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August 2004

DISTRICT OF COLUMBIA JAIL

Management Challenges Exist in Improving Facility Conditions

GAO-04-742

Highlights of GAO-04-742, a report to the Chairman, Committee on Government Reform, House of Representatives

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DISTRICT OF COLUMBIA JAIL

Management Challenges Exist in Improving Facility Conditions

Why GAO Did This Study

The District of Columbia's Jail and Correctional Treatment Facility (CTF), which are the District's detention facilities for misdemeanant and pretrial detainees, have been repeatedly cited for violations of health and safety standards. The Jail also has had problems with releasing inmates before or after their official release date, in part, because of inaccuracies in its electronic inmate records. As a follow-on to problems at the Jail reported in 2002 by the District's Inspector General, GAO addressed the following questions: (1) What are the results of recent health and safety inspections? (2) What is the status of the Jail's capital improvement projects, and what policies and procedures does the Department of Corrections (DoC) use in managing the projects? and (3) What progress has been made in improving electronic inmate records at the Jail?

What GAO Recommends

GAO made two recommendations, one concerning the specificity of reports about facility conditions; the other concerning time frames for developing and implementing guidance on managing projects.

DoC and the Department of Health (DoH) agreed with our finding concerning the lack of specificity in inspection reports, and DoH agreed to implement our recommendation. The Office of Property Management did not comment on our second recommendation.

www.gao.gov/cgi-bin/getrpt?GAO-04-742.

To view the full product, including the scope and methodology, click on the link above. For more information, contact Cathleen Berrick, (202) 512-8777 or berrickc@gao.gov.

What GAO Found

Health and safety inspection reports for the Jail and CTF that were prepared from January 2002 through April 2004 by the District's Department of Health consistently identified problems with air quality, vermin infestation, fire safety, plumbing, and lighting. Officials attributed some of the health and safety deficiencies to the age of the Jail and inmate behavior at both facilities. DoH inspection reports did not always document the specific locations where deficiencies were identified and did not document the date and time when the deficiencies were identified. For example, one report might identify a problem in a specific cell, while another report might state that the problem occurred in some locations, most locations, or throughout the Jail. This limits DoC's ability to determine how prevalent the health and safety deficiencies are, whether problems are recurring in the same locations, or whether conditions changed over time.

Of the 16 capital improvement projects for the Jail approved for fiscal years 2000 through 2004, 1 project was completed and 15 were in various stages of development. In addition, the Office of Property Management lacked written policies and procedures concerning project management, which could be important tools in guiding project managers through the planning and management of projects. Although the Office of Property Management established a working group to develop standard operating procedures for managing projects, time frames had not been established for when the working group should complete this work.

With respect to early and late inmate release errors, DoC has taken several steps to improve its efficiency and accuracy in processing inmate records, but release errors continue to occur. DoC's improvement efforts have included simplifying the workflow in the Records Office, issuing an operations manual, and developing additional guidance and training for staff. Additionally, DoC developed a database to capture detailed information on incidents that led to each inmate release error. DoC analyzed the information in this database to determine how frequently the incidents occurred. Based on this information, DoC has developed proposals for corrective action to reduce release errors. DoC officials attributed staff processing errors to limited staff resources and the large volume of documents that are continuously received in the Records Office. Because DoC did not have complete data on early and late inmate releases, DoC does not know the full extent to which the release errors occurred. Specifically, DoC may not discover an early release error until long after the inmate has been released. For late releases, DoC used an incomplete methodology, which led to an understated number of actual late releases. During our review, DoC modified this methodology to more accurately identify the number of late releases.

Contents

Letter 1

Results in Brief 3
Background 5
Health and Safety Deficiencies at the Jail and Correctional Treatment Facility 6
Capital Improvement Projects at the Jail 13
DoC Has Taken Steps to Improve Inmate Records, but Effects on Reducing Release Errors Are Difficult to Determine 19
Conclusions 23
Recommendations for Executive Action 23
Agency Comments and Our Evaluation 24

Appendix I **Objectives, Scope, and Methodology** 29

Appendix II **Capital Improvement Projects at the Correctional Treatment Facility** 32

Appendix III **Results of Health and Safety Inspections at the Jail** 34

Appendix IV **Quality Controls DoC Implemented to Improve the Accuracy of Inmate Records** 40

Appendix V **Programs and Services Provided at the Jail and the Correctional Treatment Facility** 41

Appendix VI **DoC's Implementation of the District of Columbia's Office of the Inspector General's Recommendations** 43

Appendix VII — Comments from the District of Columbia, Department of Corrections 45

Appendix VIII — Comments from the District of Columbia, Department of Health 55

Appendix IX — Comments from the District of Columbia, Office of the Inspector General 58

Appendix X — Comments from the District of Columbia, Office of Property Management 59

Appendix XI — GAO Contacts and Staff Acknowledgments 62

GAO Contacts 62
Acknowledgments 62

Tables

Table 1: Capital Improvement Projects at the District's Jail 14
Table 2: Capital Improvement Projects at CTF Completed during 2003 32
Table 3: Programs and Services Provided at the Jail and CTF in 2003 41
Table 4: The District's Office of the Inspector General's Findings and Recommendations to the Department of Corrections 43

Figures

Figure 1: Air Quality deficiencies at the Jail as Reported by DoH in Reports Prepared between March 2002 and April 2004 34
Figure 2: Vermin Deficiencies at the Jail as Reported by DoH in Reports Prepared between March 2002 and April 2004 35

Figure 3: Fire Safety Deficiencies at the Jail as Reported by DoH in Reports Prepared between March 2002 and April 2004 36
Figure 4: Plumbing Deficiencies at the Jail as Reported by DoH in Reports Prepared between March 2002 and April 2004 37
Figure 5: Shower Deficiencies at the Jail as Reported by DoH in Reports Prepared between March 2002 and April 2004 38
Figure 6: Lighting Deficiencies at the Jail as Reported by DoH in Reports Prepared between March 2002 and April 2004 39

Abbreviations

CCA	Corrections Corporation of America
CTF	Correctional Treatment Facility
DoC	Department of Corrections
DoH	Department of Health
OIG	Office of the Inspector General

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United States Government Accountability Office
Washington, DC 20548

August 27, 2004

The Honorable Tom Davis
Chairman
Committee on Government Reform

Dear Mr. Chairman:

The District of Columbia's Jail, which is the District's primary facility for misdemeanant and pretrial detainees, has repeatedly been cited for violations of health and safety standards and has been reviewed by other agencies for its management of inmate records.[1] In October 2002, a report by the District's Office of the Inspector General (OIG)[2] noted numerous health and safety violations at the Jail, as well as problems with electronic inmate records that have resulted in errors in releasing inmates before or after their official release date.[3] The District's Department of Corrections (DoC), the agency that manages and operates the Jail, has taken several actions, including implementing capital improvement projects, to address some of the problems that have been identified. The District's other major detention facility—the Correctional Treatment Facility (CTF)—is managed and operated by a private company and has also been cited for health and safety violations.

To assist in the oversight of certain management and operational issues at the District's detention facilities, this report addresses the following questions: (1) What are the results of recent health and safety inspections conducted by the District's Department of Health at the Jail and the Correctional Treatment Facility? (2) How many capital improvement projects were approved at the Jail during fiscal years 2000 through 2004, what is their status, and what policies and procedures does DoC use in managing the projects? (3) What progress has been made in improving electronic inmate records at the Jail? Additionally, we are providing information on the Correctional Treatment Facility's capital improvement

[1]The D.C. Jail is also known as the Central Detention Facility.

[2]*Report of Inspection of the Department of Corrections*, Number 02-00002FL, District of Columbia Office of the Inspector General, October 2002.

[3]For the purposes of this report, the term "inmate" includes offenders who have been convicted of a crime as well as detainees who are awaiting trial or being held for questioning.

projects during calendar year 2003 (see app. II), the annual costs for operating the detention facilities during 1999 through 2003, the types of programs and services that the detention facilities provided during 2003 (see app. V); and recommendations relevant to our review that were part of the District's 2002 Office of Inspector General report (see app. VI).

To answer these questions, we held discussions with officials in DoC headquarters, the Jail and CTF, and OIG. We reviewed applicable laws and regulations, policies and procedures guiding operations at the Jail and CTF, and standards for internal control in the federal government.[4] We did not compare the conditions of the Jail or its records office with conditions at other detention facilities because this was outside the scope of our review.

To obtain information on the results of health and safety inspections, we interviewed District Department of Health (DoH) officials, reviewed the American Correctional Association's and American Public Health Association's standards for health and safety conditions for correctional institutions, and reviewed inspection reports that the District's DoH and Fire and Emergency Medical Services prepared during 2002 through 2004. It was beyond the scope of this review to determine whether the DoH inspector applied the health and safety standards correctly, took accurate measurements, or accurately reported the inspection results. We also did not review the adequacy of any corrective actions taken at the Jail or the CTF.

To determine the number and status of capital improvement projects at the Jail, we reviewed documentation and information provided by District officials on the estimated cost, scope, and schedule time frames for each capital improvement project that the District approved during fiscal years 2000 through 2004. We did not assess the quality of work on projects that were in construction at the time of our review. Because the District's Office of Property Management is the implementing agency for DoC's capital projects, we interviewed the office's Director, Deputy Director of Operations, and project management staff.

[4]GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: Nov. 1, 1999).

To determine DoC's progress in improving the accuracy of inmate records at the Jail and CTF,[5] we reviewed DoC's operations manual, internal controls for managing inmate records, and available data on the number of early and late inmate releases. We sought to determine the reliability of these data by reviewing DoC's process for determining release errors and tracing reported figures to available source documentation. DoC's data on errors in early and late inmate releases were not reliable enough for the purposes of this review since DoC may not discover an early release until long after it occurs. In addition, until March 2004, DoC was using an incomplete methodology to identify late releases. Therefore, DoC's data on both early and late release errors may have understated the true number of errors.

We performed our work in Washington, D.C., between June 2003 and July 2004 in accordance with generally accepted government auditing standards. Appendix I provides more detailed information about the scope and methodology of our work.

Results in Brief

Department of Health inspection reports for the Jail and CTF prepared from January 2002 through April 2004 consistently identified health and safety deficiencies concerning air quality, vermin infestation, fire safety, plumbing, and lighting. A Jail official attributed some of the health and safety deficiencies to the age of the facility and inmate behavior. The inspection reports prepared by DoH were not consistently specific about the location within the facilities of the identified deficiencies and did not document the date or time the deficiencies were identified. This limits DoC's ability to determine how prevalent the health and safety deficiencies were, whether problems recurred in the same locations, or whether conditions changed over time.

Sixteen capital improvement projects were approved at the Jail for fiscal years 2000 through 2004. As of June 1, 2004, 1 project had been completed and 15 were in various stages of development. The District's Office of Property Management, the District agency responsible for managing the implementation of the Jail's capital improvement projects, did not have information on what the final costs and schedule time frames would be for most of the 16 capital projects, as they were still subject to design and/or

[5] DoC's Records Office, located at the Jail, processes both the Jail's and CTF's inmate admissions and releases.

scope changes. In addition, the Office of Property Management lacked written policies and procedures concerning project management, which could be important tools in guiding project managers through the planning and management of projects. However, in April 2004, the Office of Property Management established a working group to develop standard operating procedures for managing projects. As of May 2004, time frames had not been established for completing the work of the working group.

DoC has taken several steps to improve its efficiency and accuracy in processing inmate records, but release errors continued to occur. DoC's improvement efforts have included simplifying the workflow in the Records Office, issuing an operations manual, and developing additional guidance and training for staff. Additionally, DoC developed a database to capture detailed information on incidents that led to each inmate release error. DoC analyzed the information in this database to determine how frequently the incidents occurred. Based on this information, DoC has developed proposals for corrective action to reduce release errors. DoC attributed staff processing errors to limited staff resources and the large volume of documents that are continuously received in the Records Office. Because DoC did not have complete data on early and late inmate releases, DoC does not know the full extent to which they occurred, and may not discover an early release error until long after the inmate has been released. With respect to late releases, DoC used an incomplete methodology and, therefore, may have understated the actual number of late releases. During our review, DoC modified the methodology to more accurately identify the number of late releases.

To help improve facility operations, we are making two recommendations. First, we recommend that DoC work with the Department of Health to develop a format for inspection reports that would enable DoC to determine the prevalence of health and safety deficiencies at the Jail and monitor changes in facility conditions over time. Second, toward the goal of strengthening management of capital improvement projects, we recommend that the Office of Property Management establish time frames for completing its work on developing and implementing policies and procedures.

We provided a draft of this report to the District's Department of Corrections, Department of Health, Office of the Inspector General, and Office of Property Management for comment. In response, DoC and DoH concurred with our finding that inspection reports did not consistently identify locations where deficiencies were found, and DoH agreed to implement our recommendation. The OIG affirmed that we accurately

portrayed the findings and recommendations contained in its October 2002 inspection report on the Jail. The Office of Property Management did not comment on our recommendation. A copy of the comments from all of these agencies and offices is included as appendix VII, VIII, IX, and X respectively.

Background

The Jail opened in 1976 and is a maximum-security facility for males and females that is managed and operated by the District's DoC. The Jail has over 1,700 heavily used cell doors and gates, approximately 1,500 prison-grade sink/toilet combinations, and security systems that are maintenance intensive. In addition, systems and jail areas that may require maintenance include the heating, ventilation, and air conditioning system; water systems; plumbing, electric wiring, piping, elevators, laundry equipment, and kitchen equipment, among others. According to the District's fiscal year 2003 budget and financial plan, the Jail required significant structural repairs because it had not been well maintained. Inmates at the Jail are housed in 18 cellblocks that contain 1,380 cells. In fiscal year 2003, the average daily inmate population was 2,328. DoC's policy states that the Jail is to be clean, sanitary, and environmentally safe, and that its equipment is to be maintained in good working order and meet all applicable codes, standards, and sound detention practices. The District of Columbia Jail Improvement Amendment Act of 2003, effective January 30, 2004, requires DoC to obtain accreditation by the American Correctional Association for the Jail by January 30, 2008.[6]

The Jail has operated under court-ordered supervision for much of the past 28 years, largely because of court orders relating to class action lawsuits brought in the 1970s challenging the constitutionality of various conditions at the facility.[7] In March 2003, the U.S. District Court for the

[6]Among other things, the act directs DoC to develop and implement a classification system and housing plan for inmates at the jail; mandates the establishment of weekend visiting hours at the jail; and requires an independent consultant to determine a population ceiling for the jail.

