has established policies and procedures designed to protect staff and inmates. These policies and procedures provide that:

- **Staff must sign a “Code of Ethics.”** This code prohibits staff from abusing their power or establishing any form of a personal relationship with an inmate. Staff also are required to sign that they have read the rules of conduct and the internal policies, statutes, and administrative rules related to undue familiarity, trafficking of contraband, and sexual misconduct. Any violation of policies can be grounds for disciplinary action, including dismissal.
- **Staff have a duty to report any knowledge, suspicion, or information regarding any incident of sexual misconduct.** This duty to report includes undue familiarity between staff and inmates, volunteers and inmates, or contractors and inmates. Any violation of policy is to be reported.

The Largest Contraband Problems Often Involve Items That Are Perfectly Legal Outside Prison

Trafficking in contraband by employees has always been something officials have had to address. Officers receive relatively low pay, so financial gain is a significant draw for some. Some officers get to be friends with inmates and bring them things they shouldn't. Also, inmates are adept at observing and manipulating weak or naive employees. If the employee allows the manipulation to go far enough, he or she can end up being compromised by the inmates and forced into trafficking.

One of the wardens we interviewed said that, in the past, the most popular items smuggled into prisons were drugs. He said that employee trafficking was less of a problem in those days because of the illegality of drugs. In essence it was just harder for inmates to get officers to smuggle drugs for them.

Things have changed a lot in the last few years. Now, the most popular items are tobacco and cell phones. The Department began cracking down on tobacco in the late 1990s when it instituted a policy that inmates couldn't smoke indoors. Finally, in 2002 the Department went the rest of the way and made facilities totally smoke free environments, not allowing anyone to possess tobacco in any form inside a facility. With this decision, tobacco became very valuable. In 2008, cell phones also were banned inside all facilities. The cell phone ban resulted from the Lansing and El Dorado escapes described in this report. In both those escapes, individuals smuggled cell phones in to the inmates, which were then used to help plan the escapes.

Of course, both tobacco and cell phones are legal everywhere except inside prisons. Without the stigma of illegality that drugs have, it's much easier for inmates to get staff to bring in tobacco and cell phones. Because of their value to inmates, correctional officers can make a lot of money providing them. Here are several examples from one facility:

- Investigators found tobacco, a cell phone, and over \$1,000 in cash thrown on the floor during a surprise search. They are investigating to determine if an employee was involved.
- While conducting employee searches, investigators discovered an employee with 30 pouches of tobacco. He admitted it was his second delivery. The employee was terminated.
- Investigators interviewed an employee who admitted to bringing 3.25 pounds of tobacco into the facility. The employee was terminated.
- An employee was overheard on the phone telling the caller that "she wasn't bringing in any more dope because they weren't paying enough." The employee was terminated.

The Department has aggressively pursued enforcing these bans. In 2003 it developed a "zero tolerance" policy for tobacco and in 2008 for cell phones, and set exact penalties for employees bringing them in:

- 1st offense, three-day suspension
- 2nd offense, 10-day suspension
- 3rd offense, termination

It's important to note that these apply only to cases where it appears the items were being brought in by mistake, for example an employee having a cell phone in a coat pocket. If investigators confirm the employee was "trafficking" cell phones or tobacco (having cigarettes hidden in the lining of a coat), the punishment generally is termination, as in the examples above.

Wardens have no flexibility in these punishments. While only one employee has had a 3rd offense, there have been a significant number of suspensions. Between April 2008 and June 2009, there were 232 recorded violations for cell phones. In the three-year period ending October 2009, there were 119 recorded violations for tobacco.

The Department also requires employees to pass through a metal detector to get to work. If they refuse they are denied access to the facility and subject to discipline for refusing a search. Metal detectors won't find tobacco, so the Department periodically conducts searches at the entrances using dogs that can detect drugs and tobacco. If the dog alerts, the employee is searched and sent for urine tests. Cell phones have become such a problem in the corrections industry that some states now use cell phone-sniffing dogs to detect them.

- **All allegations of staff sexual misconduct or sexual harassment are to be investigated.** If substantiated, the Department can take a variety of disciplinary action including possible referral for criminal prosecution. This would include allegations involving sexual misconduct by a volunteer or contractor toward an inmate.

These policies are designed to inform staff of proper conduct and to help identify and curtail improper conduct as discussed earlier, failure to follow these policies can have serious consequences.

What Happened in the Lansing, El Dorado and Topeka Incidents, and What Were the Contributing Factors?

Answer in Brief:

For the three cases at Lansing, El Dorado and Topeka Correctional Facilities there were red flags facility officials should have recognized and acted upon which could have prevented each of those incidents. At both Lansing and El Dorado Correctional Facility staff failed to follow policies and procedures in place at the time of those incidents. However, the facilities and the Department of Corrections have taken steps to reduce the likelihood such incidents will happen in the future. At Topeka Correctional Facility there were a variety of reasons that made conditions ripe for staff sexual misconduct. While Topeka Correctional Facility has made some changes, such as installing additional cameras, more steps need to be taken. Further, we found other systemic problems at the Topeka Correctional Facility that may lead to more instances of staff misconduct.

In the course of our review, we noted additional areas of concern including the fact that statutory penalties in Kansas for staff sexual misconduct aren't as severe as other states and are even less severe than staff trafficking in contraband. Further, we found the Department lacks sufficient management information to ensure that officials are aware of the level of staff misconduct. There needs to be better consistency for tracking allegations and investigations, the investigative process and how staff discipline is determined. These and other findings are described in the following sections.

We Reviewed Three Recent Incidents To Assess Whether the Actions Taken by Facility Staff Appeared To Be Reasonable and Appropriate

During the course of our review, we visited El Dorado, Lansing, and Topeka Correctional Facilities. We interviewed Department of Corrections officials and correctional facility staff, reviewed investigative files, court records, personnel files, and staffing levels. We also compared Kansas statutes, Kansas Administrative Regulations and Department policies and procedures on contraband, sexual misconduct and undue familiarity to best practices.

Using this information and other information we collected, we assessed whether the actions taken by facility staff and officials appeared to be reasonable and appropriate in each of the three cases we reviewed. As described in the sections that follow, we concluded that, in all three cases, facility officials should have recognized certain red flags and acted on them. Doing so likely would have prevented the incidents from occurring.

The reader should be aware that auditing incidents like these has certain limitations, and some concerns can't be addressed. For example, we can't say how prevalent staff sexual misconduct or staff

trafficking in contraband is inside State correctional facilities. Some of the limitations that prevent us from providing specific information include:

- **Allegations of staff misconduct often aren't "black-and-white."** Individual perceptions of what was said, how it was said, what was meant, as well as how the situation was handled can vary.
- **Lack of evidence hampers some investigations.** Some situations concern allegations of inappropriate staff actions, such as inappropriate touching, sexual misconduct, smuggling contraband, coercion and pat searches. Often these cases are "he said, she said" in that the only evidence is the statement of those involved. If there were no witnesses or video, the investigator doesn't have much to work with.
- **Many instances go unreported.** In some cases, both parties involved have a vested interest in keeping the incident quiet. An inmate may be receiving contraband in exchange for money paid to staff, or both sides could be receiving sexual gratification from the relationship. In such cases, the parties involved aren't likely to report the action.

The following sections detail our findings related to the three incidents we were asked to review. We reviewed the complete investigative files, the personnel files, and other facility files in our audit. Our findings were based on those file reviews and on interviews with Department and facility staff, including wardens and investigators.

Findings Related to an Inmate's Escape From Lansing Correctional Facility

Details of the case: *Inmate Manard was serving time at Lansing Correctional Facility for first degree murder and robbery. Toby Young was the President of the Safe Harbor Dog Program. In this Program, inmates would train and rehabilitate dogs and then the dogs would be put up for adoption at pet stores. Young would bring dogs to the facility in a van, work with the inmates on training the dogs, and drive the dogs away again. Manard was involved in this Program at Lansing in late 2005 and early 2006.*

According to records, Inmate Manard and volunteer Young started planning Manard's escape in December 2005. Young admitted she was able to smuggle a cell phone into the facility for inmate Manard in late January 2006. In preparing for the escape, Young bought a truck and rented a storage unit to hide it. She also purchased cell phones and clothing, made arrangements to have her prescriptions filled for a period of time, and collected a significant amount of cash.

On February 12, 2006, Inmate Manard concealed himself inside a dog kennel that was loaded into the dog program van driven by Young. Young's van was allowed to leave Lansing Correctional Facility without being searched. The two subsequently were caught in Tennessee in late February.

Young pled guilty and was sentenced to 21 months on State charges for aiding and abetting a convicted felon and introducing contraband into a correctional facility. She also was sentenced on federal charges for providing a convicted felon with a firearm.

Two Lansing Facility Staff Failed To Follow Policies and Procedures That Were In Place At The Time of the Incident

Our conclusions were based on the following.

The Program coordinator failed to report concerns of undue familiarity between Young and Inmate Manard to investigative staff. The Lansing facility employee who was the Program coordinator worked closely with volunteer Young. Although she had been volunteering only for about a year, Lansing officials said because she was trusted Ms. Young wasn't always supervised when she was with inmates.

At least two staff and more than one inmate approached the Program coordinator several times with concerns that Ms. Young was overly familiar and showing favoritism to a few of the inmates in the Program, including Manard. Showing favoritism is an example of undue familiarity and something that can lead to improper relationships. The Program coordinator should have reported this information to investigative staff, but he didn't.

After the escape the Program coordinator told investigators that he had counseled Ms. Young on numerous occasions about not showing favoritism because it could lead to more serious things. Although counseling may have been an appropriate action to take the first time someone reported a problem to the Program coordinator, repeated concerns should have resulted in more serious actions being taken, including reporting the situation to his superiors and to investigative staff.

The Program coordinator also failed to report that gate officers didn't regularly search the dog program van. Each gate at Lansing has procedures for how vehicles should be searched by gate officers when entering or exiting the facility. Vehicles require additional security controls because they present a larger risk of escapes. For gates that lead to secure areas, the facility has "heartbeat monitors," or machines that detect living things that might be hidden in the vehicle. The monitor scans vehicles, after all passengers have stepped out.

Every vehicle is supposed to go through the detector. Evidently, however, the gate officer was used to seeing the Program van carrying dogs in and out, so he regularly failed to search it or use the heartbeat detector.