[7]The U.S. District Court for the District of Columbia found certain conditions at the jail, such as those relating to severe overcrowding, inadequate health care, unsanitary conditions, and unsafe facilities, to be constitutionally impermissible, and through a series of decisions and orders, required the District to take corrective actions. *See e.g.*, *Campbell v. McGruder*, 416 F. Supp. 106 (D.D.C. 1975); *Inmates of D.C. Jail v. Jackson*, 416 F. Supp. 119 (1976); *Campbell v. McGruder*, 416 F. Supp. 111 (D.D.C. 1976); and *Campbell v. McGruder*, 580 F. 2d 521 (D.C. Cir. 1978). The *Campbell* and *Inmates of D.C. Jail* cases were eventually consolidated.

District of Columbia terminated the remaining court orders and dismissed these cases on the basis that such court orders were no longer necessary to correct current and ongoing constitutional violations.[8]

CTF opened in 1992 and is an American Correctional Association-accredited facility that has been managed and operated since 1997 by the Corrections Corporation of America (CCA) under contract to the District's DoC. As part of its contract with the District to manage CTF, Corrections Corporation of America undertakes capital improvements intended to improve operations at CTF or address issues that may affect security at the facility. (App. II provides information about projects completed at CTF during 2003 and the cost of each project.) CTF is a medium-security facility for male and female inmates and inmates with specialized confinement needs (e.g., pregnant women and inmates with physical disabilities). Since 2001, CTF has also served as an overflow facility for the Jail. Inmates in CTF are housed in 27 units consisting of between 16 and 48 single cells each. In fiscal year 2003, CTF began placing two inmates per cell and had an average daily inmate population of 787 inmates.

Health and Safety Deficiencies at the Jail and Correctional Treatment Facility

The most recent health and safety reports for the Jail and CTF indicated that they have similar areas of deficiencies. They included problems with air quality, vermin, fire safety, plumbing, and lighting. A DoC official attributed some deficiencies at the Jail and CTF to inmate behavior and deterioration of the physical plant over a number of years leading up to 2000. The DoH reports did not consistently identify the specific locations in the Jail where the deficiencies occurred. The DoH reports also did not always include all of the deficiencies identified, particularly if the deficiency was repaired during the course of the inspection. As a result, DoC cannot determine (1) how prevalent the health and safety deficiencies were, (2) whether problems recurred in the same locations, or (3) whether conditions have improved, stayed the same, or gotten worse over time. Beginning September 2004, DoH intends to begin using a detailed inspection tool that will specify the location, severity, and frequency of occurrence of identified deficiencies. DoH inspections for the

[8]The U.S. District Court took this action upon a motion by the defendants in these cases pursuant to the Prison Litigation Reform Act (PLRA) of 1995, P.L. 104-134, 110 Stat. 1321-66 (1996). The PLRA generally provides for the termination of certain court orders with respect to prison conditions upon a court finding that court-ordered relief is no longer necessary to correct any "current and ongoing" constitutional violations. The district court decision was upheld on appeal in January 2004. See *Campbell v. McGruder*, 2004 U.S. LEXIS 1069 (D.C. Cir. Jan. 23, 2004).

Jail and CTF cannot be used to compare conditions at these facilities because DoH applies American Correctional Association standards in its inspections of the Jail and American Public Health Association standards in its inspection of CTF. Beginning in September 2004, DoH plans to apply the American Public Health Association's standards in its inspections of the Jail.

Health and Safety Deficiencies Reported at the Jail

Our review of all six inspection reports prepared by DoH between March 2002 and April 2004 shows that DoH repeatedly identified the same types of health and safety deficiencies at the Jail. In its 2002 and 2003 annual inspections, the District's Fire and Emergency Medical Services also found the same types of fire safety deficiencies at the Jail as DoH. These two district agencies, DoH and Fire and Emergency Medical Services, are responsible for conducting inspections at the Jail to determine whether the facility meets health and safety standards. Legislation enacted by the District government in 2003 requires DoH to conduct environmental health and safety inspections of the Jail at least three times a year.[9] DoH has randomly inspected at least 20 cells per cellblock (or a minimum of 360 cells) during each inspection at the Jail and has applied American Correctional Association standards, as well as other applicable local standards and codes, in these inspections. In conducting its inspections, DoH does not determine what, if any, corrective actions DoC may have taken in response to deficiencies that DoH reported previously. The inspections cover, among other things, inmate housing units, kitchen areas, inmate receiving and discharge, and emergency procedures including fire safety. Following completion of an inspection, DoH is to prepare a report of its findings. In accordance with District regulations, Fire and Emergency Medical Services conducts annual fire safety inspections of the Jail. Fire and Emergency Medical Services applies local fire and life safety codes and Building Officials' Codes in its inspections.

DoH inspections at the Jail are conducted over a period of time up to 30 days. According to DoC officials, Jail maintenance staff accompany the DoH inspector during the inspection, and they are to repair identified deficiencies immediately, if possible. According to DoH officials, the inspection report may or may not include a deficiency that was repaired immediately. They told us that deficiencies that the DoH inspector

[9] A series of three D.C. laws, both temporary and permanent, require DoH to conduct such inspections. See Central Detention Facility Monitoring Temporary Amendment Act of 2003 (D.C. Law 15-30), Jail Improvement Emergency Amendment Act of 2003 (D.C. Act 15-188), and District of Columbia Jail Improvement Amendment Act of 2003 (D.C. Law 15-62).

considers to be more significant or severe are more likely to be included in the inspection report, even if they are repaired on the spot.

The DoH reports did not consistently identify the specific locations where the deficiencies occurred. For example, one DoH report would identify the specific cell where a health and safety problem occurred, while another report might state that the problem occurred “throughout” the Jail. According to a DoH official, when a deficiency is identified throughout the facility, it means that the problem was found in at least one cell in each of the 18 cellblocks inspected. According to DoC, specific information on such things as the location and prevalence of an identified problem and the time that it was identified would be more useful than generally characterizing deficiencies as occurring in “some” or “most” locations or “throughout” the Jail. DoC officials believe that if the inspection reports were more specific, the information could be used to determine if the deficiency was newly identified, was currently being corrected, or was already corrected. According to a DoH official, there are no explicit criteria for the level of specificity that should be included in inspection reports of the Jail or CTF. The following illustrates some of the identified deficiencies and how they were reported. (App. III provides additional information about the health and safety deficiencies reported by DoH).

- **Air quality deficiencies:** This deficiency was identified in four of six DoH inspection reports. In these reports, DoH noted that at the time of an inspection, there was no measurable airflow coming out of the vents for the areas inspected. Recognizing the need to remedy the Jail’s heating, ventilation, and air conditioning system problems, DoC sought and obtained approval in fiscal year 2001 for a capital improvement project that would replace the Jail’s heating, ventilation, and air conditioning system. As of June 2004, construction on the project was 99 percent complete. DoC officials said that they expect most airflow problems to be eliminated once this project is completed.

- **Vermin:** In three of six inspections, DoH found vermin in at least one of the following areas, the Jail’s main kitchen, loading dock, dry storage areas, and officers’ dining area. Mice and flies were the types of vermin DoH reported most frequently. However, DoH did not report the extent of the vermin problem identified. Recognizing that food and water lodged in the cracks and crevices of the Jail’s deteriorated kitchen floor contributed to the problem with vermin, DoC initiated a capital project to remedy the problem. The project was approved in fiscal year 2002 and completed in March 2004. DoH also reported evidence of vermin in the inmate shower areas in all six reports we reviewed. Specifically, flies were observed

coming through inmate shower drains at the time of five inspections. DoC recognizes that vermin control is continuously challenging because of the size, age, and location of the facility. To control for vermin, DoC administers pest control treatments throughout the year, including treating the housing units quarterly, common areas bimonthly, and culinary areas biweekly. According to a DoC official, DoC sprays for flies, cockroaches, and other insects and sets traps for rodents. Additionally, shower areas in cellblocks are steam cleaned and chemicals are applied to control for flies. DoC's *Environmental Safety and Sanitation* manual dictates the time frames for these treatments.

- **Fire safety deficiencies:** Problems with fire extinguishers and smoke detectors were identified in all six DoH reports and in Fire and Emergency Medical Services' 2002 and 2003 annual reports. With respect to fire extinguishers, five of six DoH inspections reported that the Jail had an insufficient number of extinguishers. Five of six DoH inspections found that fire extinguishers were improperly mounted on the walls. The reports did not always state which locations in the Jail had this problem or how many extinguishers were improperly mounted. With respect to smoke detectors, each DoH inspection report, as well as Fire and Emergency Medical Services' 2002 and 2003 inspection reports, noted that some of the Jail's approximately 200 smoke detectors were missing or not working in each of the facility areas inspected. Neither DoH nor Fire and Emergency Medical Services specified in any inspection report how many smoke detectors were missing or not working. In April 2003, Fire and Emergency Medical Services conducted a re-inspection of the deficiencies it had identified in its January 2003 inspection and reported that the Jail had corrected all deficiencies. According to a DoC official, DoH's October 2003 and April 2004 findings that there were again missing smoke detectors was most likely due to inmate vandalism.

- **Plumbing deficiencies**: In all six inspection reports, DoH noted that (1) inmate cells had faulty plumbing fixtures, such as leaking toilet knobs or stuck faucets; (2) inmate cells throughout the facility lacked hot or cold water; (3) sinks and toilets in inmate cells had low water pressure; and (4) showers in some cellblocks could not be used because of malfunctioning.[10] However, the reports were not consistent in reporting the problems identified. For example, in one of six inspections, DoH reported the specific number of cells without hot or cold water, whereas in the remaining five inspections, DoH reported that this occurred

[10]Individual inmate cells do not have showers.

throughout the facility. As part of its capital improvement program, DoC received approval in fiscal year 2001 to replace plumbing fixtures throughout the Jail's 18 cellblocks. As of June 2004, construction on the plumbing fixture project was 35 percent complete.

- **Lighting deficiencies:** In all six inspection reports, DoH indicated that light fixtures were damaged. In three of the six inspection reports, the number of cells affected was not given; in the remaining three, between 3 and 160 inmate cells were reported as having damaged light fixtures. As part of a capital improvement project that was approved in fiscal year 2001, DoC intends to replace light fixtures throughout the Jail's 18 cellblocks. As of June 2004, construction on this project was 35 percent complete.

In addition to being inspected by DoH, DoC conducts its own routine internal inspections. Both the DoH and DoC inspections address (1) maintenance-related problems; that is, problems whose remedy involves repairing a malfunction such as a broken toilet or a faulty air system, and (2) nonmaintenance-related problems; that is, those that involve sanitation conditions, such as improper storage of chemicals. DoC staff are to conduct daily and monthly health and safety inspections at the facility.[11] DoC's *Environmental Safety and Sanitation Manual* details the procedures to be used for reporting both maintenance- and nonmaintenance-related deficiencies. Additionally, the manual includes time frames for correcting maintenance-related deficiencies, but does not include time frames for correcting nonmaintenance-related deficiencies.

For maintenance-related deficiencies, DoC has an automated system in which to record the deficiency, the corrective action to be taken, and whether the corrective action was completed. The system is designed to assign each maintenance-related problem to one of three priority levels according to the impact it may have on the health and safety of the inmate.[12] Once a maintenance-related problem is entered into this system,

[11]Daily inspections are to include common areas of the Jail, shower areas, and cells, and monthly inspections are to include fire safety, pest control, and sanitation.

[12]DoC requires that priority one deficiencies—those that affect inmate health and safety—be corrected within 4 hours. If this is not possible, DoC staff are to determine if an inmate should be removed from a cell. Priority two deficiencies include problems such as broken light covers or other nonemergency maintenance projects. Priority three deficiencies include painting and other nonemergency projects. According to DoC's *Environmental Safety and Sanitation Manual*, both priority two and three deficiencies are to be fixed within 24 hours.

a work ticket is to be generated and the status of the corrective action is to be monitored. DOC officials said that once the deficiency is entered, it remains active in the system until it is corrected. DoC noted that the number of maintenance calls ranges between 50 and 250 on any given day.

For certain nonmaintenance-related deficiencies that are not corrected at the time of the DoH inspection and are later documented in the inspection report, DoC is to complete an abatement plan and document corrective actions taken, according to a DoC official. DoC officials noted that they do not have a formal mechanism for responding to nonmaintenance-related deficiencies identified in internal inspections. DoC officials said that their practice is to take immediate corrective action for fire safety violations identified by Fire and Emergency Medical Services to ensure compliance with applicable fire codes and regulations.

Health and Safety Deficiencies Reported at CTF

At CTF, DoH and Fire and Emergency Medical Services generally identified the same areas of health and safety deficiencies—that is, air quality, vermin, fire safety, plumbing, and lighting—as at the Jail. DoH and Fire and Emergency Medical Services are responsible for conducting health and safety inspections at CTF. According to a DoH official, twice a year, DoH conducts inspections at CTF applying the American Public Health Association’s standards for correctional institutions in its health and safety inspections at CTF. A Fire and Emergency Medical Services official said that the same fire safety codes are applied in its inspection of CTF as at the Jail. The available inspection data from DoH cannot be used to compare conditions at the Jail with those at CTF because (1) inspection reports for CTF did not document the prevalence or severity of the problems, and (2) DoH applied American Correctional Association standards in its inspection of the Jail and American Public Health Association standards in its inspection of CTF. Beginning in September 2004, DoH will apply the same set of standards—American Public Health Association standards—in its inspections of the Jail and CTF.

Three DoH reports prepared between September 2002 and May 2003—the most recent reports available—identified deficiencies related to air quality, vermin, fire safety, and lighting. DoH found plumbing deficiencies in its September 2002 inspection, but not in the two inspections conducted in 2003.

As was the case with the Jail, the DoH reports did not consistently identify the specific locations where the problems occurred. The following illustrates some of the reported deficiencies.

- **Air quality deficiencies:** Deficiencies related to air quality included dirty vents and air temperatures above or below the required level. All three DoH inspection reports that we reviewed documented the presence of dirty vents. Two of the three inspection reports reported that the air temperature was below the required temperature of 65 degrees Fahrenheit.[13] However, none of the reports indicated where the air quality deficiencies occurred at CTF. In its February 2003 inspection report, DoH noted that CTF corrections officials had offered to move inmates who were in cells with the low temperature, but the inmates chose to remain in the cells. The officials reportedly provided the inmates with extra blankets and clothing.

- **Vermin:** This deficiency was identified in each DoH inspection report. None of the reports indicated the severity of the problem identified. DoH reported in September 2002 that at the time of its inspection, mice were observed in the trash compactor area entering and exiting through a wall that was missing rubber caulking. DoH's February 2003 report noted that at the time of the inspection, outside cracks and crevices were repaired, with the exception of those located near the trash compactor area. Correctional standards state that facilities must be maintained to prevent vermin access. CTF's abatement plan did not include information on planned or completed corrective actions for the cracks and crevices. However, DoH's May 2003 report indicated that there continued to be evidence of vermin at CTF. Specifically, in May 2003 DoH reported a fly infestation problem. Although CTF was opened about 22 years ago, CTF officials said that cracks and crevices continue to develop because of the settling of the building. Under CCA policy, CTF is to have weekly pest exterminations conducted. According to CTF officials, since 1997 CTF has had a contract with a pest control company for pest extermination. CTF documentation showed that pest extermination is to be done on a weekly basis.

- **Fire safety deficiencies:** Fire safety violations were reported in two of three DoH reports. Specifically, DoH found burnt electrical plugs, exposed electrical cables, and improperly placed fire extinguishers.[14] CTF

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[13]In one case, the air conditioning was malfunctioning; in the other case, the heating was malfunctioning.

[14]In 2002, the District's Fire and Emergency Medical Services completed a follow-up inspection of violations previously cited in 2001. CTF officials said this follow-up inspection also served as the annual inspection. Fire and Emergency Medical Services did not prepare a report of findings because it did not identify any fire safety deficiencies in 2002. Similarly, DoH did not identify any fire safety deficiencies in 2002.

documentation did not show what, if any, corrective action was taken. DoH's reports did not provide specific information about where these deficiencies were located. In a September 2003 fire safety inspection, Fire and Emergency Medical Services found, among other things, deficient exit signs. However, Fire and Emergency Medical Services reported in November 2003 that CTF had corrected these deficiencies. According to CTF records, deficient exit signs were corrected by replacing the lightbulbs.

- **Plumbing deficiency:** In its September 2002 inspection, DoH found that three cells out of 1,014 had hot water temperatures above the maximum recommended temperature of 120 degrees Fahrenheit at the time of its inspection. DoH noted that this problem was corrected the following day.

- **Lighting deficiencies:** Deficiencies with lighting were reported in each inspection report we reviewed. The problems included burnt lightbulbs and damaged light fixtures, switches, and fuses. Burnt lightbulbs were reported in DoH's September 2002 and February 2003 reports. For example, DoH's September 2002 report showed that some cells had one burnt light bulb. According to CTF officials, each cell is to have approximately three lightbulbs. Similarly, the February 2003 report showed that some cells had burnt-out lightbulbs, but all lightbulbs were replaced before the inspector left.

In addition, CTF staff are to conduct daily, weekly, and monthly health and safety inspections of the facility. They are to document the deficiencies reported, including planned and completed corrective actions. Additionally, CTF has had a comprehensive maintenance program since July 1997. In 2003, 13,476 maintenance deficiencies were reported and corrected.

Capital Improvement Projects at the Jail

Sixteen capital improvement projects were approved at the Jail during fiscal years 2000 through 2004.[15] Between 1976, when the Jail opened as a newly constructed detention facility, through the 1990s, capital improvements at the Jail primarily dealt with its heating, ventilation, and air conditioning system. By the late 1990s, the Jail had deteriorated and conditions had become unsanitary and unsafe for inmates and staff. To address these conditions and upgrade the facility's infrastructure, DoC

[15]The District defines capital improvements as a permanent improvement to a fixed asset that is valued at $250,000 or more and with an expected life of more than 3 years.

began to request additional funding for capital improvements at the Jail in its fiscal year 2000 capital budget request.

Of the Jail's 16 capital improvement projects, 1 project—involving improvements to the kitchen flooring—was complete as of June 1, 2004. The remaining 15 projects were in various stages of construction or design: 6 were in the construction phase, 6 were in the design phase, and 3 were in the predesign phase. Of the 6 projects in the construction phase, 3 were at substantial completion.[16] These projects included upgrading the hot water system and replacing the heating, ventilation, and air conditioning system. Table 1 presents a description of each project, the fiscal year each project was approved, the project's current working estimate as of July 13, 2004, and each project's status as of June 1, 2004.[17]

Table 1: Capital Improvement Projects at the District's Jail

Projects by phase	Description	Fiscal year	Current working estimate, as of July 13, 2004	Project status, as of June 1, 2004
Complete				
Kitchen flooring and miscellaneous improvements	This project includes replacing the kitchen flooring and renovating the kitchen area.	2002	$1,911,907	Construction 100 percent complete
Construction				
Hot water system[a]	This project includes replacing all of the main water lines, converters, pumps, piping valves, and other equipment associated with the hot water system throughout the Jail.	2001	9,498,054	Construction 99 percent complete.[b]
Heating, ventilation, and air conditioning system replacement[a]	This project includes replacing the existing equipment in the Jail.	2001	See current working estimate for the hot water system project	Construction 99 percent complete.[b]
Lighting upgrades[a]	This project includes replacing the light fixtures, lightbulbs, and switches throughout the 18 cellblocks.	2001	2,960,943	Construction 35 percent complete and estimated complete by October 2005.

[16]Substantial completion means that the project was completed enough to be used by DoC for its intended purpose.

[17]Current working estimate represents the current estimate of total project cost to provide a complete and usable facility.

Projects by phase	Description	Fiscal year	Current working estimate, as of July 13, 2004	Project status, as of June 1, 2004
Plumbing upgrades[a]	This project includes replacing the plumbing fixtures throughout the 18 cellblocks.	2001	See current working estimate for the lighting upgrades project	Construction 35 percent complete and estimated complete by October 2005.
Sally port and adjoining areas[c]	This project includes redesigning and reconfiguring the sally port and adjoining areas so that inmates and vehicles can be processed more efficiently.	2000	858,120	Construction is ongoing as this project is being implemented in phases. Construction on the sally port parking and laundry is 100 percent complete. Construction on the armory is 98 percent complete.[b] Additional work, such as improvements to the guard tower and receiving and discharge, may be determined at a later date.
Energy management system	This project includes improvements to the energy efficiency of the Jail's building systems, such as its electrical; plumbing; and heating, ventilation, and air conditioning systems. This project will also include installing a computerized energy management system.	2002	Not available	Construction is ongoing as this project is being implemented in phases.
Design				
Central security system	This project includes installing a new, integrated, comprehensive security system, including door controls, cameras, motion detectors, card readers, duress alarm system and intrusion detection system; and refurbishing the existing control centers, including central command, floor control, and control bubbles.	2000	5,973,405	This project is being implemented in phases. Installation of the closed circuit television is 35 percent complete, and estimated complete by October 2004. Design of the overall central security system is 100 percent complete. Construction contract for the overall central security system project not yet awarded.
Cell doors and motors	This project includes demolishing all existing cell door operating mechanisms and retrofitting all cell doors throughout the 18 cellblocks.	2000	9,936,951	Design 100 percent complete, construction contract not yet awarded.
Elevators[a]	This project includes demolishing and replacing the Jail's existing elevators.	2000	2,123,005	Design 100 percent complete, construction contract not yet awarded.
Escalators[a]	This project includes demolishing and replacing the Jail's existing escalators.	2003	See current working estimate for the elevators project	Design 100 percent complete, construction contract not yet awarded.

Projects by phase	Description	Fiscal year	Current working estimate, as of July 13, 2004	Project status, as of June 1, 2004
Fire alarm and sprinkler system	This project includes demolishing all remnants of the existing fire alarm and sprinkler system and installing a new, modern, and comprehensive fire alarm and sprinkler system, including strategically located fire, heat, and smoke detectors.	2000	1,766,795	Design 100 percent complete on fire alarm and 95 percent complete on sprinkler system. In process of awarding the construction contract for the fire alarm system.
Emergency power system	This project includes reconfiguring the Jail's electrical distribution system.	2002	420,238	Design 80 percent complete.
Other				
Staff and visitors' entrances	This project includes redesigning, expanding, and reconfiguring the staff and visitors' entrances.	2003	Not available	Not determined[d]
Inmate shower renovations	This project includes demolishing the shower stalls throughout the 18 cellblocks and replacing them with new, prison-grade shower stalls, including new fixtures, piping, drains, and improvements to the floors and ceilings.	2004	Not available	Not determined[d]
Exterior structural refinishing	This project includes repairs to the Jail's exterior structure.	2004	Not available	Not determined[d]
Total			**$35,449,418**	

Source: GAO analysis based on information provided by the District of Columbia's Department of Corrections and Office of Property Management.

[a]According to Office of Property Management officials, work on these projects has been combined because of, among other things, similarities in the work to be performed. Specifically, combined projects include work on the following: (1) hot water system and heating, ventilation, and air conditioning system replacement; (2) lighting upgrades and plumbing upgrades; and (3) elevators and escalators.

[b]These projects are at substantial completion.

[c]The sally port is the area where all vehicles coming into the Jail are checked and processed. The adjoining areas are the guard tower, the external yard, receiving and discharge, and the laundry.

[d]DoC and the Office of Property Management did not agree on the status of the project. According to DoC, the project was in the design phase; according to the Office of Property Management, the project was not yet in design because the scope of work had not yet been finalized.

The District's Office of Property Management is the implementing agency for the Jail's capital improvement projects and manages the projects' actual construction. Its responsibilities include monitoring the progress of the projects to ensure that (1) the original intent of the project is fulfilled, (2) financing is scheduled for required capital expenditures, and (3) DoC's highest priority projects are implemented first. We sought to obtain

current working estimates for the Jail's capital improvement projects from the Office of Property Management (see table 1). However, current working estimates were not available for four of the Jail's capital improvement projects. This is because those projects were either ongoing and being implemented in phases—meaning that work was being completed in conjunction with the Jail's other capital improvement projects, or the project did not have a fully defined scope of work.[18]

When managing the projects, Office of Property Management officials noted that such factors as unforeseen site conditions and unexpected events can affect the progress of implementing the projects and change their cost, scope, or schedule. As an example of an unforeseen site condition, Office of Property Management officials noted that while working on the Jail's hot water system and heating, ventilation, and air conditioning replacement projects, contractors discovered that the Jail's cold water system had also deteriorated and needed to be replaced. As a result, DoC changed the scope of the projects to include upgrading the Jail's cold water system. This, in turn, increased the projects' construction costs from about $7.1 million to $9.1 million and extended the projects' schedule from about 24 months to 34 months. As an example of an unexpected event, DoC further accelerated the installation of the closed circuit television portion of the Jail's electronic security system project following a shooting incident in December 2003.[19] This portion of the project was pulled out of the Jail's larger central security systems project whose drawings had been completed prior to December 2003. As of June 1, 2004, the installation of the closed circuit television portion of this project was 35 percent complete.

Our work on capital improvement projects has noted that it is important that capital projects be well managed.[20] For example, our work has noted the importance of having written policies and procedures that can help

[18]According to Office of Property Management officials, the process of defining the scope of work, among other things, is essential to the establishment of a reliable cost estimate. Thus, for those projects, no cost estimate was available.

[19]According to DoC officials, the Department of Homeland Security provided DoC with a grant in August 2003 to help ensure that no breaches of security occur. Through this grant, DoC had already begun procuring security cameras that were to be part of this project.

[20]GAO, *Executive Guide: Leading Practices and Capital Decision-Making*, GAO/AIMD-99-32 (Washington, D.C.: December 1998).

project managers in planning and managing their projects.[21] Typical policies and procedures that might be provided to project managers include policies that establish the roles and responsibilities of project staff and procedures that define how the project will be executed. When used, such policies and procedures help guide project execution and ensure overall project oversight. We did not systematically review the management of the Jail's capital improvement projects, nor did we determine whether management issues may have contributed to increased costs or time frames for certain projects. Therefore, we have no information indicating that the Office of Property Management's projects at the Jail were not well managed. However, during our review we noted that the Office of Property Management lacked written policies and procedures to guide its project managers through the planning and management of projects.

Office of Property Management officials we interviewed acknowledged the importance of having written project management policies and procedures to guide its staff through the planning and management of projects. In April 2004, the Office of Property Management (1) established a project management working group, consisting of its Deputy Director of Operations, project managers, and other staff, to develop a standard operating procedure for managing projects, and (2) began revising its current reporting procedures for providing up-to-date information on, among other things, each project's budget and schedule. However, at the time of our review the working group had not yet developed the guidance, and time frames for completing its work had not been established. Thus, it is too early to determine specifically what guidance this working group will develop and the extent to which it will assist project managers in planning and managing their projects.

[21] GAO, *Kennedy Center: Improvements Needed to Strengthen the Management and Oversight of the Construction Process*, GAO-03-823 (Washington, D.C.: September 5, 2003).

DoC Has Taken Steps to Improve Inmate Records, but Effects on Reducing Release Errors Are Difficult to Determine

DoC has taken several steps since the summer of 2002 to improve its efficiency and accuracy in processing inmate records, but release errors have continued to occur. Prior to 2002, errors in releasing inmates too early prompted the U.S. District Court for the District of Columbia to request that two agencies review DoC's management of inmate records.[22] These agencies identified problems with inmate record processing, including DoC's lack of policies and procedures related to Records Office management. In response to some of the problems identified, in 2000 DoC implemented a new electronic record system as its primary case management and inmate record system. By the end of October 2002, DoC had simplified the workflow in the Records Office,[23] issued an operations manual, developed a database to help track and resolve discrepancies in inmates' court documents, and provided training for staff. (See app. IV for more information about these DoC improvement efforts.)