The Program coordinator told investigators he was aware the van wasn't being searched during these trips. He even commented that when he delivered supplies for the dogs in his own car, the gate officers always searched it and used the heartbeat detector. However,

he claimed he didn't know what procedures gate officers were supposed to take with the van, and didn't realize they were deficient in not searching the dog van.

Had the Program coordinator reported this to someone, or even questioned the disparity, action could have been taken to correct the gate officers' behavior to ensure that the van was appropriately searched each time it entered and left the gate.

Staff familiarity with Young as a volunteer with the dog program led to complacency and failure to enforce policies.

The investigation of the escape found that the gate officer allowed Young's van to enter the facility even though she was not on the authorized visitor list, failed to call it in, and also failed to log the entry. More importantly, the officer failed to search the van before it exited the facility or to require the van to pass through the proper security checks, such as the heartbeat monitor. This was likely caused by the staff being too comfortable with Ms. Young coming and going—a subtle form of undue familiarity.

In interviews with Ms. Young after she was captured, she said she knew from past experience that the gate officers wouldn't search the van, thus making the escape possible.

No disciplinary action was taken against the Program coordinator. Following the escape, the officer that failed to search the dog van was fired, but no action was taken against the Program coordinator for failing to report information to the proper authorities within the Facility. When we asked the warden why he hadn't disciplined the coordinator, he said he hadn't been aware of these facts until we pointed them out. However, all of our information came from investigative files at the Facility.

The Serious Incident Review Board Focused Solely on the Escape And Failed To Address The Undue Familiarity That Led to the Escape

After all escapes or other types of serious incidents, the Department convenes a "Serious Incident Review Board." The Review Board's purpose is to undergo a "lessons learned" type of process in which upper-level Department staff try to determine what went wrong and recommend changes to Department policies, procedures, or practices to reduce the risk of the same thing happening again. Each Review Board is made up of Department staff appointed by the Secretary, who work under the direction of the Department's chief legal counsel. Members gather information, interview witnesses, report their findings, and make recommendations.

A Serious Incident Review Board was held after the Lansing escape. Staff from Lansing prepared the information for the Board. In addition to reviewing the documentation, Board members interviewed staff, reviewed video tapes, and observed operations at the Facility gate involved in the escape.

We reviewed the same documentation the Board reviewed. Most of the information related to the logistics of the escape and not the undue familiarity that had occurred. Apparently, Board members weren't provided the investigator's interview with the Program coordinator, and therefore were unaware of some of the circumstances leading up to the escape, including the multiple allegations of undue familiarity. Lansing officials were responsible for providing information for the Board to review. At the time the Board met, the investigation hadn't been completed, so only limited information could be provided.

This is a problem because the main circumstance that led to the escape—the relationship between Ms. Young and Inmate Manard—developed long before the escape actually happened. Without this critical piece of information, Board members couldn't make a complete assessment of the situation or make appropriate recommendations.

Lansing Correctional Facility Has Addressed The Issues Directly Related to the Escape, But Not the Issue of Undue Familiarity

Although the Facility has maintained the Dog Training Program, staff have made several adjustments to improve security measures and reduce the areas of vulnerability:

- Security changes were made regarding how dogs come into and leave the facility. Dogs are now walked out on a leash, rather than being driven out in the van.
- Inmates aren't allowed to load the dogs into the vans to ensure that inmates were further removed from the outside gate and vehicles.
- Changes were made to clarify that all vehicles should be searched when leaving the Facility.

The staff failures in this case highlight the importance of reporting concerns about undue familiarity regardless of how minor they may appear at the time. This is especially critical when there are repeated allegations from a variety of sources.

Findings Related to an Inmate's Escape From El Dorado Correctional Facility

Details of the case: Amber Goff went to work as a correctional officer at the El Dorado Correctional Facility in September 2006. Shortly after her first day, Inmate Ford winked at her. According to records, the two started talking more often, kissed, and became more familiar with each other's lives.

Other staff noticed a relationship developing between Goff and Inmate Ford. A fellow officer reported concerns about their relationship, first to Goff's immediate supervisor, and later to investigative staff.

In February 2007, Inmate Ford was briefly transferred to Lansing Correctional Facility for security threat concerns. El Dorado investigative staff asked Lansing investigative staff to monitor his mail, phone calls, and any funds received into his account because of possible undue familiarity with staff. Officer Goff and Inmate Ford still corresponded by mail during this time.

Inmate Ford was transferred back to El Dorado in April 2007 because of threats he'd made to staff at Lansing. In July 2007, Goff asked to be transferred to work in the same cell house as Inmate Ford. The request was granted, and shortly thereafter, other staff again reported concerns about undue familiarity between Goff and Ford.

The supervisor in the new cell house counseled Goff and reported the undue familiarity to the investigative staff. During this time, Goff also arranged for a cell phone to be smuggled into the facility for Ford.

Investigative staff looked into the allegations of undue familiarity, and in early October 2007 intercepted correspondence from Goff to Ford. Goff denied any relationship or undue familiarity with Inmate Ford, and was allowed to resign.

About two weeks later, Goff helped inmates Bell and Ford to escape. She penetrated the perimeter fence without detection, and provided them with bolt cutters, firearms, and ammunition. The three were captured on October 31, 2007, in New Mexico. Goff pled guilty and was sentenced on federal charges for her involvement in the escape and providing a firearm to a felon.

This Case Involved A Series of Failures At Almost Every Level

We reviewed the complete investigative files, personnel files, and other Facility files in this audit. We also spoke with Facility officials, including the warden and investigative staff. Based on that information, we determined that at both El Dorado and Lansing Correctional Facilities, staff failed to act appropriately.

This incident involved a series of failures at both facilities where staff failed to act when they had clear notice of undue familiarity between Goff and Ford. Those failures and other significant events are summarized below:

1. When informed by another officer of Goff's possible undue familiarity with Inmate Ford, Goff's supervisor failed to address the issue with Goff, as required by policy. The policy required supervisors to provide counsel and discipline to an employee at the first sign of a problem to correct the behavior or performance. The supervisor also failed to report the concern to investigative staff.

2. When the other officer saw that Goff's supervisor had taken no action, the officer reported it directly to facility-based investigators. However, the investigators didn't take any action at that time.
3. When Inmate Ford was transferred to Lansing, El Dorado investigative staff asked Lansing investigative staff to monitor his mail, phone calls, and funds received into his account because of possible undue familiarity concerns. Lansing staff acknowledged the request, but they didn't monitor Ford's communications. El Dorado investigative staff also didn't follow up with Lansing staff regarding the request or any status updates. Goff later admitted that she sent letters to inmate Ford while he was at Lansing, but there is no record of any of his mail being intercepted or monitored.
4. When Inmate Ford was transferred back from Lansing to El Dorado, Goff was allowed to transfer to the cell house in which Ford was being housed, despite the allegations of undue familiarity between Goff and Ford. The El Dorado Facility failed to properly flag or monitor either Goff or Ford in a way that would notify facility officials if Goff began working in the same cell house where Ford was housed.
5. In early August 2007, other staff reported concerns to Goff's new supervisor about undue familiarity between Goff and Inmate Ford. The new supervisor spoke with Goff about the allegations, and properly reported the allegations to investigative staff. This second report of undue familiarity finally prompted action by the investigators.
6. Until the report from Goff's new supervisor, investigative staff were unaware that inmate Ford had returned to the El Dorado Facility from Lansing. Investigators should have known Ford was back because his name was on a list of transferred inmates that regularly is sent to investigative staff. Further, a copy of his investigative file was sent from Lansing to El Dorado when he transferred. Given the reported concerns about the potential relationship between Goff and Ford, El Dorado Facility staff should never have approved Goff's transfer to his new cell house.
7. Officer Goff admitted helping Inmate Ford smuggle a cell phone into the facility after he was transferred back from Lansing, and Inmate Ford used the phone to call Goff when she was off duty. Investigators searched his cell because they received intelligence he had a phone, but they never found it.

8. In early October 2007, El Dorado investigators intercepted a greeting card from Goff to Inmate Ford. They questioned Goff, who denied everything. The warden initially proposed termination, but allowed Goff to resign. After her resignation, Goff and Ford continued to talk on the smuggled cell phone. A few weeks later, inmates Ford and Bell instructed Goff on the plan to escape and what to do, including renting a vehicle and obtaining bolt cutters, guns, and clothing.

This series of missteps represents multiple instances of staff and inmate failures to follow policies on undue familiarity, failure to report inmate misconduct to supervisors, supervisor failures to counsel staff and report allegations of staff misconduct to investigators, and failure of investigative staff to take appropriate action. Appropriate action to address any one of those failures potentially could have prevented the escape.

No disciplinary action was taken against any of the staff for any of the above infractions. Goff was allowed to resign when confronted with the allegations of undue familiarity, but no one else was disciplined. That includes her original supervisor who failed to act in any way, and the investigative staff at both Lansing and El Dorado.

However, one staff member was disciplined in relation to the escape. Just before the escape, a correctional officer was distracted by an inmate instead of closely supervising inmates in the yard, including Ford and Bell. That officer received a written reprimand and also was to receive remedial training on supervising segregation inmates.

Another correctional officer failed to follow proper procedure when responding to the alarm immediately after the escape. That officer was to be re-trained on proper emergency response and the duties and responsibilities for that particular post.

The Serious Incident Review Board Again Focused Primarily on The Escape, and Not On The Undue Familiarity That Led Up To It

The primary focus of the Board's review was the escape, and whether appropriate security practices were followed. The file we reviewed didn't contain copies of the investigation report regarding the relationship between Goff and Inmate Ford. However, a Department official told us Board members heard verbal testimony on the relationship and made a recommendation based on the information.

The Board recommended that, when an employee has been investigated for undue familiarity, that employee shall not be placed

in a post or area where that person will have direct supervision over the inmate or inmates implicated in the investigation. As a part of that recommendation, the Board also stated that if an inmate implicated in such an investigation transfers to another State facility, investigative staff at that facility must be fully informed of the facts of the investigation.

In our review of the Board's report, we noted that the Lansing Correctional Facility warden was a member of the Board. His staff failed to act appropriately in what eventually led to an escape of two prisoners. We think Board members shouldn't be associated with a facility that has had some involvement or contact with the parties being reviewed.