To capture information on the sequence of events that led to each identified release error, in 2002 DoC established a new database, known as the Release Discrepancy database. This database is used to generate incident reports that contain information on release errors and to notify management of release errors. In general, DoC's incident reports indicated that some inmates were released early or late because Records Office staff made such errors as (1) processing records without having all pertinent documents, (2) entering information incorrectly into the electronic record system, and (3) not processing documents quickly enough to avoid a release error. Actions that led to these types of errors included misfiling documents, placing documents in a duplicate file folder, placing documents in a pending folder, or filing documents before they were processed. In commenting on a draft of this report, DoC noted that it had analyzed 100 documented late releases in the Release Discrepancy database and used the results to propose corrective actions for reducing such errors. DoC found that in 39 percent of late releases, the cause was lack of timely document processing by Records Office staff. As a result of this analysis, which, according to a DoC official, was conducted in April

[22]The D.C. Corrections Trustee and the Court Services and Offender Supervision Agency Trustee for the District of Columbia conducted these reviews.

[23]DoC's Records Office processes the legal documents that provide authority to move inmates into and out of the Jail and CTF. The Records Office's primary functions are to receive, review, and maintain records from the courts in order to make sentence computations and process inmate admissions, releases, and transfers.

and May 2004, DoC has begun identifying and providing refresher training to staff that are frequently associated with late release errors.

DoC officials further attributed errors in record processing to the large volume of documents received in the Records Office and limited staff resources.[24] According to a DoC official, the Records Office receives an average of 300 to 400 documents a day, and Records Office staff process an average of over 1,500 intakes and releases each month. DoC officials noted that five additional Records Office staff had been hired, and they should help to improve the efficiency of records processing after they are trained.

Although DoC's quality control efforts were intended to improve the operations of its Records Office, DoC did not have sufficiently complete data to determine whether or to what extent these efforts may have reduced early and late releases.[25] Therefore, it is difficult to determine if the intended effects of the improvement efforts were achieved or the extent to which progress has been made in improving electronic inmate records since the District's Office of Inspector General's October 2002 report.[26]

With respect to early releases, DoC may not know the full extent to which this is a problem because DoC may not discover its error until after the fact, which may be after the inmate has been out of DoC custody for some time. Therefore, at a given point in time, DoC cannot be sure it has complete information on early releases. According to DoC records, 22 inmates were released early between January 2002 and February

[24]According to an information technology official at the District of Columbia Courts, plans are being developed for transmitting information to DoC in an automated format, rather than in a hard copy format as is currently the case. The official said that if DoC received inmate case information more quickly, records-processing errors might decrease. The official said he expected the system to be implemented at the end of fiscal year 2005.

[25]For the purposes of this report, we are using the terms "early" and "late" releases to refer to nonjustifiable, and therefore erroneous, releases of inmates. According to DoC officials, there are instances where inmates can be justifiably released before or after their official release date. For example, if the official release date falls on a Saturday, Sunday, or holiday, an inmate may be released on the last business day before the weekend or holiday. As another example, an inmate who receives a court order to be assigned to a residential treatment facility could be released late if bed space is not immediately available in that facility.

[26]Some problems identified in this report included the lack of policies and procedures, inaccurate information in the computer system, and missing official inmate files.

2004. Although these 22 identified cases may understate the true number of early releases, they are instructive for understanding how early releases can occur. According to incident reports completed by DoC, these early releases occurred because of such staff errors as computing the sentence incorrectly or failing to process incoming documents that extended the inmate's detention before the inmate was released. Of the 22 inmates known to have been released early, 17 did not have a release date set because they had at least one legal matter that had not yet been resolved.[27] Although a release date would not have been set for these 17 inmates, DoC defines them as early releases because they were released before the legal matters for which they were detained had been resolved. For example, some inmates were released before they were sentenced or before charges were dismissed. The remaining 5 inmates had received sentences. Of these 5, 4 were released approximately 2 months before their release date and 1 was released almost a year and a half early.[28]

With respect to late releases, DoC did not have full information on the extent of its late releases because until recently, it was using a methodology to identify inmates who had been released late that produced incomplete results. In April 2004, we noted a discrepancy in which two late releases were documented in one set of reports and not in another report covering the same time period.[29] This discrepancy prompted DoC to review the methodology it had used to identify late release cases in its electronic record system. DoC's review revealed that its script—computer code that extracts specific data from a large set of data—had not been

[27]According to a DoC official, inmates may be admitted to DoC upon sentence, admitted and held until the matter is resolved, or admitted and held by DoC until other jurisdictions are able to place and process them. DoC defines an early release as a release that occurs before an inmate's sentence is complete in the absence of a legal document authorizing the inmate's release or a release that occurs before all matters have been legally resolved.

[28]Of the 22 early release errors, 14 were discovered within a week of the error occurring, 6 were discovered between 1 and 5 weeks, 1 was discovered approximately 2 months later, and DoC could not provide us with information on the remaining inmate. The information DoC provided shows that all 22 inmates identified as having been released early were re-apprehended and taken into custody after the error was discovered. Eleven of these occurred within 2 weeks of the mistaken release, 6 occurred between 3 weeks and 9 months later, 4 occurred between 11 and 20 months after the error was made, and one inmate released December 2003 remained at large as of May 2004. Three of the 22 inmates were taken into custody when they were charged with committing new misdemeanors. None of the other 19 inmates had been charged with committing new crimes while out of DoC custody.

[29]One was a report that DoC used to identify late releases, and the second was a group of reports generated by DoC's database to track the basis for the early and late release errors.

written to incorporate all of the relevant information in DoC's automated record system. Specifically, DoC determined that three types of releases could occur for which different time rules for release apply.[30] Prior to April 2004, DoC's methodology identified late releases based on a definition that incorporated primarily one category of release—those made pursuant to court orders. Subsequent to April 2004, the script also incorporated categories of release that were related to when an inmate's sentence had expired, and to the length of time that the inmate had already served relative to his or her sentence length. For February 2004, the only month for which DoC retroactively applied its new methodology and for which data using both the old and new methodology were available, the number of late releases was revised upward from 1 to 18. For the period, February through June 2004, DoC has identified 65 late releases out of 5,112 inmate total releases. This is an error rate of 1.3 percent.[31] We recognize that some level of human error is inevitable in an environment where staff handle 300 to 400 documents per day. Although we do not know what an acceptable level of error may be, the consequences of such errors for individuals who are eligible to be released from detention are very real.

DoC has taken other steps since March 2004 to try to improve the accuracy of the late release data. Specifically, DoC officials reported that they have streamlined the process for identifying late releases, added a review component to that process, and increased staff access to late release data. DoC officials believe that the involvement of more staff in maintaining and analyzing the data will facilitate quicker identification and resolution of data issues. Since we have not reviewed DoC's record system or methodology, we do not know if DoC's recent efforts to improve its script and processes will enable it to identify all late releases. DoC officials

[30]Time rules pertain to the time designated for DoC to process a release. For example, an inmate released pursuant to a court order is considered released late if released more than 48 hours after the time the inmate returns to DoC from court.

[31]In commenting on a draft of this report, DoC informed us that 67 out of 8,233 inmate releases between February and June 2004 were inappropriate. In subsequent communications with DoC, we learned that DoC had discovered an additional early release and that out of 68 inappropriate releases, 65 were late releases and 3 were early releases. Of the 8,233 total releases, 5,112 were releases that could have resulted in a late release into the community, while 3,121 were other types of release transactions, such as releases to the U.S. Marshal's Service, releases to drug programs, and extraditions. We did not include early releases in our computation of the error rate because, as we note on page 20, data on early releases may be understated. We did not include the 2,121 cases involving other types of release transactions because they did not involve releasing inmates into the community.

told us, however, that DoC is monitoring the script's ability to detect late releases to ensure that it is immediately modified if necessary.

Conclusions

DoH's inspections produce important information on health and safety deficiencies that occur at the District's detention facilities. DoC could further benefit from the information it receives from DoH if the information it receives in inspection reports contained the specific date, time, and location of each identified deficiency. This could help DoC determine the prevalence of the identified deficiency, whether it was new or recurring, if the deficiency had already been fixed, and if health and safety conditions at the facilities are generally improving, worsening, or staying the same over time.

The Office of Property Management recognizes the importance of, and has begun to take steps toward, developing policies and procedures that will guide its project managers in planning and managing capital improvement projects. We commend the Office of Property Management for forming a working group to develop standard operating procedures for managing projects. However, as of June 2004, time frames for the working group to complete its assignment had not been established. We believe such time frames would be useful to the Office of Property Management for ensuring accountability and monitoring its desired pace of progress toward implementing policies and procedures against its actual pace of progress. Helping ensure that the work of the working group stays on schedule will also better position the Office of Property Management for effectively managing the implementation of the Jail's capital improvement projects.

Recommendations for Executive Action

To help DoC determine the prevalence of health and safety deficiencies at the Jail and monitor changes in facility conditions over time, we recommend that the Mayor direct the DoC Director to take the following action:

- coordinate with the Director of DoH to develop an inspection report format that will provide DoC with specific information on the date, time, and location of each health and safety deficiency identified.

To help strengthen management of capital improvement projects, we recommend that the Mayor direct the Director of the Office of Property Management to take the following action:

- establish time frames for completing its work on developing and implementing policies and procedures.

Agency Comments and Our Evaluation

We requested comments on a draft of this report from the District's DoC, DoH, Office of Property Management, and OIG. Between July 8 and July 14, 2004, we received written comments on the draft report, and these are reproduced in full in appendixes VII through X. DoH concurred with our finding that inspection reports did not consistently identify locations where deficiencies were found and agreed to our recommendation that it develop a detailed inspection report format. In response to a comment by DoC, we dropped a recommendation in our draft report that DoC conduct an analysis of reasons why inmate release errors occurred and use the results to make data-based decisions on how to reduce staff errors. In its July 9 letter, DoC provided new information indicating that it had conducted such an analysis, and it was taking corrective action to reduce such errors. The Office of Property Management did not comment on our recommendation that it establish time frames for completing its work on developing and implementing policies and procedures to help strengthen the management of capital improvement projects. The OIG limited its comments to affirming that we accurately portrayed the findings and recommendations contained in its October 2002 inspection report on the Jail. DoC, DoH, and the Office of Property Management also made additional substantive comments, which we address below. Additionally, DoC, DoH, and the Office of Property Management provided additional context and clarifying information as well as technical comments, which we incorporated into the report as appropriate.

- With respect to health and safety inspections:

1. DoC noted that by addressing the lack of specificity in DoH inspection reports, we focused attention on a significant issue. DoC believes it would be useful for it to receive detailed inspection reports containing specific information on the location, severity, and frequency of occurrence of identified deficiencies. In response to our recommendation, DoH has indicated that it will have a new, detailed inspection tool ready for use in correctional facility inspections by September 1, 2004. Such a tool should help DoC's concern that existing reports—which discuss deficiencies that may be minor or limited in extent—may produce an inaccurate overall picture of conditions at the Jail.

2. DoH and DoC commented on our observation that inspections at the detention facilities were conducted using two different sets of

standards—American Correctional Association standards at the Jail and American Public Health Association Standards at CTF. Both DoH and DoC believe it would be preferable to use the same set of standards when inspecting the Jail and CTF. In contacts with DoH and DoC subsequent to our receipt of their comment letters, we learned that beginning September 2004, DOH intends to use American Public Health Association Standards in its Jail inspections, and that DoC welcomes this change.

3. DoC said that our report highlighted specific DoH inspection results that were incorrect. DoC cited airflow, lighting, and fire safety as examples of areas in which DoH either used an erroneous standard or arrived at an inaccurate conclusion. We note on page 2 and in appendix I of the report that it was beyond the scope of this review to determine whether the DoH inspector applied the health and safety standards correctly, took accurate measurements, or accurately reported the inspection results. In compiling information on health and safety conditions at the Jail and CTF, we relied on DoH inspection reports because prior court orders and recently passed legislation require DoH to conduct environmental health and safety inspections of the Jail at least three times a year and prepare and provide a report to the District's Council. DoH health and safety inspection reports represent the District's official record of the Jail's health and safety conditions. The Office of Inspector General's October 2002 inspection report on the Jail similarly relied on DoH inspection reports.

   Pursuant to DoC's comments, however, we reviewed the standards pertaining to airflow, lighting, and fire safety that DoC cited. For example, DoC stated that on numerous occasions, DoH applied the wrong metric or standard (that is, feet per minute rather than cubic feet per minute to measure airflow, and 30 foot-candles rather than 20 foot-candles to measure lighting) in assessing whether an area being inspected was above or below the standard. DoC also believed that heat detectors, which were located in areas that DoH identified as having missing smoke detectors, provided fire protection, thereby obviating the need for smoke detectors in those locations. Further, DoC disputed DoH's findings that smoke detectors in the Jail were not working or were missing. DoC maintained that in some instances, smoke detectors that were reported as not working were, in fact, working.

   Based on our review of the specific standards related to airflow, lighting, and fire safety, in conjunction with input from the DoH administrator responsible for inspections at the Jail, we determined

that DoC was correct in saying that there were specific instances in which the DoH inspector applied an incorrect standard. The DoH administrator told us that DoH is taking corrective action, including training inspectors on the application of the standards, to ensure that errors won't happen again. We removed from the report any reference to DoH inspection results that cited feet per minute as a measure of airflow and foot -candles as a measure of lighting. However, we retained information that documented instances in which there was no airflow and problems with lighting fixtures in inmates' cells.

With respect to fire safety, a FEMS fire safety inspector told us that heat detectors do not meet local fire safety codes for residential areas such as cellblocks. Therefore, according to the inspector, heat detectors would not be an appropriate replacement for cellblocks that were reported as missing smoke detectors at the time of an inspection. Concerning DoC's comment that DoH erroneously reported working smoke detectors as not working, it is impossible for us to know if smoke detectors were or were not working at a given point in time.

- With respect to DoC's capital improvement projects:

1. DoC did not agree with the way we reported the status of the last three projects in table 1; that is, the staff and visitors' entrances, inmate shower renovations, and exterior structural refinishing projects. Based on information from the Office of Property Management—the District's implementing agency for the Jail's capital improvement projects—we had listed the status of these three projects as being in the "process of finalizing scope of work with DoC." According to DoC, however, these three projects are in the design phase. Pursuant to DoC's comments, we contacted the Office of Property Management's project manager for the Jail's projects, and he maintained that these three projects were not yet in the design phase because their scope of work had not yet been finalized. We modified Table 1 to indicate that there exists a disagreement between DoC and the Office of Property Management concerning the status of these three projects.