El Dorado Correctional Facility and the Department of Corrections Have Made Adjustments To Prevent Similar Situations

The El Dorado Correctional Facility and Department officials have taken several steps and made numerous modifications since October 2007 to address the issues related to the escape, trafficking in contraband, and undue familiarity involved in this case. Those efforts include the following:

- The facility has increased security measures to prevent movement of and find contraband. The facility made physical changes, like installing angle iron in segregation cells to prevent inmates from digging through a cell's corner and passing items between cells. Staff added rubber strips across the bottom of cell doors to prevent inmates from sliding items under the doors. The facility also added X-ray machines and package scanners that can be used to scan items as large as a mattress.
- The Department developed additional restrictions on what staff, contractors, volunteers, and visitors can bring into the facility. The Department now prohibits anyone from bringing cell phones into the facility. The Department is also making greater use of metal detectors to scan employees and visitors. The Department now has limits on the size of lunch boxes and purses, and directions on how food must be packaged.
- The facility improved its undue familiarity training for staff, volunteers, and contract employees. A facility investigator also developed training based on the facts of the Goff case.
- The facility added additional tower officers. Officers are now posted in the one tower when inmates are in the exercise area.

Although these measures appear to be reasonable and appropriate, it's important to understand that the escape likely could have been prevented if Facility staff had followed the procedures that already were in place at the time.

Findings Related to Staff Sexual Misconduct at Topeka Correctional Facility

Details of the case: *Inmate Keith participated in the plumbing/maintenance program at Topeka Correctional Facility. In that Program, inmates would attend classes in the morning to learn a skill, then would respond to service calls with maintenance staff in the afternoons. Ted Gallardo was an instructor/maintenance employee at the Facility.*

In October 2007, Gallardo made arrangements to have sex with Inmate Keith in exchange for tobacco. The sexual encounter took place in an old gymnasium used to store maintenance equipment and items for the plumbing class. Gallardo and two inmates had gone to the old gym on the pretext of getting an old sink. Facility officials were tipped off in November 2007, through an anonymous note left in the maintenance classroom, that inmate Keith was pregnant and Gallardo was the father. Meanwhile, Gallardo had stopped showing up for work.

The case was turned over to the Topeka Police Department for investigation and to the Shawnee County District Attorney's Office for prosecution for sexual relations with an inmate and trafficking contraband into a correctional facility. In June 2008 Gallardo entered into a guilty plea. Sentencing issues are currently on appeal to the Kansas Court of Appeals.

No Formal Reports of Undue Familiarity Had Been Made Against Gallardo, But Other Problems With This Program Had Gone Unchecked for Many Years

Unlike the other two incidents we reviewed, Topeka Facility officials apparently hadn't received any reports of undue familiarity between instructor Gallardo and Inmate Keith. We reviewed the investigation file to evaluate Facility officials' response once they were alerted to Keith's pregnancy. The investigation appeared to be prompt and thorough, including a timely referral of the case to the Topeka Police Department.

However, the information we reviewed also showed that conditions were ripe for staff misconduct to have occurred in this Program without being detected, and no action had been taken to address those conditions.

The warden knew of issues with the Maintenance Program before this incident, but he didn't make the changes necessary to remedy them. During this audit, the warden told us he had had concerns about the Program in the past, including the following:

- Although cameras were in the classrooms, instructors received sporadic supervision and no additional monitoring. When inmates and instructors were moving around the Facility, no one monitored which inmates were going with which staff person, where they were going, or how long they were gone. Additionally, some buildings where supplies were stored and work orders were being done didn't have cameras.

- The Program didn't have a set curriculum. The warden said he was concerned the inmates weren't learning the skills they should have been, and that the Program might not be accomplishing its goals.

The records also show that at least three male staff members associated with the Maintenance Program were investigated in the two years before this incident occurred because of improper behavior with inmates, although that behavior wasn't always sexual misconduct.

- In one case, it was alleged that a male staff member was alone with an inmate in a locked room. To address the issue, the warden established the practice that maintenance staff would no longer be assigned to work with only one inmate. However, this practice was shown to be ineffective when Gallardo and Inmate Keith had sex while another inmate was in the building with them and acted as a lookout.
- In the second case, a male staff member had five prior disciplinary actions, three of which had been for undue familiarity. The incident leading to his dismissal was he allowed inmates to work with equipment they hadn't been trained to use, used profanity towards them and improperly stored his personal medication. He had previously allowed inmates access to his vehicle without supervision, and had contact with a former inmate.
- In a third case, a male staff member gave an inmate some work gloves the inmate wouldn't have had access to and for which there was a formal process for requesting. That staff member had other allegations of undue familiarity with inmates. He eventually was dismissed from service.

Since the Gallardo incident, at least one other maintenance staff member has come under investigation because of allegations of an inappropriate relationship with an inmate. Although the case was unsubstantiated, the warden indicated the case points to the need for more accountability for maintenance staff as to their whereabouts and work order assignments. As of the time of our review, that accountability hadn't been established, and inmates and staff continued to move around the facility without appropriate supervision or accountability.

Department officials told us they are working with Topeka Correctional Facility officials to develop and implement policies that will allow them to better track staff and inmates.

Topeka Correctional Facility Has Taken Some Actions, But More Actions Are Needed

Over the last two years, Facility officials took several steps to address security issues raised by the Gallardo case, but more needs to be done. Among the actions taken:

- Installation of 247 digital surveillance cameras since June 2007 in various locations around the Facility.
- Heavily restricting access to the building where the Gallardo-Keith incident took place. Staff must now follow an intensive procedure to have access. That procedure includes getting advance permission from a physical plant specialist, a shift captain, or a member of the institutional management team. Further, staff must inform the shift captain of who will be going in and the purpose of the visit. Staff aren't allowed to enter alone. At least two staff members must enter the building, and make radio contact with control staff when they leave.
- When staff members transport inmates, they must fill out a log that is kept in each vehicle. They must log the names of the inmate(s) they are transporting, the mileage when they begin, and the mileage when they return. When the staff leave and re-enter the facility, they must make radio contact and report the odometer readings. The radio contact is recorded so that supervisors can check on their staff, but no one routinely monitors that information. (However, a staff member has admitted to a sexual relationship with an inmate in a parking lot within a mile of the facility. As such, the policy on mileage readings only prevents misconduct where the employee has to drive a significant distance to find an isolated spot.)
- When taking an inmate on a planned shopping trip or on an apartment hunt, at least two staff members must accompany her.

Facility officials haven't taken appropriate steps to correct the following issues:

- Inmates still are able to go with maintenance staff around the facility with little supervision, although Department officials told us they are taking steps to address this issue.
- The warden identified one building that is still a possible site for misconduct. The building is not secured and has no cameras. However, it is shared with a third-party contractor whose employees must have ready access, which creates security issues. The warden originally advised us he was waiting to see how well the restrictions on the building where the Gallardo-Keith incident occurred were working, before making a decision on how to handle this building. Recently, the warden advised us he would implement a policy to limit access to this building with the same restrictions mentioned above.

As of late 2007, portions of the Vocational Maintenance Instruction Program were suspended because of budget issues. However, the Facility is considering having an outside contractor take over the Program, which would be required to establish a set curriculum with better monitoring, supervision, and performance measures. Before that happens, the problems identified above would need to be resolved.

No Serious Incident Review Board was convened for this incident because the policy at the time didn't require it. At the time of the Gallardo incident, sexual misconduct didn't trigger a Serious Incident Review Board. Since then, the Department has changed its policy to require a Serious Incident Review Board to be convened for confirmed staff sexual misconduct.

We Found Other Systemic Problems at The Topeka Correctional Facility That May Lead To More Instances of Staff Misconduct

Topeka Correctional Facility has unique issues because it is the only prison in the State that houses female inmates. Officials told us that female offenders tend to be more vulnerable than male offenders, and are therefore at a higher risk of being manipulated or abused by staff or other inmates. As such, we would have expected even more stringent adherence to policy and more strict disciplinary actions at Topeka Correctional Facility than at the other facilities.

That's not what we found. As described more fully in the sections that follow, we noted the following:

- The Topeka Correctional Facility had more instances of undue familiarity and sexual misconduct investigations per 100-employees than the other two facilities. Further, more investigations at the Topeka facility had unsubstantiated findings than the other Facilities.
- The Topeka Correctional Facility was more inconsistent and lenient in response to staff misconduct situations, especially in cases of undue familiarity.

Over the past five years, Lansing, El Dorado, and Topeka Correctional Facilities reported 278 allegations involving sexual misconduct, undue familiarity, or trafficking in contraband that led to investigations (these include investigations on facility staff, contract employees, volunteers and vendors). These are shown in **Figure 1-1**.

Figure 1-1
2005-2009 Total # of Investigations of Staff and Contractors for Allegations of Sexual Misconduct, Undue Familiarity, and Trafficking in Contraband for Topeka, Lansing and El Dorado Correctional Facilities

Facility	Sexual Misconduct	Undue Familiarity	Contraband	Total
Topeka	54	33	11	98
El Dorado	7	42	19	68
Lansing	16	63	33	112
Total	77	138	63	278

Source: Unaudited investigations data from Topeka Correctional Facility, El Dorado Correctional Facility and Lansing Correctional Facility

These investigations revolved around allegations of staff smuggling tobacco or drugs, exposing body parts, exchanging letters, and having romantic relationships.

It's important to understand that correctional records capture only those allegations that lead to an investigation, so the numbers presented in this

report don't reflect all the allegations that may have been made. As will be explained later, all allegations are not tracked.

For a variety of reasons, instances of staff misconduct also may not be reported at all. For example, staff members receiving sex or money have no reason to report, and their co-workers may fear retaliation if they report. Inmates who are receiving sexual gratification or contraband don't have an incentive to report, and can exercise some power over staff members who participate in the activities by threatening to report the misconduct. And other inmates may not have an incentive to report because they fear retaliation by staff or other inmates.

In the sections that follow, in order to compare one facility to another, we focus on Department of Correction's employees investigated for these types of misconduct. We had good data on the number of employees at each facility, but not on the number of contracted workers. Of the 278 investigations, 197 were focused on facility staff. Although contractors and volunteers also commit misconduct, our focus in the following sections is on facility staff.

The investigations data we reviewed showed significant differences between Topeka Correctional Facility and the Lansing and El Dorado Facilities, mostly related to sexual misconduct investigations. Some of those differences can be seen in *Figure I-2* on page 23. The top half of the figure shows the total number of allegations (197) against facility staff related to sexual misconduct, undue familiarity, and contraband that led to investigations between 2005 and 2009. The bottom half puts these same numbers on a per-100-employees basis, which makes them more comparable from facility to facility.

The figure shows several significant differences between the facilities in terms of the number of investigations related to staff misconduct. These are summarized as follows:

- As the top half of the figure shows, Topeka Correctional Facility had far more investigations related to allegations of sexual misconduct than the other two facilities. At Topeka, 43 of the 74 investigations were related to sexual misconduct—that's 58%. El Dorado and Lansing were 9% and 16% respectively. Lansing Correctional Facility had more allegations related to contraband than the others.
- As the bottom half of the figure shows, putting the facilities on an equal basis, Topeka Correctional Facility had far more total investigations per 100-employees than the two other facilities over the past five years. This is mostly because of significantly larger number of investigations

Figure 1-2
2005-2009 Total # of Investigations into Staff for Sexual Misconduct with Inmates,
Undue Familiarity with Inmates, or Trafficking in Contraband

	Sexual Misconduct	Undue Familiarity	Contraband	TOTAL	%
Topeka Correctional Facility					
Substantiated (Verified)	6	13	2	21	28.4%
Unsubstantiated (Not verified)	30	13	2	45	60.8%
Unfounded (False)	3	0	0	3	4.1%
No finding	4	1	0	5	6.8%
TOTAL	43	27	4	74	100%
El Dorado Correctional Facility					
Substantiated (Verified)	1	21	13	35	77.8%
Unsubstantiated (Not verified)	1	3	1	5	11.1%
Unfounded (False)	1	2	1	4	8.9%
No finding	1	0	0	1	2.2%
TOTAL	4	26	15	45	100%
Lansing Correctional Facility					
Substantiated (Verified)	5	34	20	59	75.6%
Unsubstantiated (Not verified)	7	7	4	18	23.1%
Unfounded (False)	0	0	0	0	0.0%
No finding or ongoing	1	0	0	1	1.3%
TOTAL	13	41	24	78	100%
Average # of Investigations Per 100 Staff					
	Sexual Misconduct	Undue Familiarity	Contraband	TOTAL	%
Topeka Correctional Facility					
Substantiated (Verified)	2.2	4.8	0.7	8	28.4%
Unsubstantiated (Not verified)	11.2	4.8	0.7	17	60.8%
Unfounded (False)	1.1	0.0	0.0	1	4.1%
No finding	1.5	0.4	0.0	2	6.8%
TOTAL	16.0	10.1	1.5	28	100%
El Dorado Correctional Facility					
Substantiated (Verified)	0.2	3.7	2.3	6	77.8%
Unsubstantiated (Not verified)	0.2	0.5	0.2	1	11.1%
Unfounded (False)	0.2	0.4	0.2	1	8.9%
No finding	0.2	0.0	0.0	0	2.2%
TOTAL	0.7	4.6	2.6	8	100%
Lansing Correctional Facility					
Substantiated (Verified)	0.6	4.3	2.5	7	75.6%
Unsubstantiated (Not verified)	0.9	0.9	0.5	2	23.1%
Unfounded (False)	0.0	0.0	0.0	0	0.0%
No finding or ongoing	0.1	0.0	0.0	0	1.3%
TOTAL	1.6	5.2	3.0	10	100%
Source: Unaudited investigations data from and interviews with officials from Topeka Correctional Facility, El Dorado Correctional Facility, and Lansing Correctional Facility					

related to sexual misconduct. The differences are significant. At Topeka, investigators conducted 16 sexual misconduct investigations per 100 employees, compared to less than one at El Dorado, and less than two at Lansing per 100 employees.

Department officials indicated that Topeka has a lot of allegations involving inappropriate pat searches, a situation that's exacerbated when male staff conduct pat searches on female inmates. Inappropriate pat searches are categorized as sexual misconduct because they involve inappropriate touching. See the profile box below for more information related to pat searches and the implementation of a new pat search policy.

Male Staff Conducting Pat Searches On Female Inmates Creates a Unique Issue for Topeka Correctional Facility

The Department of Corrections has a pat search video for inmates to review so they know what to expect when a pat search is conducted. The video is also used as a training tool for staff to show them the proper way to conduct a pat search. Yet, pat searches have been a constant source of concern for correctional facilities, in part because by the very nature of the pat search. When done correctly, the pat search can appear to be invasive. At Topeka Correctional Facility, it is an inherent issue because of the population, but facilities still have a duty to address the concern.

Our review of the investigations data and inmate grievances showed that pat searches are a constant source of allegations at Topeka Correctional Facility, and can be difficult for facility officials and investigators to verify. Inmates alleged that staff members touched them inappropriately when doing pat searches. When we asked department officials about the pat searches, they told us many staff members are uncomfortable doing a thorough pat search because they are expected to touch inmates in sensitive areas. In many cases, those staff members don't do thorough pat searches. Thus, when another staff member does do one thoroughly, it seems overly invasive to the inmate.

When we used the data to do our calculations, we categorized allegations of pat searches that actually led to an investigation as sexual misconduct because they were based on inappropriate touching. Because the facility is the only one for female inmates and many of those doing the searches are males, the set-up is ripe for this type of allegation. Because the allegations are difficult to verify, this might account for the higher number of unsubstantiated claims, although it does not explain the difference completely.

Department officials noted that allegations involving inappropriate pat searches are more difficult to prove. Although these allegations have been fairly constant over the years, Facility officials have only recently required them to be conducted in areas with good camera coverage, so that officials could review the tapes when allegations were made.

Because formal disciplinary action is taken only after an allegation is substantiated, it is crucial that wardens keep a close eye on staff members who are suspected of undue familiarity with inmates. Also, supervisors should monitor those staff and take appropriate informal corrective action when needed.

Far fewer investigations at Topeka Correctional Facility were substantiated than at the other two facilities. An investigative finding of “substantiated” means the allegations were proven to be true. A finding of “unfounded” means the allegations were proven to be false. A finding of “unsubstantiated” means the allegations couldn’t be proven as true or false. Information about the results of investigations is also shown in *Figure 1-2*. As both tables show, only about 28% of the allegations that led to investigations at Topeka Correctional Facility were substantiated by the investigators. At the El Dorado and Lansing facilities, more than three-quarters of investigations are substantiated—78% and 76%, respectively.

The same trend is reflected in the Prison Rape Elimination Act data. As mentioned in the Overview, the Department also must report confirmed sexual violations to the Department of Justice, in accordance with the Prison Rape Elimination Act. We reviewed the Department’s database for cases investigated since January 2009 for each facility as required under the Act. We focused on cases involving staff-on-inmate abuses. The results are shown in *Figure 1-3*.

Figure 1-3
January - October 2009 Prison Rape Elimination Act Investigations for Each Facility for Staff on Inmate Sexual Violations

Facility	Substantiated	Unsubstantiated	Unfounded	Total for facilities
Winfield	0	1	1	2
Larned	0	0	0	0
Ellsworth	0	2	0	2
Hutchinson	0	7	5	12
Lansing	0	0	4	4
Norton	0	1	0	1
El Dorado	0	1	2	3
Topeka	1	12	1	14
Total by Disposition	1	24	13	38

Source: Unaudited data from the Department of Corrections

As the figure shows, the Department reported 38 investigations of staff-on-inmate sexual violations between January and October 2009 for all facilities. Of those, 24 were unsubstantiated with 12 of those unsubstantiated cases at Topeka Correctional Facility. Thirteen cases were unfounded and one case was substantiated. The substantiated case was referred for prosecution but the prosecutor declined to file charges. See more on prosecutions in the profile box on the next page.

Facilities Have Referred Cases Involving Staff Sexual Misconduct, Trafficking in Contraband, and Undue Familiarity for Prosecution

The Department provided us with information about the number of cases referred for prosecution over the last three years, for all facilities. The figure below provides a summary of the number of cases referred. Generally facilities appear to refer for prosecution substantiated cases involving staff trafficking in contraband or staff sexual misconduct. While a facility may refer a case for prosecution, there are no assurances the case actually will be prosecuted.

Cases Referred for Prosecution between January 2007 and October 2009	
Type of Cases Referred	# of Cases Referred
Sexual relations	8
Traffic in contraband	27
Other	2
Total	37

Source: Unaudited data from Department of Corrections

Status of Cases Referred for Prosecution between January 2007 and October 2009	
Status	# of Times
Convicted	12
Declined	11
Dismissed	2
Diversions	4
Pending	4
Unknown	4
Total	37

Source: Unaudited data from Department of Corrections

For cases that were substantiated, only 62% resulted in termination or resignation of the employee at Topeka Correctional Facility, compared with 80%-86% at El Dorado and Lansing. Cases that are substantiated often lead to employees being terminated or resigning. The top half of *Figure 1-4* on the following page shows the outcome for all substantiated cases of staff sexual misconduct, undue familiarity, or trafficking contraband. The bottom half shows these same figures on a per-100-employees basis.

As the figure shows, far fewer substantiated cases ended in an employee’s termination or resignation at Topeka Correctional Facility than at the two other facilities.

More employees at Topeka Correctional Facility who were investigated for sexual misconduct, undue familiarity or contraband were investigated more than once. We analyzed the investigative data from 2005-2009 and focused on which staff member was subject to the investigation. The results are shown in *Figure 1-5* on page 28.