2. DoC took issue with a statement in our report in which we stated that following a shooting incident in December 2003, DoC accelerated the installation of the closed circuit television portion of the Jail's electronic security system project. DoC commented that the closed circuit television project was initiated in August 2003, months before the shooting incident, and that there was no connection between these two actions. We did not intend to imply that closed circuit television project was initiated as a result of the shooting incident. Instead, we

cited this incident as an example of an unexpected event that caused an existing capital project to be accelerated. According to the Office of Property Management project manager who is responsible for implementing this project, he was asked to expedite the installation of the closed circuit television project after the shooting incident, and this was to take precedence over all other projects. Following receipt of DoC's comment letter, DoC's chief facilities manager told us that the closed circuit television project was already moving quickly toward construction in December 2003, but that the shooting incident further accelerated the project. We modified language in the report to reflect this information.

3. In response to comments by DoC and the Office of Personnel Management concerning the availability of current working estimates and scheduled time frames for completing the projects, we incorporated this information into table 1.

4. The Office of Property Management expressed concern that our draft report implied that its capital projects at DoC were not well managed. We did not assess the Office of Property Management's management of the Jail's capital projects, and we did not intend such an implication. We state in the report that we did not systematically review the management of the Jail's capital improvement projects, nor did we determine whether management issues may have contributed to increased costs or time frames for certain projects. We added language to further clarify that we have no information indicating that the Office of Property Management's projects at the Jail are not well managed.

- With respect to release errors:

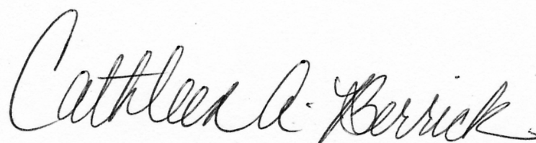
1. DoC expressed concern that our report does not put the issue of release errors in proper perspective, and therefore casts DoC's performance in this area in an undeservedly negative light. DoC pointed out that its Records Office staff manually processes large volumes of documents and that no workflow system is 100 percent error free. DoC further reported that between February and June 2004, its rate of inmate release errors was only 0.81 percent, a rate that DoC believes is within the norm when compared with other manual work process systems. We agree with DoC that it is unreasonable to expect perfection when dealing with a manual, high-volume paperwork process. We do not know, however, what an acceptable error rate is for large-scale manual records-processing systems, particularly when the consequence of an error may be the erroneous release of a jail inmate. To illustrate that DoC's error rate is within the norm, DoC directed us to a Web site containing two e-mail messages

indicating that industries with robust, data-driven cultures commit 3 to 4.5 process errors per 1,000 opportunities. The e-mail messages do not contain sufficient information for us to determine their reliability or if they are comparable to DoC's records data. Therefore, the appropriateness of using these reported error rates as a benchmark for DoC's reported error rates is unclear. We note, however, that 3 to 4.5 errors per 1,000 represent error rates of 0.30 and 0.45 percent, a fraction of DoC's reported error rate. We added language to the report indicating that it is unrealistic to expect that a data entry system based on manual processing of large volumes of paperwork to be error free and that we have no basis for determining what an acceptable rate of error is.

2. DoC felt that we should give it credit for publicly and routinely reporting release errors. DoC stated that few, if any, other correctional systems do this. We do not know how DoC compares with other systems in publicly reporting release errors because comparing DoC with other correctional systems was outside the scope of our review.

As agreed with your office, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days from its issue date. At that time, we will send copies of this report to the District's Mayor and other interested parties. We will also make copies available to others upon request. In addition, the report will be available at no charge on GAO's Web site at http://www.gao.gov. Major contributors to this report are listed in appendix XI. If you or your staff have any questions concerning this report, contact Evi Rezmovic, Assistant Director, or me on (202) 512-8777.

Sincerely yours,



Cathleen A. Berrick
Director, Homeland Security and Justice Issues

Appendix I: Objectives, Scope, and Methodology

Our objectives were to determine (1) the results of recent health and safety inspections at the Jail and Correctional Treatment Facility (CTF), (2) the number and status of capital improvement projects at the Jail and issues related to the management of these projects, and (3) the progress made in improving electronic inmate records at the Jail. To address these objectives, we met with and obtained information from corrections officials at the District's Department of Corrections (DoC) headquarters, the Jail, and CTF; interviewed officials at the District's Office of the Inspector General; and reviewed applicable District laws and regulations.

To determine the results of the health and safety inspections at the Jail and CTF, we interviewed officials at the District's Department of Health (DoH) and Fire and Emergency Medical Services, reviewed DoC and Corrections Corporation of America (CCA) policies and procedures, American Correctional Association *Standards for Adult Local Detention Facilities* and the American Public Health Association's *Standards for Health Services in Correctional Institutions.* We also reviewed all available reports on DoH health and safety inspections of the Jail and CTF prepared between March 2002 and April 2004. We developed a data collection instrument to record the deficiencies reported by DoH.

Through discussions with DoH officials, we obtained information on DoH's methodology for conducting inspections and the standards applied to the Jail and CTF inspections. We did not assess the quality of how DoH completes its inspections, nor were we able to determine the prevalence, seriousness, or recurrence of deficiencies identified. This was because the DoH reports did not always record specific information on the location of each deficiency. Our data collection instrument captured information on those deficiencies that the District's Office of the Inspector General (OIG) reported in its October 2002 report.

To report on the findings of fire safety inspections, we reviewed three Fire and Emergency Medical Services inspection reports—two for the Jail dated January 2002 and January 2003 and one for CTF dated September 2003. In 2002, a follow-up inspection of violations previously cited in 2001 was completed. This inspection also served as the annual inspection. Because deficiencies were not found, Fire and Emergency Medical Services did not issue a report of findings. We did not assess the quality of the fire safety inspections. However, through discussions with Fire and Emergency Medical Services officials, we gained an understanding of Fire and Emergency Medical Services' methodology for conducting fire safety inspections and the fire safety codes applied.

To determine the status of the Jail's 16 capital improvement projects, we interviewed officials at the District's Office of Property Management and its Office of the Chief Financial Officer. We also reviewed documentation, including project status reports. To obtain information on the scope of the Jail's capital projects, we reviewed DoC's *Capital Improvements Program*, as of August 2003. To identify management issues, we reviewed the Office of Property Management's project management, but we did not conduct an in-depth evaluation on the effectiveness of its management. To observe the capital improvement projects under construction, we accompanied DoC officials on a tour of the Jail. We did not assess the quality of work on of the Jail's projects that were in design or construction or that had been completed at the time of our review. To gain an understanding of construction best practices and capital projects, we reviewed industry resources from the Project Management Institute, *Project Management Institute Standards Committee*, *A Guide to the Project Management Body of Knowledge*, and prior GAO reports.[1]

To describe the changes that DoC has made to improve the accuracy of inmate records, we met with DoC officials, including its Records Office staff. We also reviewed DoC's *Operations Manual* and policies, including internal controls for inmate records. To determine whether there had been an increase or decrease in the number of early or late releases, we obtained DoC summary data for inmates that had been mistakenly released before or after their official release date. Specifically, we reviewed early release data for the period January 2002 through February 2004. Our review of late release data included inmates released in May 2002 through February 2004 and total releases for the same time period. We also reviewed federal internal control standards to gain an understanding of the types of control activities that may be applied for information processing and staff training.[2] We did not directly observe record processing to determine the causes for and the full range of errors made by Records Office staff.

[1] GAO, *Kennedy Center: Improvements Needed to Strengthen the Management and Oversight of the Construction Process*, GAO-03-823 (Washington, D.C.: September 5, 2003), and GAO, *United Nations: Early Renovation Planning Reasonable, but Additional Management Controls and Oversight Will Be Needed*, GAO-03-566 (Washington, D.C.: May 30, 2003).

[2] GAO, *Standards for Internal Control in the Federal Government*, GAO/AIMD-00-21.3.1 (Washington, D.C.: Nov. 1999).

To assess the reliability of release data, we reviewed the process by which DoC tracks these data and the extent to which each relevant data element is complete and accurate. To do this, we interviewed DoC staff about the processes used to capture early and late release errors, the controls over those processes, and the data elements involved. For late release errors, we also traced data to their corresponding source documents. We identified inconsistencies in the information, prompting DoC to review its methodology for identifying late releases. DoC's review led it and us to conclude that its methodology had been incomplete and had produced an undercount of the true number of late releases. DoC modified its methodology in April 2004 to be more comprehensive.

For capital improvement projects at CTF, we obtained relevant information for only those projects completed in 2003. We did not review the CCA's project management for these projects because this was outside the scope of our review. To identify the types of programs and services that the Jail and CTF provide, and the facilities' annual costs during 1999 through 2003, we met with DoC and CTF officials and reviewed program descriptions. To determine the annual cost of these facilities, we reviewed DoC budget documents, including the costs of the Jail, and CCA's summary reports on income and expenses for CTF for each year included in our review.

We conducted our review from June 2003 to July 2004 in accordance with generally accepted government auditing standards.

Appendix II: Capital Improvement Projects at the Correctional Treatment Facility

As part of its contract with the District to manage CTF, CCA performs capital improvements at the facility that are intended to remedy current or potential breaches of security or improve the facility's normal operations. CCA defines capital improvements as those valued at $5,000 or more and may include furnishings, equipment, vehicles, or alterations to the facility.[1] As shown in table 2, during 2003, 11 capital improvement projects were completed at CTF at a total cost of $289,956. Of these 11 projects, 3 were designated emergency projects. These 3 projects (that is, the last 3 shown in table 2) were associated with CTF's kitchen and were deemed by Corrections Corporation of America to be necessary in order to provide meals for the Jail's inmates while the Jail's kitchen was closed for renovation.

Table 2: Capital Improvement Projects at CTF Completed during 2003

Project	Cost
Replace existing fire alarm system	$125,000
Batteries and chargers for radios	30,000
Fabricate four noncontact visit cages	6,300
New perimeter truck	15,000
Replace cameras and monitors	25,000
Pave perimeter road	10,515
Switchgear preventive maintenance[a]	27,252
Batteries for switchgear[a]	12,850
Ovens	11,795
Steamers	12,244
Two new chilled water coils	14,000
Total	**$289,956**

Source: GAO analysis of information provided by Corrections Corporation of America.

[1] CCA's definition of a capital improvement differs from that of the District. The District defines capital improvements as a permanent improvement to a fixed asset that is valued at $250,000 or more with an expected life of more than 3 years.

[a] Corrections Corporation of America's capital improvement projects do not include the day-to-day maintenance and general repair of existing equipment. These were improvements designed to extend the longevity of the equipment that helps distribute power coming into CTF from the District.

Appendix III: Results of Health and Safety Inspections at the Jail

This appendix provides information on the results of the District's DoH health and safety inspection reports prepared between March 2002 and April 2004 for health and safety inspections of the Jail. We reviewed six inspection reports that included information on deficiencies identified for the following: (1) air quality, (2) vermin, (3) fire safety, (4) plumbing, and (5) lighting.

Air Quality

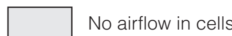
As shown in figure 1, problems with air quality were reported in four of six inspection reports. Specifically, in four of the reports, DoH reported that at the time of an inspection, there was no airflow. According to a DoH official, "no airflow" included those instances in which there was no measurable airflow coming out of the vent during an inspection. For example, in October 2003, DoH reported that in general, all cellblocks had cells with no airflow.

Figure 1: Air Quality deficiencies at the Jail as Reported by DoH in Reports Prepared between March 2002 and April 2004

	Deficiency type identified	Extent of problem reported
Mar 02	N	NA
Aug 02	Y	S
Nov 02	Y	10 cb
Apr 03	N	NA
Oct 03	Y	18 cb
Apr 04	Y	M

Y = Yes N = No

S = Some cb = cellblock(s)
NA = Not applicable
M = Most


No airflow in cells

Source: GAO analysis of data collected from the District's Department of Health inspection reports of the Jail.

Vermin

DoH found evidence of vermin in all six inspections. DoH found vermin in, among other areas, the Jail's main kitchen, loading dock, dry storage, and officer dining areas. Mice and flies were the types of vermin DoH found most frequently. For example, in its October 2003 report, DoH reported that bread loaves with holes and mice droppings were found in the bread

storage room. In each of its six inspections, DoH found evidence of flies, primarily in the inmate shower areas. In August 2002, showers in 8 cellblocks were reported as having flies. In April and October 2003, DoH noted flies coming from under the showers in each of the 18 cellblocks inspected. DoH reported in April 2004 that flies were observed in shower areas, but the report did not specify the number of cellblocks affected. Figure 2 shows the vermin types identified in the kitchen areas and showers.

Figure 2: Vermin Deficiencies at the Jail as Reported by DoH in Reports Prepared between March 2002 and April 2004

	Mice	Rats	Flies	Main kitchen	Dishwashing	Loading dock	Dry storage	Other	Shower
Mar 02	Y	N	Y	NA	NA	NA	NA	Y[a]	Y
Aug 02	N	Y	Y	Y	N	Y	N	N	Y
Nov 02	Y	N	Y	N	N	N	Y	Y[b]	Y
Apr 03	Y	N	Y	Y	Y	Y	Y	Y[b]	Y
Oct 03	Y	N	Y	Y	Y	Y	Y	Y[b]	Y
Apr 04	N	N	Y	N	N	N	N	N	Y

Y = Yes N = No

NA = Not applicable

Vertical groupings: Vermin type reported (Mice, Rats, Flies); Kitchen areas (Main kitchen, Dishwashing, Loading dock, Dry storage, Other); Shower areas (Shower)

Source: GAO analysis of data collected from the District's Department of Health inspection reports of the Jail.

[a]Officer dining area.

[b]Bread storage area and hallway near canteen storage.

Fire Safety

DoH found an insufficient number of fire extinguishers, smoke detectors that were either missing or not working, and other fire safety deficiencies at the Jail. Figure 3 identifies each of the deficiencies. In five of six inspections, fire extinguishers were reported as being improperly stored. For example, in August and November 2002, DoH reported that extinguishers were placed on the floor when they should have been mounted on the wall. All six reports noted that fire extinguishers throughout cellblocks inspected had inaccurate or missing documentation indicating that they been inspected.

DoH reported that in five of six inspections, there were cellblocks without the required number of fire extinguishers. According to the DoH reports, each cellblock is to have three extinguishers. Burnt-out or nonworking exit lights were also noted in all six inspection reports we reviewed.