**Figure 1-4
2005-2009 Disciplinary Actions Taken Against Staff for Substantiated
Investigations of Sexual Misconduct with Inmates, Undue Familiarity with Inmates, or
Trafficking in Contraband**

	Sexual Misconduct	Undue Familiarity	Contraband	TOTAL	%
Topeka Correctional Facility					
Terminated (a)	5	4	1	10	47.6%
Resigned	1	2	0	3	14.3%
Suspended	0	6	0	6	28.6%
Other (b)	0	1	1	2	9.5%
TOTAL	6	13	2	21	100%
El Dorado Correctional Facility					
Terminated (a)	0	14	9	23	65.7%
Resigned (c)	1	3	1	5	14.3%
Suspended	0	0	3	3	8.6%
Other (b)	0	4	0	4	11.4%
TOTAL	1	21	13	35	100%
Lansing Correctional Facility					
Terminated (a)	5	26	15	46	78.0%
Resigned	0	5	0	5	8.5%
Suspended	0	2	4	6	10.2%
Other (b)	0	1	1	2	3.4%
TOTAL	5	34	20	59	100%

Staff Disciplinary Actions Taken per 100 Employees

	Sexual Misconduct	Undue Familiarity	Contraband	TOTAL	%
Topeka Correctional Facility					
Terminated (a)	1.9	1.5	0.4	3.7	47.6%
Resigned	0.4	0.7	0.0	1.1	14.3%
Suspended	0.0	2.2	0.0	2.2	28.6%
Other (b)	0.0	0.4	0.4	0.7	9.5%
TOTAL	2.2	4.8	0.7	7.8	100%
El Dorado Correctional Facility					
Terminated (a)	0.0	2.5	1.6	4.1	65.7%
Resigned (c)	0.2	0.5	0.2	0.9	14.3%
Suspended	0.0	0.0	0.5	0.5	8.6%
Other (b)	0.0	0.7	0.0	0.7	11.4%
TOTAL	0.2	3.7	2.3	6.2	100%
Lansing Correctional Facility					
Terminated (a)	0.6	3.3	1.9	5.8	78.0%
Resigned	0.0	0.6	0.0	0.6	8.5%
Suspended	0.0	0.3	0.5	0.8	10.2%
Other (b)	0.0	0.1	0.1	0.3	3.4%
TOTAL	0.6	4.3	2.5	7.5	100%

(a) Terminations listed under sexual misconduct and contraband for Topeka Correctional Facility, contraband for El Dorado Correctional Facility, and undue familiarity and contraband at Lansing Correctional Facility include cases referred to the local district attorney.

(b) Other discipline includes staff counseling, letters of reprimand, or cases where no action was taken.

(c) The resignation under sexual misconduct for El Dorado Correctional Facility is Amber Goff, the correctional officer who assisted inmates Bell and Ford to escape after her resignation.

Source: Unaudited investigations data from and interviews with officials from Topeka Correctional Facility, El Dorado Correctional Facility, and Lansing Correctional Facility

Figure 1-5 Number of Investigations for Individual Employees from 2005-2009 for Sexual Misconduct, Undue Familiarity and Trafficking in Contraband						
Facility	Number of Times <u>Same</u> Staff Investigated				Unduplicated Total	% Investigated More Than Once
	1	2	3	4 or more		
Topeka	32	13	3	1	49	34.7%
El Dorado	41	2	0	0	43	4.7%
Lansing	67	4	1	0	72	6.9%

Source: Unaudited investigations data from Topeka Correctional Facility, El Dordado Correctional Facility and Lansing Correctional Facility.

As the figure shows, more than one-third of staff at Topeka Correctional Facility who were investigated for sexual misconduct, undue familiarity or trafficking in contraband were subsequently reinvestigated for one of those same issues, in that time period. This is likely due to the fact that fewer investigations at Topeka are substantiated, as mentioned above. Further, it's also related to the fact that even for the cases that are substantiated, fewer at the Topeka Facility end in employee termination or resignation than the other two facilities.

The Topeka Correctional Facility was more inconsistent and lenient in response to incidents of staff misconduct—especially in regard to cases of undue familiarity—than the two other facilities. During our review, we came across the following examples at the Topeka Facility:

- An employee received a letter of reprimand for hugging an inmate.
- An employee was counseled after being found by his supervisor in an office with an inmate with the door closed and the lights out.
- The warden recommended dismissal of the employee for giving a bike to a former inmate. The Civil Service Board amended this dismissal to a suspension, citing inconsistent disciplinary measures and specifically citing cases where employees' actions appeared to be much more egregious, yet those employees received less stringent disciplinary action.

Moreover, the warden reduced punishment for several employees he determined were “salvageable” or had shown sufficient remorse. Our limited review found the following examples:

- One staff member admitted to distributing confidential information about male inmates to the female inmates under that staff person's supervision. The warden originally proposed dismissal, but reduced the discipline to a 30-day suspension after the employee accepted responsibility and demonstrated remorse. The warden said reducing the discipline was appropriate because it served to correct the behavior and salvage the officer.

- Another staff person was given a 10-day suspension for that employee's third violation of undue familiarity. The third violation was based on the employee caressing an inmate's ear, hanging a sex toy discovered during a cell search from the ceiling, and making statements on audio tape that he would "nail" troublemakers in the unit. Prior offenses included releasing confidential personnel information to inmates (not the same staff person mentioned above), and being unduly friendly with them.
- One staff had allegations of an inappropriate relationship, and based on staff's history the warden recommended termination. But upon the staff showing remorse the discipline was amended to demotion and 30 day suspension.

We also reviewed the disciplinary actions taken in substantiated cases of staff misconduct for Lansing and El Dorado and didn't note any examples of lenient or inconsistent disciplinary actions at those two facilities.

As noted earlier, wardens, facility investigators, and Department officials told us the more significant incidents of staff misconduct—such as staff-inmate relationships, sexual misconduct, and staff trafficking in contraband—have their roots in undue familiarity. As such, it's critical that instances of undue familiarity be dealt with appropriately to try to prevent major violations in the future.

If employees see that staff members who are engaged in misconduct aren't appropriately disciplined, that can reduce the incentive to report employee misconduct. Further, staff members may be more likely to engage in misconduct when they don't see evidence of serious consequences.

The Topeka facility also has failed to provide targeted training based on the population they serve. Female staff at Lansing and El Dorado Correctional Facilities receive training tailored to working with male inmates. However, male staff at Topeka Correctional Facility don't receive tailored training for working with female inmates.

As noted earlier, officials told us that working with female inmates is different and creates unique issues, such as pat searches, privacy concerns, and the more social nature of female inmates.

Other Findings Related to Staff Misconduct

In the course of our review of the three cases, we noted that the Department's written policies covered most areas of best practices. However, we noted some policy weaknesses and several other areas of concern that aren't limited to Lansing, El Dorado, or Topeka Correctional Facilities. These are described in the sections that follow.

***The Department's
Overall Policies and
Procedures Generally
Met Best Practices***

We compared the Department's written policies and procedures related to dealing with instances of potential undue familiarity, sexual misconduct or staff trafficking in contraband. These policies cover reporting, investigation, and discipline. The Department's policies in all three areas generally met best practices. For example, the policies:

- Have an adequate and appropriate definition of sexual misconduct.
- Require mandatory reporting of sexual misconduct.
- State all allegations of sexual misconduct and undue familiarity must be investigated.
- Prohibit retaliation against employees or inmates who report sexual misconduct.
- Require confirmed cases of sexual misconduct and trafficking in contraband to be referred for prosecution.

There are a few areas where the Department's policies and procedures fall short. For example:

- There are no specific training requirements for investigative staff. The policy needs to specify the training and the curriculum for investigators.
- All reports of misconduct don't end up at the central office. Often only completed cases end up getting reported. The only way central office officials can ever have a handle on the prevalence of staff misconduct is if they are able to track not just investigative files but also allegations and intelligence information investigators are collecting related to possible staff involvement in such activities.
- Some terminology in the policies is vague and does not appear to be appropriate such as "No employee shall engage in any unauthorized game, horseplay, contest or sport with any incarcerated offender while on duty with the Department." One could interpret the wording as allowing "authorized" horseplay, and allowing horseplay when the employee was off duty. Department officials have indicated they are in the process of cleaning up this language.

Although we found the Department and facility policies generally were appropriate, as noted in our case reviews above, these aren't always followed or enforced by facility officials.

Kansas' Penalties for Staff Sexual Misconduct Aren't as Severe as Other States'

K.S.A. 21-3520 makes sexual misconduct by an employee a level 10 person felony, with a presumptive sentence of probation. According to a 2009 survey by the National Institute of Corrections all but six other states have stronger penalties for staff sexual misconduct than Kansas. The states with the stiffest penalties are Idaho and Alaska, which have maximum penalties of up to life in prison. Even the states where sexual misconduct is a misdemeanor have penalties of up to a year in prison. In addition, 32 states have mandatory registration as a sex offender.

Also under K.S.A. 21-3826 trafficking in contraband is a level 5 non-person felony which is a higher-level felony than sexual misconduct. In other words, the statutory punishment is lighter for an employee being caught having sex with an inmate than bringing tobacco into a facility.

Department officials are supportive of increasing penalties for both contraband and sexual misconduct. Officials told us they would like to see the following happen:

- The sexual misconduct law be strengthened to a level 5 felony or higher and include a tougher presumptive punishment.
- The sexual misconduct law include a requirement for registering as a sex offender.
- The trafficking in contraband law have a tougher penalty for cases trafficking in contraband that increase the risk of violence, such as guns or ammunition.

In 2009 the Department Centralized the Investigation Process, But Improvements Are Still Needed

Until 2009, each facility's investigative staff reported to the warden. Early in 2009, the Secretary of Corrections reorganized the investigative staff so they now report directly to the central office, instead of to each individual warden.

The Secretary told us that centralizing the investigative function was recommended by the National Institute of Corrections to give the investigators greater independence from facility management. The Secretary said he also wanted to develop greater consistency and uniformity in investigations, and to improve the communication between the facilities and the central office. This should also provide the Department with information on how investigative resources are utilized at each facility and what resources may be needed at each facility.

The Department has a policy that says investigators will receive specialized training, doesn't specify what that training will be. In the past, investigators received the same training that all correctional officers were provided, but no special investigative training. Last year, the Department provided a week of specialized training that most investigators attended. However, the Department has no approved plans for continuing that training. Officials told us they are working on some curriculum plans but haven't submitted them to the Secretary for approval yet.

Some facility officials said they don't feel like they get as much information from the investigators as they used to. Central office officials said they hadn't intended this, and the only thing that should have changed is the investigators now receive their direction from central office. Although, it's essential the investigation process be independent, it's also important for wardens to be kept apprised of what's happening in his or her institution. Corrections officials will need to review the existing situation to see if improvements are needed.

The Department Lacks Sufficient Management Information Regarding Staff Misconduct

In the course of this audit, we found problems with the data regarding allegations of staff misconduct, investigations thereof, and any resulting discipline. The Department had trouble providing us with data that was complete, accurate, and consistent. We noted the following problems:

The Department lacks sufficient management information to ensure that officials are aware of the level of staff misconduct.

Investigators at each facility make weekly reports to the Department's central office, but those reports don't adequately identify staff misconduct. For example, reports only give brief descriptions of new investigations and give updates on some, but not all, open cases. Moreover, in gathering Department-wide statistics on staff misconduct for us, officials had to turn to each facility to provide the information, which wasn't always in a uniform format.

Improvements are needed to ensure that the officials are aware of the level of potential staff misconduct. Investigators have a lot of freedom to determine what gets investigated. As mentioned earlier, allegations of sexual misconduct are to be investigated. But, if an investigator receives allegations of other types of staff misconduct, he or she isn't required to investigate. Although there may be valid reasons to not investigate (e.g. if the allegation is anonymous and specific information isn't given, such as a time or place of the

alleged incident), it's critical for all allegations to be recorded. This way management, or an independent third party, can review all allegations made, which ones were or weren't investigated, and why. Recording all allegations would also help identify staff who frequently are complained about.

The Department needs better consistency and accuracy in the information facilities report. Our review of the Department's data found a number of problems, including:

- Investigators don't always use a newly implemented computer program designed to track investigations. Moreover, that program doesn't track allegations that aren't investigated, and some facilities don't enter data about cases until they are complete or nearly complete.
- The Department's rape allegation database and survey data the Department reports to the Department of Justice are inconsistent. The Department of Corrections maintains a database for each facility to report inmate rape allegations as required by Prison Rape Elimination Act. The Act also requires each state to report annually, through a survey, the number of allegations and disposition of each allegation of inmate rape. We reviewed the data for all eight facilities and noted, the Department's database reported 21 cases, compared to 29 cases reported through the survey.
- The Department's disciplinary database isn't always accurate. For example, based on a limited review of the Topeka Correctional Facility's discipline cases, we found that information in the disciplinary database on two of the four cases we reviewed was incorrect.
- Facility data didn't include all investigations involving undue familiarity or contraband.

Disciplinary actions are recorded, but facility officials don't always use the information. As mentioned above, all eight facilities provide monthly reports to the central office with information on staff discipline for that month. Of the three facilities that we spoke with, only the warden at Lansing said he refers to the discipline database each time he gets ready to discipline an employee. He said he uses it as a part of his standard method of determining appropriate and consistent discipline, by comparing to other similar cases. Other facilities don't appear to use the database for this purpose.

The lack of good information prevents us from knowing the true extent of staff misconduct. Throughout the report we have analyzed and outlined the various resources we reviewed. Although we found inconsistencies in the investigative files, the disciplinary data, and grievances, it is clear staff sexual misconduct, undue familiarity and trafficking in contraband are going on inside the correctional facilities. We just can't know for sure how prevalent it is.

The Department has developed a video to provide information to inmates about the Prison Rape Elimination Act of 2003, but it falls short. The video provides good information to inmates about their rights to be left alone and not subject to sexual harassment or abuse. The Secretary of Corrections addresses the inmate directly in the video and specifically addresses inmate-on-inmate abuses and encourages the inmate to report any abuse. However, the Secretary focuses on abuse by other inmates and never addresses staff-on-inmate abuses. Further, the video only addresses staff-on-inmate misconduct at the end by showing the statutory language contained in K.S.A. 21-3520. As shown in this report, staff sexual misconduct is also a problem at Kansas facilities, and as such should be addressed.

Department officials have responded that some of the issues raised in this audit could be addressed, and some of the risks potentially minimized, if the Department had the budget to operate the facilities at proper staffing levels. Our 1999 performance audit of correctional staffing levels showed that the Department often was operating facilities below operational staffing levels. Department officials indicated those staffing levels continue to be inadequate. Officials stated that more staff would be more eyes and ears and would provide greater deterrence.

Conclusion:

Department and facility officials have stressed that undue familiarity leads to more significant problems, and potentially can lead to putting the safety of other employees and inmates at risk. Identifying when behavior crosses into misconduct sometimes is a fine line, especially when actions on the surface appear to be harmless, such as having a personal conversation with an inmate, or bringing cigarettes into the facility. However, the experience of correctional officials, and the review of cases in Kansas, prove that seemingly innocent gestures can put both correctional employees and inmates at risk.

It's crucial that the Department know the extent of what's going on in its facilities. From our review of the data, there's no doubt that some staff are misbehaving, and the concerns of staff taking advantage of inmates is a valid concern. However, because the Department doesn't have complete data, the true extent of staff sexual misconduct and staff trafficking in contraband can't be known. Although this behavior likely will never be completely eliminated in this environment, the Department could take more aggressive and consistent steps to track and curb it.

**Recommendations for
Legislative Consideration:**

1. To bring Kansas' statutory penalties in-line with other states for correctional staff convicted of sexual misconduct, and to more appropriately address the issues of staff trafficking in contraband, the Legislature should do the following:
 - a. amend K.S.A. 21-3520 to require individuals convicted under this statute to register as a sex offender.
 - b. amend K.S.A. 21-3520 to toughen the penalty for sexual misconduct, so it includes jail time rather than just presumptive probation.
 - c. amend K.S.A. 21-3520 to bring the penalty for sexual misconduct more in-line with the penalty for staff trafficking in contraband.
 - d. amend K.S.A. 21-3826 to provide proper consideration and allow a tougher sentence when staff trafficking in contraband could put lives in direct jeopardy, such as staff trafficking in guns, ammunition, or other weapons.

The House and Senate Judiciary Committees, or another appropriate legislative committee should introduce legislation that would accomplish these steps.

**Recommendations for
Executive Action:**

2. To help ensure that department policies and procedures are in-line with best practices and provide appropriate guidance to staff, the Department of Corrections should do the following:
 - a. review and amend any policies that are ambiguous or outdated, or that don't adequately address volunteers or contractors.
 - b. implement policies that adequately and completely outline training standards for investigative staff.
3. To help ensure that Department officials have good management information about staff involved in undue familiarity—including sexual misconduct and trafficking in contraband—the Department should do the following:
 - a. require investigative staff at all facilities to fully use the investigative computer system to allow better tracking of all investigative files, from the time the investigation starts to completion.
 - b. establish a consistent training curriculum for all investigative staff.
 - c. require investigative staff to track all allegations of undue familiarity, sexual misconduct and trafficking in contraband, not just those that are investigated. If these allegations aren't investigated, that tracking system should capture the reason(s) why.

- d. establish a system where management separately reviews unsubstantiated allegations that repeatedly involve the same correctional staff member(s), to ensure that management evaluate any patterns of conduct or take appropriate actions to reduce continued areas of concern.
 - e. Require weekly reports submitted to the warden and central office show the status of all cases, including age, and any new developments.
4. To help ensure that staff are consistently and appropriately disciplined, the Department should require all facilities to track in an appropriate computer format all disciplinary actions taken by the facility. Department officials should periodically review this information to ensure consistency from case to case and facility to facility.
5. To help ensure that inmates receive proper notice about their rights to be free from sexual violence while in prison, and to conform to the Prison Rape Elimination Act of 2003, the Department should update the information DVD for inmates to include additional information about staff-on-inmate violations.
6. To help ensure that Prison Rape Elimination Act information is properly and consistently reported, the Department should put out additional guidance to the facilities on what incidents to report and the proper format for doing so.
7. To help ensure that all facility failures are detected and that unbiased recommendations are made, all Serious Incident Review Boards should:
 - a. be provided with a complete investigative file and not be limited to the investigative records the facility determines to be relevant.
 - b. be made up of members who don't have any connection to the issues or individuals under review.
8. To further protect the female inmates at Topeka Correctional Facility and require additional accountability of facility maintenance staff, the Department should do the following:
 - a. implement a process for tracking inmates as they perform work order duties with maintenance staff. This tracking should include, but not necessarily be limited to, staff name, type of work, location of work, and time in and time out.
 - b. secure any buildings that are used by maintenance or other staff when accompanied by inmates.

c. increase the training and supervision of maintenance staff who work in the vocational programs with inmates.

9. To further protect the female inmate population, the Department of Corrections should do the following:

a. identify and provide specialized training for male staff working with female prisoners.

b. conduct a review of investigative and disciplinary cases at Topeka Correctional Facility to determine why fewer cases are substantiated, and why more staff are repeatedly investigated for misconduct issues.

APPENDIX A

Scope Statement

This appendix contains the scope statement approved by the Legislative Post Audit Committee on October 12, 2009. The audit was requested by the Legislative Post Audit Committee.

Revised
SCOPE STATEMENT

Department of Corrections: Determining Whether the Department Has Adequate Policies and Procedures in Place to Deal with Misconduct by Staff at Correctional Facilities

The Department of Corrections is a cabinet-level agency managed by the Secretary of Corrections. The Department is responsible for inmate programs and operates eight correctional facilities across the State.

Recently, a Topeka newspaper did an extensive story about corrections officers exchanging cash and contraband – such as tobacco, pharmaceuticals, and illegal drugs – for sexual favors at the Topeka Correctional Facility. That facility houses more than 500 female inmates committed to the custody of the Secretary of Corrections. The story centered around a female inmate who became pregnant after a sexual encounter with a former vocational plumbing instructor who had agreed to deposit money into that inmate’s prison bank account in return for sex. That employee originally was charged with rape, but the rape charge later was dropped. In 2008, the employee entered guilty pleas to unlawful sexual conduct and trafficking. He was sentenced to 18 months for taking banned items to prisoners and 6 months for having sex with an inmate. Both sentences were converted to probation for two years by a Shawnee County District Court judge.

The same article quoted one former inmate as saying, “I managed to get pretty much anything into that facility that you could think of through guards or drop-offs along the fence.” The article also said that, according to inmates and employees of the Topeka Correctional Facility, as many as one-third of the facility’s employees have been involved in contraband activities with prisoners. Department officials think that number is closer to 2%.

The Governor has announced he would order a policy and legal review in response to documented cases of sexual misconduct among State employees and female inmates at the Topeka Correctional Facility. He indicated he would ask the Secretary of Corrections to analyze Department policy to make sure “that we are doing everything that we can to reduce the incidence of exploitation in the future.”

Additional instances of employee misconduct have occurred in recent years at other Kansas correctional institutions. In October 2007, a former female prison guard at the El Dorado Correctional Facility assisted in the escape of two inmates, one of whom she was reported to be romantically involved with. In 2006, a woman who ran a dog rehabilitation program working with inmates at the Lansing Correctional Facility also used her access to help an inmate she was romantically involved with to escape.