Figure 3: Fire Safety Deficiencies at the Jail as Reported by DoH in Reports Prepared between March 2002 and April 2004

Deficiency type	Deficiency type identified						Extent of problem reported					
	Mar 02	Aug 02	Nov 02	Apr 03	Oct 03	Apr 04	Mar 02	Aug 02	Nov 02	Apr 03	Oct 03	Apr 04
Missing fire extinguishers	N	Y	Y	Y	Y	Y	NA	1 cb	1 cb	1 cb	1 cb	S
Improper storage of fire extinguishers	N	Y	Y	Y	Y	Y	NA	other	other	1 cb & other	1 cb & other	S
Insufficient number of fire extinguishers	N	Y	Y	Y	Y	Y	NA	1 cb & other	other	1 cb	1 cb	S
Uninspected fire extinguishers	N	N	Y	N	N	N	NA	NA	16 ext.	NA	NA	NA
Fire extinguishers with inaccurate or missing inspection dates documented	Y	Y	Y	Y	Y	Y	T	1 cb & other	5 cb & other	T	8 cb & other	cb & other
Broken flashlights	Y	Y	Y	Y	Y	N	7 cb	7 cb	7 cb	7 cb	7 cb	NA
Emergency lights not working	N	N	Y	N	N	N	NA	NA	1cb	NA	NA	NA
Exit lights burnt out or not working	Y	Y	Y	Y	Y	Y	1 cb	other	1 cb & other	1 cb & other	1 cb & other	1 cb & other
Smoke detectors not working	N	N	Y	Y	Y	N	NA	NA	1cb	3cb	3cb	NA
Smoke detectors not connected to electrical system	N	N	Y	N	N	N	NA	NA	NR	NA	NA	NA
Missing smoke detectors	Y	Y	Y	Y	Y	Y	S	S	S	S	S	3 cb & other

Y = Yes N = No

S = Some
T = Throughout
NR = Not reported
NA = Not applicable
Other = Areas other than cellblock
Ext = Extinguishers

c = cell(s)
cb = cellblock(s)

Source: GAO analysis of data collected from the District's Department of Health inspection reports of the Jail.

Plumbing

DoH reports identified such plumbing deficiencies as (1) nonoperational plumbing fixtures, (2) unavailability of hot or cold water, (3) sinks and toilets with low water pressure, and (4) malfunctioning showers. For example, in its October 2003 inspection, DoH found that in all 18 cellblocks inspected, there were faulty plumbing fixtures. The DoH inspector reported in April 2004 that at that time, there were fewer problems with plumbing fixtures than in October 2003. DoH found in all

six of its inspections that inmate cells throughout the Jail lacked hot or cold water.

Low water pressure affecting inmate sinks and toilets was noted in all six DoH reports. In each inspection report, low water pressure was reported as occurring in some instances throughout the 18 cellblocks inspected. In April 2003, DoH reported that there were some instances in which the water pressure was so low that it was impossible for the sinks to be used for hand washing. According to a DoC official, most water pressure problems in cellblocks had been caused by blockages caused by debris from old pipes and plumbing fixtures. Figure 4 presents plumbing-related deficiencies—other than those pertaining to showers—identified in DoH reports.

Figure 4: Plumbing Deficiencies at the Jail as Reported by DoH in Reports Prepared between March 2002 and April 2004

	Deficiency type identified			Extent of problem reported		
	Nonoperational plumbing fixtures	Cells without hot and/or cold water	Low water pressure	Nonoperational plumbing fixtures	Cells without hot and/or cold water	Low water pressure
Mar 02	Y	Y	Y	T	T	S
Aug 02	Y	Y	Y	93 c	T	S
Nov 02	Y	Y	Y	117 c	T	S
Apr 03	Y	Y	Y	NR	T	S
Oct 03	Y	Y	Y	18 cb	T	S
Apr 04	Y	Y	Y	NR	30 c	S

Y = Yes N = No

S = Some
T = Throughout
NR = Not reported
c = cell(s)
cb = cellblock(s)

Source: GAO analysis of data collected from the District's Department of Health inspection reports of the Jail.

In all six of its inspections, DoH found broken showers that could not be used. The number of cellblocks affected ranged from 1 to 8. All six reports also indicated that between 2 and 13 cellblocks had water temperatures above or below the suggested range for inmate safety and hygiene. The number of cellblocks affected ranged from 2 in March 2002 to 13 in April 2003. Each inspection found showers with leaking knobs, affecting

between 1 and 2 cellblocks. Figure 5 presents the shower-related deficiencies identified in DoH reports.

Figure 5: Shower Deficiencies at the Jail as Reported by DoH in Reports Prepared between March 2002 and April 2004

	Deficiency type identified				Extent of problem reported			
	Showers did not work or were broken or could not be used because of malfunctioning	Shower temperature was too hot or too cold	Shower knob leaking	Damaged floor treatment	Showers did not work or were broken or could not be used because of malfunctioning	Shower temperature was too hot or too cold	Shower knob leaking	Damaged floor treatment
Mar 02	Y	Y	Y	N	2 cb	2 cb	2 cb	NA
Aug 02	Y	Y	Y	Y	5 cb	13 cb	1 cb	4 cb
Nov 02	Y	Y	Y	Y	8 cb	3 cb	2 cb	12 cb
Apr 03	Y	Y	Y	Y	4 cb	13 cb	2 cb	4 cb
Oct 03	Y	Y	Y	Y	4 cb	8 cb	2 cb	4 cb
Apr 04	Y	Y	Y	Y	1 cb	3 cb	1 cb	4 cb

Y = Yes N = No

NA = Not applicable c = cell(s) cb = cellblock(s)

Source: GAO analysis of data collected from the District's Department of Health inspection reports of the Jail.

Lighting

All six DoH inspections found problems with light fixtures, including burnt-out lightbulbs and damaged light fixtures. Figure 6 presents information on this deficiency.

Figure 6: Lighting Deficiencies at the Jail as Reported by DoH in Reports Prepared between March 2002 and April 2004

	Deficiency type identified	Extent of problem reported
Mar 02	Y	3 c/2 cb
Aug 02	Y	160 c/15 cb
Nov 02	Y	119 c/17 cb
Apr 03	Y	T
Oct 03	Y	T
Apr 04	Y	NR

Y = Yes N = No

T = Throughout
NR = Not reported
c = cells(s)
cb = cellblock(s)

Source: GAO analysis of data collected from the District's Department of Health inspection reports of the Jail.

Appendix IV: Quality Controls DoC Implemented to Improve the Accuracy of Inmate Records

DoC has taken several steps since the summer of 2002 to improve the efficiency of records processing and the accuracy of inmate records. DoC simplified the workflow in the Records Office and implemented a number of quality controls over its inmate records processes by the end of October 2002. For example, DoC sought to improve the handling of incoming paperwork by reorganizing the layout of the Records Office and changing the process for entering records into the system. Workstations were centralized to streamline the distribution of documents for processing. To minimize the possibility of misplacing paperwork, the process for entering records was changed so that a record transaction is handled from beginning to end by a single staff member rather than by several staff members as was previously done. Additionally, DoC implemented a number of quality control measures consistent with federal control standards that require agencies to (1) clearly document transactions, conduct edit checks of data entered into systems, and reconcile summary information to verify the completeness of the data and (2) train employees so they have the skills necessary to meet changing organizational needs. DoC took the following steps, among others, to improve the accuracy of its inmate records:

- To clearly document how to conduct transactions, DoC issued an operations manual in August 2002. The manual details steps that are to occur during such records transactions as intake, transfer, court return, and temporary and permanent release of inmates. Since October 2002, DoC has been preparing incident reports containing information on how release errors have occurred.

- To verify the completeness and accuracy of its data, DoC has also been generating numerous quality control reports. In addition, to reconcile discrepancies in inmates' court documents, DoC has developed a database to help DoC track and subsequently resolve errors in these documents. For example, when a Records Office staff member encounters a discrepancy in these documents, he or she is to file a report and e-mail it to the DoC staff person responsible for contacting the courts.

- To improve guidance and training for employees, DoC officials developed a tool to identify those individuals with low productivity or those who worked on a record that resulted in a release error who may need additional guidance and training. Also, DoC provided training on the use of its operations manual in months following its initial release and additional training each time the manual has been updated to ensure that staff are familiar with the new procedures.

Appendix V: Programs and Services Provided at the Jail and the Correctional Treatment Facility

For the period 1999 through 2003, the cost of operating and maintaining the Jail was about $195 million and about $121 million for CTF. At the time of our review, DoC and CTF officials told us that volunteers administer many of the inmate programs and services offered at these two facilities and that other programs and services are included in the operation costs for each facility. For example, food services are administered at both facilities through DoC's contract with the ARAMARK Corporation and are therefore included in DoC's contract costs.[1] We did not obtain cost information for those programs and services that DoC and CCA fund. As shown in table 3, in 2003 DoC and CCA provided a variety of programs and services for inmates housed in these facilities, including, among other things, work, health services, and education.

Table 3: Programs and Services Provided at the Jail and CTF in 2003

Facility	Program and service areas
Jail	Substance abuse treatment and education
	Academic and vocational education
	Prerelease readiness
	Work detail
	Recreation
	Religion
	Mail
	Telephone
	Visitation
	Classification
	Case management
	Health and mental health
	Food
	Sanitation and hygiene
Correctional Treatment Facility	Substance abuse treatment and education
	Academic and vocational education
	Prerelease
	Work detail
	Recreation

[1] In April 2003, DoC entered into a contract with the ARAMARK Corporation to provide food services at the Jail and CTF, according to a DoC official.

Facility	Program and service areas
	Religion
	Mail
	Telephone
	Visitation
	Classification
	Case management
	Health and mental health
	Food
	Legal
	HIV/AIDS prevention education
	Therapeutic community
	Volunteer services
	Adjusting Our Attitude Training
	Barber science
	Graphic arts

Source: GAO analysis based on information provided by the District of Columbia's Department of Corrections and Corrections Corporation of America.

Appendix VI: DoC's Implementation of the District of Columbia's Office of the Inspector General's Recommendations

In its *Report of Inspection of the Department of Corrections, October 2002*, the Office of the Inspector General made a number of recommendations for the D.C. Department of Corrections. The table below identifies OIG's findings and recommendations for issues pertinent to our review for which DoC and OIG agreed DoC needed to demonstrate compliance. While DoC has provided interim documentation of the progress being made to address OIG's recommendations, an OIG official said that a final determination of compliance would be made when the OIG conducts its reinspection. The official said the reinspection date has not been scheduled.

Table 4: The District's Office of the Inspector General's Findings and Recommendations to the Department of Corrections

OIG finding	OIG recommendation
Deficiencies cited during the Department of Health (DoH) and Department of Consumer and Regulatory Affairs (DCRA) inspections remain unabated in violation of the stipulation following the Federal Appellate Court's decision in *Campbell v. MacGruder,* 580 F. 2d 521 (D.C. Cir. 1978).	That the Director, DoC, direct the Warden Central Detention Facility (CDF) / Compliance Officer and Cellblock Officer(s) in charge to ensure that the deficiencies cited in inspections provided by internal and external agencies are abated.[a]
	That the Director, DoC, direct staff to comply with DOC housekeeping policies and procedures.
Despite numerous studies of the Records Office and recommendations for improvements, its poor handling of inmate records and other information continues to cause significant problems, including premature and delayed release of inmates.	That the Director, DoC, establish policies and procedures to verify the accuracy of data in the Jail and Community Corrections System (JACCS).
	That the Director, DoC, establish policies and procedures to ensure accurate sentence computations are entered into JACCS to ensure that inmates are not held beyond their release dates.
	That the Director, DoC, establish quality control policies and procedures for use by the Records Office during quarterly reviews of information in JACCS.
	That the Deputy Warden for Programs immediately takes action to locate or re-create all missing official inmate files.
	That the Director, DoC, require the Deputy Warden for Programs to develop a means of tracking inmate file folders.
	That the Director, DoC, complies with the Trustee, D.C. Court Services and Offender Supervision Agency, recommendation R-22 to U.S. District Judge Royce Lambert, which states: "Grade enhancements—place high performing staff in lead Legal Instrument Examiner (LIE) and supervisory positions."
	That the Director, DoC, comply with all outstanding D.C Court Services and Offender Supervision Agency Trustee recommendations submitted to U.S. District Court Judge Royce Lambert in the Court Services and Offender Supervision Agency Trustee's report on the release of Oscar Veal, Jr.

OIG finding	OIG recommendation
CDF management had not complied with federal law and Building Officials and Code Administrators (BOCA) International Inc. National Fire and Prevention Codes.	That the Director, DoC, and CDF management request inspections of the CDF by DC Occupational Safety and Health and the DC Fire and Emergency Medical Services Department.
	That the Director, DoC, and CDF management stack, secure, and properly seal all materials up and away from the light fixtures and passageways.
CDF management had not complied with federal law regarding written emergency evacuation plans.	That DoC and CDF management develop and implement a written emergency evacuation plan with a floor plan showing the routes of exit as required by 29 CFR 1910.38 (a) (1) (2001).
Poor housekeeping practices and vermin contamination were observed throughout the CDF.	That the Director, DoC, and CDF management maintain and enforce a daily general maintenance and cleaning program.
The ventilation and overall indoor air quality inside the CDF ranged from poor to inadequate.	That the Director, DoC, and CDF management install a heating ventilation and air conditioning unit that is properly equipped to filer out airborne contaminants, such as bacteria and harmful viruses.
	That the Director, DoC, request that DC Occupational Safety and Health conduct an indoor air quality sampling at the CDF.
The floors, aisles, and passageways in the warehouse area of the CDF were blocked or cluttered with miscellaneous items in violation of federal law regarding safe clearances and passageways.	That the Director, DoC, ensure that CDF management complies with 29 CFR 1910.22 (2001) and keeps all floors, aisles, and passageways clear and in good repair.
Floors in the passageways to the cellblocks are not maintained in a clean and sanitary condition as required by federal law.	That the Director, DoC, ensure that CDF management cleans, sanitizes, and removes the chipped paint and mold from the floors.
Food spills on the floors impair safe movement.	That the Director, DoC, and CDF management repair the leaking pipes and broken floors in the culinary unit.
	That the Director, DoC, and CDF management clean and sanitize all areas of the floor in the culinary unit daily and as frequently as necessary to maintain cleanliness and sanitization.