These incidents have raised questions in legislators’ minds about whether the State is doing enough to prevent such misconduct by employees. In particular, they want to know whether Kansas has adequate policies, procedures, and legal sanctions to prevent trafficking in contraband and sexual misconduct at correctional institutions and whether existing policies and procedures were being followed at the Topeka Correctional Facility.

A performance audit of this topic would answer the following question:

1. **Does Kansas have adequate policies, procedures, and sanctions in place to prevent correctional employees from trafficking in contraband and having sexual misconduct with inmates?** To answer this question, we would compare Kansas' policies and procedures for controlling contraband and preventing inappropriate relationships with inmates with those of other states and with any adopted by the American Correctional Association or other national organizations. We would make the same types of comparisons for penalties and legal sanctions Kansas has in place for handling violations of policies or procedures or convictions of crimes in these areas. We would review readily available information maintained by the Department of Corrections regarding the number and nature of incidents involving contraband and inappropriate sexual relationships with inmates at all correctional facilities in Kansas. In addition, we would review relevant records and interview staff and inmates as needed to assess whether incidents leading up to the three situations mentioned in this scope statement were handled in accordance with existing policies and procedures, and if not, why not. We would look at what corrective actions the Department of Corrections took regarding any of those incidents, and whether those actions appeared to be sufficient. We would perform other test work as needed.

Estimated time to complete: 8-10 weeks

APPENDIX B

Agency Response

On January 12, 2010 we provided copies of the draft audit report to the Secretary of Corrections and received the Department's written response on January 21, 2010. That response is included in this appendix.

In its response, the Department disagreed with our interpretation of a few events but pointed out no factual inaccuracies. After a careful review of the Department's response we continue to think our analysis is correct. As a result, we've made no changes to the final report.

January 21, 2010

Barbara Hinton
Legislative Division of Post Audit
800 SW Jackson Street, Suite 1200
Topeka, Kansas 66612-2212



Dear Ms. Hinton:

I appreciate the opportunity to comment regarding the review of the Department's policies and procedures related to contraband and sexual misconduct at correctional facilities as well as the events surrounding three specific incidents that occurred separately at El Dorado, Lansing, and Topeka.

I particularly want to acknowledge the Post Audit staff for their professionalism in conducting this audit. This has resulted in a report that is constructive in nature and can be utilized to assist us in improving department and facility operations.

As summarized in the report, the Department of Corrections has strong policies regarding undue familiarity, sexual misconduct, and trafficking in contraband. Those policies are conveyed to employees at the time of hiring when they sign acknowledgements that they have read and understand the policies, and they also sign a code of ethics. The policies are also stressed during orientation and annual training. They are aggressively enforced by investigating allegations of abuse, imposing disciplinary action in cases where there is sufficient evidence, and through referral for prosecution when the evidence indicates that a crime has been committed.

We strive to operate safe and secure correctional facilities that serve to protect the public, the employees who work in the facilities, and the inmates who are incarcerated in them. We know that employee misconduct serves to undermine not only the security of a correctional facility but also the ability to change offender behavior. The credibility and effectiveness of corrections personnel is adversely impacted through such misconduct, and we are committed to eliminating such abuses to the maximum extent possible. Any recommendations and actions that strengthen our ability to do so are welcome.

LANSING INCIDENT

As summarized in the audit report, inmate John Manard escaped from the Lansing Correctional Facility in February, 2006. This escape was accomplished with the assistance of a volunteer working with a dog adoption program.

DEPARTMENT OF CORRECTIONS

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The audit report identifies two issues that may have contributed to the escape. First, the report discusses the failure of a program coordinator to report concerns of undue familiarity between the volunteer and the inmate. What the program coordinator received was a report of concerns that the volunteer, Toby Young, was overly friendly and favored inmate Manard and four other inmates over other inmates in the dog program. In response to the report the program coordinator counseled Toby Young regarding possible perceptions regarding her actions and how to properly spread the responsibilities of the program.

While with the benefit of hindsight one might conclude the concerns of undue familiarity should have been referred for a formal investigation, the report received by the program coordinator at the time did not contain specific allegations or incidents of misconduct on the part of Toby Young. The program coordinator exercised discretion based on information then known regarding how to address the matter. This exercise of discretion appears to have been reasonable at the time, thus explaining why no disciplinary action against the program coordinator was imposed. However, based on the events that subsequently occurred, other remedial actions were taken:

- >the authority over the dog adoption program was removed from the program coordinator's position. All decisions regarding the program are now the responsibility of the program coordinator's supervisor or a deputy warden;

- >The program coordinator was counseled that any time he receives reports of undue familiarity it is his responsibility to address the issue with the employee if he believes it to be a perception rather than an allegation, as well as to report the issue to his supervisor or to an investigator.

Second, the audit report discusses a concern that the program coordinator did not report that the dog adoption program van was not searched on a regular basis. The explanation offered was that he was not familiar with the search procedures so he was unaware of the deficiencies. Search procedures are primarily the responsibility of security personnel, not program staff. The investigation of the escape revealed that a corrections officer did not properly search the van on the date of the escape, thus allowing the escape to be completed. As a result of this failure the corrections officer was terminated. In addition, other security measures were taken:

- >vehicles related to the dog adoption program are no longer authorized to enter the facility;
- >all dogs being taken out of the facility are walked out and are not transported in a vehicle;
- >inmates are not allowed to leave the facility to assist with dog adoptions;
- >a new policy was issued that the tower officer is not to open the gate to allow a vehicle to depart the facility unless the officer has personally witnessed that the vehicle was both searched and checked with the heartbeat detector.

The audit report also discusses that information regarding concerns that Toby Young was favoring certain inmates, including John Manard, was not presented to the Serious Incident Review Board. This appears to have been the result of timing rather than the information being purposefully withheld. The escape occurred February 12, 2006. Due to a desire to establish the facts of the escape and to implement necessary remedial actions quickly, the Review Board was convened on February 27, 2006. This was the same date that the investigative report concerning the undue familiarity concerns was prepared. The information for review by the Serious Incident Review Board had already been prepared. Had the Review Board been convened after all investigative reports were prepared, the information regarding the undue familiarity concerns likely would have been included.

EL DORADO INCIDENT

As summarized in the audit report, two inmates escaped from the El Dorado Correctional Facility in October, 2008. A former corrections officer, Amber Goff, assisted the inmates in successfully completing the escape. Goff had been allowed to resign from employment on October 10, 2008 following allegations of undue familiarity with one of the two inmates involved in the escape.

The report states that the incident involved a series of failures where staff failed to act "when they had clear notice of undue familiarity" between Goff and an inmate. This statement appears to indicate that undue familiarity had been substantiated but not acted on. That is not the case. Undue familiarity was not substantiated until October, 2008, when the termination of Goff was proposed. While it is clear that Goff was on the radar of investigators and others regarding possible undue familiarity, everything prior to that date concerned unsubstantiated information or perceptions.

While we may not agree with how each of the events leading up to the escape is described in the audit report, it is clear that a number of factors contributed over time to this escape becoming a reality. Some of these factors occurred in the months prior to the escape and others occurred on the day of the escape. Our responsibility is to learn from the incident and to take necessary and appropriate measures to minimize the opportunity for such an incident to occur in the future. We have tried to do that. A number of measures taken in response to the escape are set forth in the audit report. That list is certainly not complete as there were many other measures taken in the areas of technology enhancements, physical plant modifications, staff training and supervision, and inmate management.

This incident is a case study of the problems that can result from staff becoming personally and emotionally involved with an inmate. The information learned regarding this escape was shared with all KDOC facilities and has been

incorporated into staff training. While we believe our training in this area has been enhanced as a result of the information learned from this incident, it is worth noting that Amber Goff, in an interview subsequent to her criminal prosecution, stated "I think everything that you guys talked about in training, the things they do and the things they say, it's true. And there's no trusting them. I mean, now that I look back, I mean, I am like, wow, I am so stupid." The training can be delivered, but regrettably not always followed.

TOPEKA CORRECTIONAL FACILITY

As summarized in the audit report, an employee of Topeka Correctional Facility engaged in sexual intercourse with an inmate, resulting in the inmate becoming pregnant. When facility personnel learned of the incident, the matter was immediately referred to the Topeka Police Department for investigation. The Shawnee County District Attorney then filed criminal charges against the individual, eventually resulting in a guilty plea as part of a plea agreement.

The action taken in this incident was consistent with the department's policy regarding sexual misconduct by employees. The department has a "zero tolerance" for this type of behavior. When an incident of sexual misconduct is substantiated, the individual will be terminated from employment and referred for criminal prosecution.

The department also has a "zero tolerance" for incidents of undue familiarity. That means that each incident that is substantiated will result in a consequence or sanction. Depending upon the nature of the incident and the employee's work history and prior disciplinary record, that sanction may range from informal discipline (counseling or reprimand) to formal discipline (suspension, demotion, or termination).

Because of the security implications resulting from instances of undue familiarity, and the criminal nature of sexual misconduct, the department takes these matters very seriously. Policies applicable to these areas are in place. Employees, volunteers, and contract employees are provided notice of these policies and receive training concerning them as well as regarding how to avoid becoming involved in this type of activity. Allegations of violations are investigated and when the violations are substantiated, disciplinary action is imposed.

We have not seen any credible evidence to suggest that undue familiarity or sexual misconduct is condoned or tolerated at any Kansas correctional facility. It was noted in a recent evaluation conducted through the National Institute of Corrections stated: "Looking at formal investigation files there is not evidence to suggest that either investigators or the administration have ignored allegations brought forward to them." We have also not seen any credible evidence to

DEPARTMENT OF CORRECTIONS

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suggest that undue familiarity or sexual misconduct is widespread among staff, volunteers, or contract employees. The data set forth in this audit report also does not support such a conclusion. What I think the available information points to is that a few individuals have chosen to betray their public trust by engaging in this inappropriate conduct, and that when their actions have been substantiated it has been appropriately dealt with.

Maintenance program

The facility is working towards development of a better accountability system for tracking the movement of inmates around the facility. While it is possible to log departure and arrival times, destinations, purpose of the movement, and staff and inmates involved, to track movement and location at all times would likely involve acquisition of technology with this capability. This is a resource issue and would require funding. It should also be noted that the movement of inmates at TCF is similar to the movement procedures for inmates at other facilities. Will this become an expectation of all inmate work crews regardless of gender? If so, the resource needs will be greater.