Source: GAO generated information based on the District of Columbia's Office of the Inspector General report.

[a]CDF is also known as the D.C. Jail.

Appendix VII: Comments from the District of Columbia, Department of Corrections

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF CORRECTIONS

Office of the Director

July 9, 2004

Ms. Cathleen A. Berrick
Director, Homeland Security and Justice Issues
U.S. General Accounting Office
441 G. Street N.W.
Washington, D.C. 20548

Dear Ms. Berrick:

This transmittal constitutes the D.C. Department of Corrections' (DOC) response to the U.S. General Accounting Office's (GAO) draft report entitled, "Management Challenges Exist In Improving Facility Conditions and Inmate Records." At the outset let me say that the Department of Corrections benefited significantly from your recent process review. Chief among the benefits was needed clarification in the definition of "late release" and development of a more comprehensive approach to selecting records for post release review. In addition, the report focuses on long-standing, unresolved issues related to external inspections, especially the need to specify deficiencies as to location, severity and frequency of occurrence. The report also makes an important contribution by documenting the existence of conflicting standards. Clearly, there is an obvious need to apply standards appropriate for the inspection of correctional facilities.

I do have a few major concerns regarding the content of the report, which are set forth below. These concerns are in the areas of Environmental Deficiencies, Release Errors, and the Capital Improvements Program. The comments that follow are intended to put selected findings in proper perspective, and correct a few erroneous statements.

1. The report highlights environmental deficiencies that are based on erroneous standards historically applied in Central Detention Facility (CDF) inspections.

Specific examples include airflow and lighting. Numerous inspection reports state that the airflow at the facility was found to be above the American Corrections Association (ACA) standard of 75 feet per minute. This is inaccurate because airflow is properly measured in units of volume per time (e.g., cubic feet per minute), and not in terms of units of velocity, i.e., feet per minute. The ACA standard for minimum airflow is 15 cubic feet per minute (CFM) [3-ALDF-2D-07], not 75 CFM. The reports also state incorrectly that the ACA maximum airflow standard is 400 CFM. In fact, there is no such ACA standard. In the case of lighting, the inspection reports state that the ACA

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Letter to Cathleen A. Berrick, Director, Homeland Security & Justice Issues, GAO
Page 2
July 9, 2004

minimum lighting standard is 30 foot-candles. The applicable ACA minimum lighting standard is, in fact, 20 foot-candles [3-ALDF-2D-02].

2. The fire safety and vermin deficiencies noted in the report are both inaccurate and overstated.

The GAO referenced an inspection report, which noted, "… some areas of the institution [CDF] were missing smoke detectors." The areas noted are not missing smoke detectors. Smoke detectors were never installed in those areas because heat detectors, which are working fine, provide fire protection. Maintenance personnel checked the smoke detectors in S3, N2 and N3, which were reported as not working; they were found to be working fine. Additionally, the D.C. Fire and Emergency Medical Services Department's Fire Investigator inspected the facility on April 21, 2003 and found the entire facility to be in compliance with all fire safety procedures and codes. The Department of Corrections has developed a project within its Capital Improvements Program (CIP) to install a comprehensive upgrade of the fire alarm system at the facility. This will significantly enhance fire safety at the institution.

Minor observations of vermin (e.g., 2 flies) were routinely reported as deficiencies in various inspection reports. Vermin control is a continuous challenge because of the nature and size of the facility, its age, and its physical location. DOC administers pest control treatments on a year-round basis. Housing units are treated quarterly, common areas bimonthly, and culinary biweekly. In each inspection it was noted that flies were in the shower areas of some cellblocks. Shower areas in cellblocks are steam cleaned and appropriate chemicals are applied to control the flies. DOC's environmental manual dictates the time frames for these treatments.

3. The repackaging of random and non-specific deficiency data conveys a distorted view of actual conditions at the Central Detention Facility.

The narrative regarding maintenance problems at the facility does not point out the limited extent of these problems. Moreover, most airflow, vermin, fire safety, plumbing and lighting problems cited by inspection reports referenced by the GAO are addressed by CDF maintenance staff on a daily basis.

The scope of the maintenance task in such a large, complex and heavily utilized facility has to be kept in perspective. The D.C. Jail is a half million square foot facility located on a ten-acre lot. Inmate housing areas are comprised of eighteen cellblocks containing 1380 cells and a dormitory. Because of the nature of the business conducted in it, the building systems of the facility are inherently much more complex than those of a normal building. In addition to the usual building systems, the facility has over 1700 heavily used cell doors and gates, approximately 1500 prison-grade sink/toilet combinations, and elaborate security systems, which are very maintenance intensive. The population of the institution is such that building system components and equipment are subjected to considerable abuse and misuse.

Letter to Cathleen A. Berrick, Director, Homeland Security & Justice Issues, GAO
Page 3
July 9, 2004

The facility is currently undergoing a major infrastructure renovation as part of DOC's ambitious Capital Improvements Program with upgrades and replacement of the HVAC system, domestic water and hot water systems, plumbing and electrical wiring. Old pumps, piping, valves, air handlers, blowers, heaters, ducts, controls and other equipment are being demolished and new system components are being installed by contractors' crews all over the facility. This causes disruptions in utility conveyance channels on a fairly regular basis.

Given the circumstances noted above, maintenance work in the institution is quite challenging. The Department's maintenance personnel answer anywhere from 50 to 250 service calls on any given day, completing most of the priority one calls within an hour of their being reported. In addition, the facility maintenance staff complete second and third tier maintenance work requests, perform routine preventive maintenance tasks, maintain 'back-end' areas such as the penthouse and six other large mechanical rooms, and services elevators, laundry equipment, kitchen equipment, and the like. And day-to-day coordination of construction activities throughout the facility is yet another responsibility of the CDF's facility maintenance staff.

Given the above, it is easy to see that if one were to walk into the facility at any given time, one would readily find maintenance issues such as plumbing leaks, low water pressure in sinks, low air flow, temperature anomalies, etc. in the process of being addressed. This is normal business routine in correctional facilities. Generally, an external inspector is in and out of the facility over the course of 30 days conducting inspections. During that time, Facilities Management personnel respond to over 3,000 service calls.

4. <u>Factual errors exist in the Capital Improvements Project Section.</u>

In the section titled "Capital Improvement Projects at CDF", in Table 1, page 16, the status of the last three projects is said to be, 'in process of finalizing the scope of work with DOC.' The actual status of all the three projects is that they are in design; the scope of work was finalized in May 2004.

In the same section, "Capital Improvement Projects at CDF", on page 17, a reference is made to a shooting incident in December 2003, relating it to the CCTV project. There is no connection between the shooting incident and the CCTV project. The CCTV project was initiated as an emergency project back in August 2003, months before the shooting incident.

In the section entitled, "Results in Brief," on page 3, and again in the section entitled, "Capital Improvement Projects at CDF," page 16, GAO reported that it was unable to get the working estimates and the schedule time frame for completion for 13 out of the 16 projects from Office of Property Management (OPM) officials. DOC has accurate

Letter to Cathleen A. Berrick, Director, Homeland Security & Justice Issues, GAO
Page 4
July 9, 2004

working estimates for all 16 projects, as well as schedules for at least 13 of 16 projects, for which design work has been completed. DOC provided this information during the review process; and, in its October 2004 submission referred GAO to the publicly available web based source documentation at the D.C. Office of the Chief Financial Officer's website.[1] Working estimates and schedules are, in fact, accurate because Architectural/Engineering studies were done on most projects. Sometimes the scope of a project needs to be modified, however, this is an exception rather than the rule.

5. The report does not put the issue of release errors in proper perspective, and thus casts DOC's performance in this area in an undeservedly negative light.

Several points are worth making here. First, DOC's records processing environment is distinguished by its complexity and heavy workload volumes. Records Office personnel manually process 300 – 400 inmate documents daily, resulting in an average of over 1500 intakes and releases each month.

Legal source documents are handwritten and cannot be recorded in the offender management system without significant interpretation by Legal Instrument Examiners. A many to one relationship exists between data contained in a variety of legal source documents and a single inmate booking. The more complex and voluminous the documentation, the more human intervention required and the greater the opportunity to introduce two kinds of errors. The first kind of error is a data entry error that may result from incorrect computations for example. The second kind is interpretation error. The combined effect of these errors is to slow down records processing and diminish accuracy.

Physical errors in documents handling or file keeping occur in all systems. And no workflow system is 100% error free; incoming documents containing new commitment information are sometimes processed only after the inmate has been released. DOC's Records Office must balance accuracy in records processing, i.e. records quality, with process efficiency in the course of daily operations.

The GAO report fails to give reviewers any perspective on errors in relation to total releases processed. If it did, it would show that out of 8,233 releases between February and June 2004, 67 were inappropriate, for a combined error rate of just 0.81% (See Figure 1). This displays excellent progress, especially given the more comprehensive approach used to detect release problems and the limited control DOC has over the quality and timeliness of source data.

[1] Complete project descriptions, expenditure and funding schedules, and project summaries including milestones are available to the public on pages 192-208 of the project description forms at the Office of the Chief Financial Officer's website: http://cfo.dc.gov/cfo/cwp/view,a,1321,q,589802.asp.

Letter to Cathleen A. Berrick, Director, Homeland Security & Justice Issues, GAO
Page 5
July 9, 2004

The e-mail referenced in the footnote below[2] documents error levels measured in manual data entry processes. Two of the e-mail respondents indicate 3 to 4.5 process errors committed per 1000 opportunities for error in industries that have very robust and mature data driven cultures. DOC's error rate is well within this norm.

Lastly, the GAO report fails to give DOC any credit for doing something few, if any other correctional systems in the world do, namely, publicly and routinely report release errors. It's not done because most organizations are wary of publicly reporting errors. In a litigious society faced with potential financial liability, they simply don't collect the data. Therefore, DOC has established itself as the benchmark for accountability and performance in this functional area.

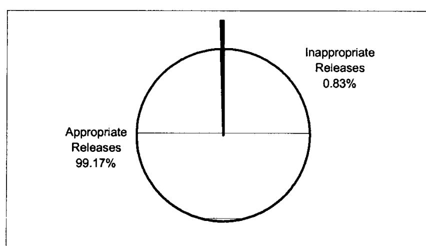


Figure 1. Appropriate and inappropriate release rates for releases between February 2004 and June 2004, post-implementation of the comprehensive records identification logic.

6. The report's finding that DOC has not fully analyzed the release discrepancy database to ascertain whether and how the data may be improved is incorrect. This finding is important because it provides the basis for GAO's records management recommendation.

GAO was provided a written response in June 2004 that included a corrective action plan, Table 1. The table was based upon a frequency analysis of the contents of the release discrepancy database. Many of the actions proposed had already been implemented as of May 2004, and contributed to a further reduction of release error rates. In June 2004, there were 4 late releases and 1 early release out of 1741 total releases, thus demonstrating the effectiveness of the corrective actions implemented.

The results of a frequency analysis of causes associated with 100 documented late releases are shown in Figure 2 below. Document processing delays were the most frequent cause of late releases, accounting for almost 40%. An overlooked document

[2] The link is http://software.isixsigma.com/library/content/c020401a.asp.

Letter to Cathleen A. Berrick, Director, Homeland Security & Justice Issues, GAO
Page 6
July 9, 2004

was the underlying cause in approximately 20% of late releases. Another 16% were due to case documents being improperly filed. Incorrect computations occurred in 14% of cases. And finally, a lack of timely inmate transfer and document interpretation errors each accounted for 5% of late releases.

Most of the errors can be traced to resource limitations and systems breakdowns. Additional staffing and process modifications reported to GAO have begun to remedy these problems. Periodic refresher training will also help by reinforcing policies and processing procedures currently in effect. DOC is working with its software vendor to implement changes that will ensure the accuracy of a wide range of sentence computations. The feasibility of automating jail credit tallies is yet another enhancement DOC is pursuing. The combined effect of these initiatives will be further reduction in DOC's already small release error rate.

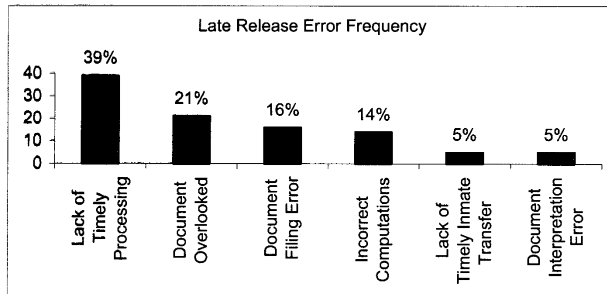


Figure 2. Frequency distribution of causes associated with 100 Late Releases documented in the release discrepancy database.

Late releases are theoretically 100% detectable and preventable. Early releases are not detectable when they occur. Early releases occur because they pass through all process checks at the time of release. In 18 of 24 cases, 75%, the release occurred because an incoming commitment order or other detaining document was not documented in the offender management information system at the time the release was processed (See Figure 3). The Department of Corrections will be requesting that its software vendor make modifications that would allow users to document date and time of inmate records receipt in the database.

A variety of factors contributed to the remaining 6 early releases. Incorrect computations resulted in the release error in two cases (8% of early releases). Records procedures were correctly followed in a third, but complex inmate transfer issues resulted in an erroneous release. Non-receipt of a court order contributed to the fourth early release. A mis-interpreted document caused the fifth; and, in the final case, a document was improperly filed and not detected prior to release.

Letter to Cathleen A. Berrick, Director, Homeland Security & Justice Issues, GAO
Page 7
July 9, 2004

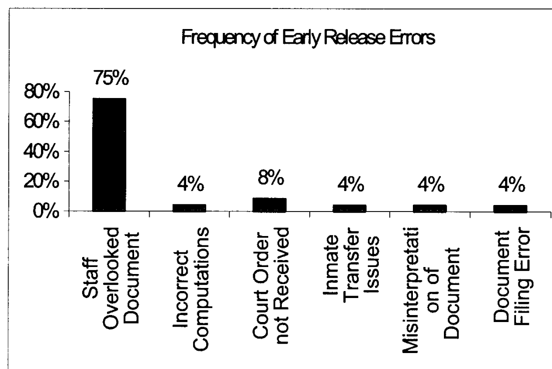


Figure 3. Frequency distribution of causes leading to Early Releases for the 23 early releases discovered since January 2002.