Disciplinary actions

Each case of discipline must be judged on its own merits. While often similar, seldom is a case just like a previous case. The sanction imposed must be reasonable. Except in cases involving tobacco or cell phone possession where the department has established standardized sanctions, in determining what is a reasonable action, the warden must consider the nature and circumstances surrounding the incident, the employee's overall work performance, his/her recognition of the violation and willingness to correct the behavior, and an assessment of the extent to which the employee's credibility or trust has been damaged. The case must also be evaluated with respect to what evidence is available to prove the violation and whether the sanction will be upheld on appeal to the Civil Service Board.

Because of the factual differences in each case, we think a general comparison of disciplinary actions is of questionable value. We also question the conclusion that disciplinary sanctions at TCF are inconsistent and lenient. With respect to the case cited on pages 28-29 of the audit report:

>Reprimand for hugging an inmate: this incident occurred at a graduation ceremony at TCF where an employee hugged an inmate who had graduated. This took place in a room with numerous other people present. The circumstances indicated that while it was inappropriate to hug the inmate, it was nothing more than an innocent and spontaneous gesture. A reprimand appears to have been quite reasonable under the circumstances.

>Employee was counseled for being observed by a peer exiting a room with an inmate: there was no evidence of any inappropriate conduct and both the inmate and the employee denied any. Absent evidence to substantiate a violation, counseling of the employee to avoid the perception of wrongdoing appears reasonable. It is questionable whether any stronger action could have been taken and sustained given the absence of any evidence to support a violation of policy or law. Personnel actions must be based on evidence, not perception.

>Employee terminated for giving a bicycle to a former inmate: On appeal the Civil Service Board amended the dismissal to a ten day suspension. The Board noted there were other cases where employees received less stringent disciplinary actions despite their case being more egregious. However, the Board did not note any specific cases so it is not possible to evaluate this finding by the Board.

>Employee distributed confidential information to inmates: a termination was imposed but was later amended by the warden to a 30 day suspension. A 30 day suspension is not a lenient sanction. The loss of six weeks of pay has a significant impact on an employee. This is an example of trying to determine a reasonable sanction for the specific circumstances of the event and of the employee.

>Employee given a 10 day suspension for third violation of undue familiarity (not sexual misconduct): The Civil Service Board has a policy of progressive discipline. As stated earlier, each instance of substantiated undue familiarity will be sanctioned. Depending upon the nature of the incident the sanction can vary from counseling to termination. In this case each instance was sanctioned. The sanction for the third violation was progressive in length.

>Staff discipline amended from termination to demotion and 30 day suspension: The specifics of the prior history are not set forth in the report but this is a case where it is necessary to evaluate the employee's entire work and disciplinary record as well as the nature of the violation and try to determine what sanction is reasonable. A demotion and 30 day suspension are severe sanctions, certainly not ones that could be construed as lenient.

It is possible to second guess any disciplinary decision, especially if the employee is subsequently disciplined or terminated. The actions, however, must be evaluated based on the facts known at the time. I do not believe any of the examples cited clearly show that the action taken by the warden was less than reasonable. Rather, I believe that the information suggests that there was an attempt to determine a fair and reasonable sanction based on the various factors referenced earlier. If the committee wishes to discuss individual cases and suggest alternative responses, we would be happy to work out a system to protect the identity of persons still covered by confidentiality, and review these on a case by case basis.

I concur with the statements made in the audit report that instances of undue familiarity must be appropriately dealt with to try to prevent major violations in the future and that staff members may be more likely to engage in misconduct when they don't see evidence of serious consequences. However, I do not believe the record supports the conclusion that appropriate actions have not been taken at TCF or appropriate sanctions imposed. The audit report produced by the National Institute of Corrections consultants suggests there was a breakdown in communication and feedback resulting in employees and inmates not knowing the results of investigations of complaints and actions taken in response to those results. While statutes, regulations, and security procedures governing employee discipline make it difficult to disclose all or even the majority of information, we believe that steps can be taken to create a more complete feedback loop that will improve confidence of both employees and inmates in the investigative and disciplinary processes.

Investigations

The audit report found that Topeka Correctional Facility had more investigations for undue familiarity with more unsubstantiated findings than at other facilities. While this may be noteworthy, we would suggest it is not conclusive regarding the scope of any problem at TCF. There are so many variables involved as to why an investigation resulted in an unsubstantiated finding, including the potential for false claims, whether evidence was available to support an allegation, and whether the claim was made in proximity to the alleged incident, that we believe it is more important and valuable to focus on the number of substantiated cases. We cannot control how many complaints are made and whether baseless allegations are lodged. We recently intercepted documentation that inmates filed a series of complaints orchestrated in an attempt to have an officer moved from a certain post.

What would be a significant concern is if there were a large number of complaints filed and a large number that were substantiated. As reflected in Figure 1-2, that is not the case at Topeka Correctional Facility. Both the NIC and Post Audit reports make reference to newly acquired software that will greatly improve documentation and our analytical capabilities regarding patterns of complaints or incidents of misconduct. This should greatly improve our capacity in this area once the system becomes operational and investigative staff are trained in its use.

Pat Searches

The Department of Corrections will be undertaking a review of the policy and training regarding cross gender pat searches. Staffing assignments and the gender breakdown of staff make it difficult to implement a policy restricting cross

gender pat searches to emergency situations only. We will be reviewing the policy of the Bureau of Prisons and other states to try to identify the most appropriate manner for such searches to be carried out. The NIC consultants recommended moving to such a policy, and if resources and suitable employees were available in abundance, we would be very amenable to such an approach. However, there are other considerations that must be made. How is such a policy balanced with our ability to recruit adequate numbers of employees of the correct gender to be able to carry it out? Most wardens of male facilities are concerned that their ability to recruit and retain good staff would be even more difficult than it already is, if they cannot hire women to work in the facilities at least the current levels. Such policies may also create conflicts with existing labor laws and union contracts. In the coming months we will look carefully at responses made by other corrections agencies to this challenge and provide a recommendation as requested by the Governor.

Targeted training

The Department of Corrections will be working with staff at Topeka Correctional Facility to develop gender specific training for male staff who work with female inmates. It is likely that we will utilize resources from the National Institute for Corrections in developing this training.

Department Policies

As noted in the audit report, department policies regarding reporting, investigating, and discipline with respect to undue familiarity, sexual misconduct, and trafficking in contraband comply with best practices. One area where a problem was noted concerned, a prohibition regarding "horseplay". has been clarified through an amendment to Internal Management Policy and Procedure 02-118. As referenced earlier, there are plans being developed to provide specific training requirements for investigators and to develop better reporting requirements, data collection, and case tracking information for investigators.

Penalty for Staff Sexual Misconduct/Contraband

KSA 21-3520, which makes sexual misconduct by employees a severity level 10 felony, became effective in 1993. This statute was proposed by the Department of Corrections because prior to that time consensual sexual activity by an employee with an inmate was not a violation of law. It took two legislative sessions to get the law enacted. We are supportive of increasing the severity level of this crime as part of the effort to end this activity in Kansas correctional facilities.

We are also supportive of an increase in the severity level for the crime of trafficking in contraband. The severity level for this crime was last increased in 1997 at the request of the Department of Corrections, from a severity level 8 to

either a level 5 (for corrections employees) or level 6, depending on the circumstances. For contraband that impacts the security of a facility, we believe a more severe sanction should be considered.

Centralized Investigation Process

In February, 2009, the Department of Corrections centralized its investigation staff. Previously facility investigators were assigned to each facility, reported to the facility warden, and worked independently of investigators at other facilities. In order to achieve better communication, better coordination, and greater consistency the decision was made to establish a centralized Division of Enforcement, Apprehension, and Investigation with a director who reports to the Secretary of Corrections.

This transition has been in place for approximately one year. The process is not yet fully complete. Our experience to date indicates that this action will enhance the effectiveness of the department's investigation function. Additional training for investigators will be developed. Better data collection and case tracking is being designed. There are opportunities for improvement, and we hope to continue making progress. Please refer to our comments in the Investigation section of this response regarding implementation of a new investigation data system.

Prison Rape Elimination Video

This video will be reissued in the near future to address the issue of staff sexual misconduct as well as inmate-on-inmate misconduct.

Staffing issues

A 1999 performance audit of staffing issues indicated that department correctional facilities operated too frequently at lower than appropriate staffing levels. A review of staffing data will show that remains the case today. Topeka Correctional Facility was at or below reduced staffing levels (called "operational staffing levels" by Legislative Post Audit) in excess of 87% of its shifts in FY 2008 and in excess of 72% of its shifts in FY 2009. Similar figures exist for almost all of our correctional facilities. Adequate resources do not exist to allow us to staff our facilities at optimal levels. Even if they did, we are concerned that current pay and benefit levels for our uniformed staff are insufficient to recruit and retain adequate numbers of qualified people with the temperament, patience and interpersonal skills necessary to be successful in a custody position. Comments made in the NIC report and statements made in our own testimony to the legislature over the last several years indicate that working short staffed for extended periods of time increases the likelihood of errors in operations and increase the opportunities for misconduct, including sexual misconduct, to occur unobserved. The opportunities for all of the events discussed in this audit to

occur were amplified by the ongoing staffing issues faced in this state's correctional facilities. Did the shortages cause the problem? No. Did the shortages make it easier for policy violations and staff misconduct to occur and go undetected? Yes. We will continue to strive to improve the security posture of our facilities, but until the staffing issues are resolved, we will be confronted by these challenges.

We view the information and recommendations presented in this audit report as being very useful in reviewing agency and facility operations towards a goal of further strengthening our ability to operate safe and secure correctional facilities. We appreciate the constructive nature of the audit findings, comments, and recommendations. We will be reviewing these recommendations, as well as those set forth in a recent evaluation through the National Institute of Corrections, and as directed by the Governor, will, in the coming days, weeks, and months, make necessary and appropriate modifications to existing policies and practices.

Sincerely,



Roger Werholtz
Secretary

**Legislative Division of Post Audit
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05PA10	Larned State Hospital: Reviewing the Growth In the Sexual Predator Treatment Program	April 2005
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03-G	Juvenile Justice Authority Information Systems: Reviewing the Authority's Management of Those Systems	March 2003
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99PA16	A K-GOAL Audit of the Dept. of Corrections, Part II: Procedures for Dealing With Parole Violators	August 1999
99PA15	A K-GOAL Audit of the Department of Corrections, Part 1: Assessing Staff Safety and Salary Issues	July 1999