In addition to this frequency analysis, DOC analyzed late release errors by staff member and shift. This full spectrum of information was then used to construct the table referred to below that outlined deficiencies detected, corrective actions proposed, and status of implementation as of May 2004. GAO was forwarded the staff member and shift analysis as well as the corrective action table in June 2004.

Letter to Cathleen A. Berrick, Director, Homeland Security & Justice Issues, GAO
Page 8
July 9, 2004

Deficiency	Proposed Correction	State of implementation in May 2004
Variation in late release interpretations	Clear definition of what is and what is not a late release, and final review and approval by the CDF Warden prior to reporting	Done
Insufficient input in defining script logic, and communication gaps among key stake holders	Seek input from all key stakeholders simultaneously prior to developing script	Done
Records receipt not time stamped	Ask for appropriate field in JACCS table and consider options outside of JACCS	Not in JACCS yet No practical option implemented yet
Insufficient data available for inmates housed at CTF	Ask for appropriate data sharing as part of contract	In process
Lack of work-piece assignment system in records office	Develop and implement work-piece assignment record system in records office	Partially
Script deficiencies not communicated to analyst and script developer in timely manner	1. Analyst has access to database for analysis purposes 2. Script to be monitored closely for 12- month period. In the event that logic fails to detect late releases, necessary modifications will be made immediately.	1. Done 2. Underway
Staff associated with key data entry not analyzed	Identify and train staff frequently associated with late releases	Done
Insufficient data maintained on causes of late releases within release discrepancy database	Analyze data from Password-Audit trails, Location-History tables, and paper jacket, and include specific write-up in release discrepancy data base on regular basis	Partially. Requires analysis and recording of information by multiple individuals from multiple sources, which is not always regular or consistent. Further improvement is possible.
Script developers did not check if script was missing late releases after initial development, and received no feedback if such were case.	Request access to Release Discrepancy Database, and Review/Monitor records and findings weekly. Implement script modifications only if old and new scripts are run simultaneously for at least 90 days.	Policy in effect and being practiced
Formal script signoff and acceptance process did not exist	Formal signoff process should be implemented.	Done.
Records checked monthly rather than daily	Script to be run daily and release discrepancy database updated daily.	Done.
Appropriate releases not recorded, and complete electronic records not maintained in Paper Clip.	Scan all pertinent legal documents into Paper Clip for each potential late release record examined.	Done.
Process effectiveness not audited regularly	Conduct annual audit	First "audit" conducted in April 2004. Next audit scheduled in 2005.

Table 1. Process deficiencies, corrective actions, and state of implementation as of May 2004.

7. Several factual corrections related to CTF are outlined below.

Upon review of the final draft of the GAO report CCA/CTF noted a few additions as follows:

Page 5 Background first paragraph

(add) The Correctional Treatment underwent a mission change from, "Adult Correctional Institute," to an "Adult Local Detention Facility." This mission change has created a more transient population.

Letter to Cathleen A. Berrick, Director, Homeland Security & Justice Issues, GAO
Page 9
July 9, 2004

Page 6 Background last paragraph

In fiscal year 2003 CTF *began double celling* and had an average inmate population of 787 inmates.

Page 12 Vermin

Under CCA policy, CTF (remove) is to have (add) *conducts* weekly pest exterminations *contracted with an outside agency.*

Page 12 Plumbing deficiencies

DOH found that three cells *out of 1,014* had hot water temperatures above the maximum recommended temperature of 120 degrees Fahrenheit at the time of the inspection.

Page 13 Concluding paragraph

(add) It should be noted that CTF has a comprehensive maintenance program in place since July of 1997. According to statistics for the year 2002, 12,665 maintenance deficiencies were reported and 12,665 were corrected. For the year 2003, 13,476 maintenance deficiencies were reported and 13,476 were corrected. Currently in 2004 1,702 maintenance deficiencies were reported, 1,684 were corrected and 17 were deferred and are awaiting parts. In addition, the Correctional Treatment Facility is audited annually by its Corporate Office, as well as, the District of Columbia Department of Corrections.

Page 38 Table 3

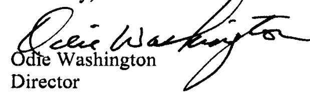
(add)
Classification
Mail
Telephone
Case management
Volunteer Services
AOAT
Barber Science
Graphic Arts.

Letter to Cathleen A. Berrick, Director, Homeland Security & Justice Issues, GAO
Page 10
July 9, 2004

I am extremely proud of the D.C. Department of Corrections performance in reconfiguring this agency from a state prison to a local detention system as mandated by the Revitalization Act of 1997. We are the only system in the nation to have done this, and we performed this charge especially well. Since November 2001, we have continued to roll out improvements in a broad range of areas, all of which serve to strengthen the department's foundation for the future. We genuinely welcome outside scrutiny and objective criticism, because we recognize both provide needed fuel for continuous improvement. And more work will be done as the D.C. Department of Corrections strives to attain best practice levels in all areas of operation. At the same time, I want to ensure that external reviews report accurate facts and a balanced perspective in assessing this department. Hopefully, our mutual needs will have been met as a consequence of this review.

If you have any further questions or need further clarification regarding this document, please contact me at 202-671-2128 or Brenda Baldwin-White, Deputy General Counsel, at 202-671-2042.

Sincerely,



Odie Washington
Director

cc: Robert Bobb
City Administrator/Deputy Mayor

Appendix VIII: Comments from the District of Columbia, Department of Health

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health

Office of the Director

July 8, 2004

Cathleen A. Berrick
Director, Homeland Security
and Justice Issues
U.S. General Accounting Office
441 G Street, N.W. Room 6Q26
Washington, D.C. 20548

Dear Ms. Berrick:

The Department of Health, Health Regulation Administration (DOH/HRA) appreciates the opportunity to provide comments on the United States General Accounting Office ("GAO") draft report **D.C. Detention Facilities (GAO 74-742)** based upon a retrospective review of DOH health and safety inspection reports for the time period March 2002 thru April 2004. HRA's response will track the report by using the same topical headings in the GAO's report. As shown below, HRA agrees with the recommendations suggested in your report.

The following responds to issues raised in the GAO report about health and safety inspections and deficiencies cited at the Jail and Correctional Treatment Facility.

1. **DOH inspection reports did not:**
   - **Consistently identify the specific locations in the jail where deficiencies occurred; and**
   - **Always include all the deficiencies identified, particularly if the deficiency was corrected during the course of the inspection.**

   DOH Response: DOH agrees that the inspection reports did not consistently identify locations where deficiencies were found. However, first note that a Department of Corrections (DOH) representative accompanied the surveyor during the inspection with the understanding that he or she is making the same observations that the surveyor is making. Second, the surveyor always conveys all relevant information to the Department of Corrections (DOC) during an exit conference held at the end of each inspection. These exit conferences are attended, at a minimum, by the inspector(s), the court monitor (when

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under court order) and a representative of the Department of Corrections (DOC). At the exit conference, DOC and the court monitor were told where the specific problems were and if any problems were found and repaired but not noted in the report.

At this point, DOH is in the process of revising the inspection forms so that the inspector can indicate specifically, e.g. by cell and building where the deficiencies are observed. The inspector will indicate all deficiencies on the form, including ones that are corrected during the survey. DOH plans to have developed this new inspection tool so that it can be used in correctional facility inspections by September 1.

2. **DOH Reports repeatedly identified the same types of health and safety deficiencies at the jail.**

DOH Response: DOH acknowledges that in many instances the same types of deficiencies were cited in different inspections. It is important to note that the buildings in question are aging, overcrowded, under-equipped and understaffed, especially in the maintenance area. We continue to recommend that DOC institute an on-going preventive maintenance program.

DOH does not have enforcement authority and cannot address DOC's corrective actions or lack thereof. DOH's responsibility is and has been to inspect and report. Originally inspections were conducted and reports submitted to the correctional facilities and court monitor in accordance with court order(s). Now the reports are submitted to the correctional facilities and the District of Columbia Council pursuant to the District of Columbia Jail Improvement Act of 2003, D.C. Law 15-62.

3. **Inspectors apply standards from the American Correctional Association to Jails and standards from the American Public Health Association to the CTF.**

DOH Response: DOH used the standards for its inspections that the court monitor, whose job it was to assess the report outcomes, recommended for use at the time. Now that the inspections no longer take place under court order, DOH has changed its policy so that each facility will be inspected in accordance with the Standards for Health Services in Correctional Institutions (3rd Edition), published by the American Public Health Association (APHA), which are the industry standards for state and local government inspections of correctional facilities. .

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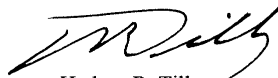
Thank you for the opportunity to respond to this report. Should you have any questions or need additional information, please don't hesitate to contact Ms. Denise S. Pope, RN, MSN, Administrator, Health Regulation Administration at (202) 442-4747.

Sincerely,



Herbert R. Tillery
Interim Director

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Appendix IX: Comments from the District of Columbia, Office of the Inspector General

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Office of the Inspector General

Inspector General

July 14, 2004

Cathleen A. Berrick
Director, Homeland Security and Justice Issues
United States General Accounting Office
Room 2440A
441 G St. NW
Washington, DC 20548

Dear Ms. Berrick:

Thank you for providing the District of Columbia Office of the Inspector General (OIG) with a copy of the General Accounting Office report *District of Columbia Jail: Management Challenges Exist in Improving Facility Conditions and Inmate Records.* Our Inspections and Evaluations Division has determined that your report accurately reflects the findings and recommendations contained in our October 2002 Report of Inspection on the Central Detention Facility.

We have no additional comments and appreciate the opportunity provided to review the report.

Sincerely,

Austin A. Andersen
Interim Inspector General

AW/lnd

717 14th Street, N.W., Washington, D.C. 20005 (202) 727-2540

Appendix X: Comments from the District of Columbia, Office of Property Management

GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF PROPERTY MANAGEMENT

Carol J. Mitten
Director

July 13, 2004

Ms. Cathleen A. Berrick
Director, Homeland Security and Justice Issues
U.S. General Accounting Office
441 G Street, N.W.
Washington, D.C. 20548

Re: Draft Report: *GAO Report to the Chairman, Committee on Government Reform, House of Representatives*
District of Columbia Jail, Management Challenges Exist in Improving Facility Conditions and Inmate Records

Dear Ms. Berrick:

Thank you for the opportunity to comment on the captioned draft report. I know your staff has had extensive discussions with Peter May, Deputy Director of OPM and Bijoy Isaac, OPM Project Manager for the Department of Corrections capital projects, including the D.C. Jail.

These comments apply equally to the Results in Brief section of the report (page 3) and the Capital Improvements section of the report (pages 13-18), although I focused on the latter section because of its greater level of detail.

Cost and Schedule Issues

In order to accurately communicate the capital improvements process, I think a few sentences describing the budgeting process would be appropriate. It is important for a reader of the report to understand, particularly in light of the original budget allocations reported at pages 14 and 15, that receiving dollars in the capital budget is the first step in a longer process. At the time that capital dollars are first allocated, projects are rather ill-defined. No detailed program has been identified nor has a schedule for completion been established. It is only after the specific program is defined, funds are put in place, and the scope of work described in detail that design work can commence.

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Berrick Letter
Page 2

Because the process of defining the scope of work and finalizing the design are essential to the establishment of a reliable cost estimate and construction schedule, no schedule or construction cost projection can be known until the program is defined in detail by the client agency. It is for this reason, as was explained to GAO representatives, that no schedule for completion is available for the three projects in the pre-design phase, as mentioned on page 16. Further (in response to GAO's statement on page 16 that, "…OPM officials stated that they could not provide a current working estimate for the 13 of the 16 projects that were not complete or nearly complete."), working cost estimates for the remaining 10 projects for which designs are complete were never requested. The information is provided in the attachment.

It should also be noted that the working cost estimates for those projects for which construction contracts have not been awarded, but where the design is complete, reflect the architect's cost estimate. The actual costs, once the projects go out for bid, may be higher or lower.

Project Management Issues

The report on page 17 includes the following observations: "Our work on capital improvements projects has noted that it is important that capital projects be well managed….However, during our review, we noted that the Office of Property Management lacked written policies and procedures to guide its project managers through the planning and management of projects." (Similar statements are also made on page 22.) These statements infer that OPM capital projects, specifically DOC projects, are not well-managed. The GAO has no basis for this conclusion. What is true, and what the working group has been formed to address, is the fact that OPM lacks *standardized* project management procedures.

On page 26 of the report, the GAO states, "To identify management issues, we reviewed the Office of Property Management's project management [procedures], but we did not conduct an in-depth evaluation of the effectiveness of its management." This statement reinforces the fact expressed above that the GAO has no basis for its conclusion that OPM's project management has not been effective. In fact, OPM has a very experienced project manager handling all DOC projects, and he is supported by other OPM staff with significant expertise. They have served DOC very well by working with the agency to understanding their needs, maximizing the use of limited resources, being flexible in responding to changing circumstances and priorities, and delivering projects that serve DOC's mission.

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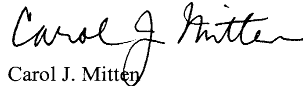
Berrick Letter
Page 3

At present, OPM cannot be judged based on its project managers' ability to adhere to specific, standardized rules and procedures – there are no such procedures. What OPM can be judged on is its ability to deliver capital projects timely and within a prescribed budget. There has been no mechanism in this GAO review on which to base conclusions in this latter regard.

Thank you again for the opportunity to comment on the draft report. If I can be of any further assistance, please call.

Respectfully,



Carol J. Mitten
Director

Attachments

cc: Robert Bobb, City Administrator
Herbert R. Tillery, Acting Director, DOH
Peter May, Deputy Director, OPM

441 4th Street, N.W., Washington, D.C. 20001 (202) 724-4400 (Fax) (202) 727-9877

Appendix XI: GAO Contacts and Staff Acknowledgments

GAO Contacts

Cathleen A. Berrick, (202) 512-8777
Evi L. Rezmovic, (202) 512-2580

Acknowledgments

In addition to those named above, Leo Barbour, Chan My J. Battcher, Grace Coleman, Tanya Cruz, Wesley A. Johnson, Evan Gilman, Omar N. Beyah, Maria Edelstein, Elizabeth Eraker, and Geoffrey Hamilton made key contributions to this report.

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