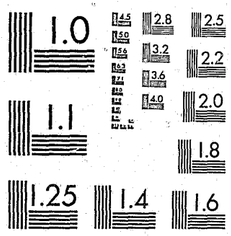
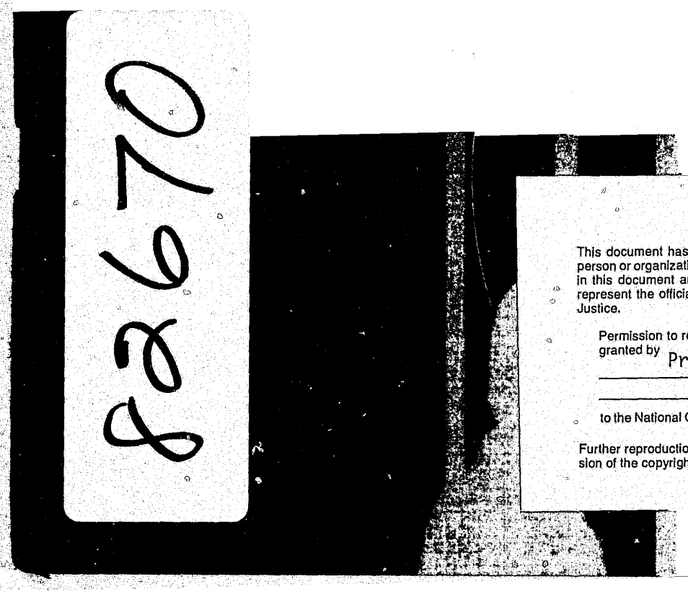


State of Kansas

OMBUDSMAN

FOR CORRECTIONS



CORRECTIONS OMBUDSMAN BOARD

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OFFICE OF THE OMBUDSMAN FOR CORRECTIONS

STAFF MEMBERS

Ombudsman
Preston N. Barton II, MSW
Ombudsman Associate
David R. Jensen, MSW
Ombudsman Associate
Carolyn L. Keith, MAJ*
Administrative Secretary
Marais (Phillips) Johnson
Typist
Lori Frickey

*Was Staff Assistant from January 22, 1981 to June 17, 1981.

ck sent 1-23-82

State of Kansas
Ombudsman for Corrections

SIXTH ANNUAL REPORT

to the

Corrections Ombudsman Board

as required by

K.S.A. 74-7403

For the Period

July 1, 1980 through June 30, 1981

Office of the Ombudsman for Corrections
503 Kansas Avenue, Suite 539
Topeka, Kansas 66603
Phone: (913) 296-5295 KANS-A-N 561-5295

ABOUT THE COVER

All of the drawings, in this Sixth Annual Report including the illustration on the cover, were done by Mr. David Foster, an inmate at the Kansas State Industrial Reformatory in Hutchinson, Kansas. These drawings illustrate vividly the setting within which our staff functions. The complaints which are handled by this Office relate to the institutional setting -- whether they come from staff or inmate or their families. We are grateful to Mr. Foster for his very creative contribution to this report.

FOREWORD

On behalf of the Corrections Ombudsman Board, I am pleased to accept this Sixth Annual Report of the Ombudsman for Corrections. A report of this nature serves to enhance public awareness of this important program, to provide a source of data about correctional issues, to inform the Legislature and the Governor of the kinds of correctional problems that demand repeated attention, and to demonstrate that the Ombudsman has fulfilled the ongoing role intended with the establishment of that Office in 1975.

The focus of this year's activity was clearly upon individual complaints. Members of the staff were asked to direct their time and energies in this direction in an even greater measure than in previous years. Such an emphasis was possible because of the stability within the staff during this year, so that less time was needed to orient new staff members to responsibilities. As a result, 40% more complaints were received and a similar increase in percentage was resolved during this year. The bulk of complaints were from the Kansas State Penitentiary. Additional staffing in FY 1982 will permit more direct contact with the Kansas State Industrial Reformatory and continued work with the Kansas Correctional Institution for Women.

Despite the additional attention to individual complaints, it was possible to develop reports of a more general nature that arise from numerous individual complaints. In these reports, one can note that most of these issues, particularly in regard to the Adjustment and Treatment Building, continue to exists because of inattention to the recommendations on those facilities and programs in the Second Annual Report and the Third Annual Report. The legislative and executive branches will need to give continued attention to these program and facility concerns.

It should be obvious from this annual report that the needs of inmates and correctional staff can be addressed through the Ombudsman program. The efforts of the Ombudsman and his staff during this FY 1981 are to be commended.

Dr. Alan Steinbach, Chairperson
Corrections Ombudsman Board

October 7, 1981

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3. "Report on Incentive Good Time," July 26, 1976, pp. 2.
4. Description of the Ombudsman Program in the 1976 Kansas Biennial Report, published by the Office of the Secretary of State, pp. 3.
5. "Report on the Adjustment and Treatment Building at the Kansas State Penitentiary," March, 1977, pp. 20.
6. "Presentation to the Legislative Interim Study Committee on Corrections," October 14, 1977, pp. 7.
7. The Second Annual Report, (July 1, 1976 through June 30, 1977), pp. 56.
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11. Description of the Ombudsman Program in the 1978 Kansas Biennial Report, published by the Office of the Secretary of State, pp. 4.
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INTRODUCTION

A. Program Description

The objectives of the Office of the Ombudsman for Corrections are to: 1) dispense with unfounded complaints, 2) substantiate valid complaints, and 3) improve administrative procedures. In the accomplishment of these objectives, the Ombudsman Office assists the executive and legislative branches of government in monitoring the form and substance of administration within the Kansas Department of Corrections. Addtionally, these objectives demonstrate to correctional employees and inmates the state's commitment to be responsive to individual concerns, while at the same time provide programs to meet the needs of large numbers of persons.

When a person's freedom is restricted, complaints are to be expected. Unresolved, these complaints become a hindrance to the security and rehabilitation missions of a correctional program. Among correctional staff members, such can be expressed through a variety of means including depression, psychotic episodes, hostility, and violence. Among inmates, these unresolved complaints unsettled issues can induce frustration and low morale, leading to the exercise of poor judgement and to a high rate of resignations, absenteeism and illness.

A statutorally established state agency, separate from the Department of Corrections, the Ombudsman Office receives and resolves complaints concerning inmates and their families, correctional staff members, and correctional volunteers. The Office works toward achieving administrative, as opposed to legal, remedies to problems. In addition to complaint handling, the Ombudsman Office conducts studies of programatic areas which appear to be the source of a large number of complaints. In examining departmental administration, the Ombudsman Office checks for discrepancies with state laws and regulations. It is particularly concerned with administrative actions which are: 1) unclear 2) inadequately explained, 3) inefficient, 4) inconsistent with any policy or judgement, 5) contrary to law or regulation, or 6) arbitrary, unreasonable, unfair or oppresive.

In an effort to deal with discrepancies of this nature, the Ombudsman Office serves in the following six capacities: An external discoverer of problems and complaints; a third party mediator of conflicts and crisis situations; an impartial observer of facilities, routine activities and disturbances; a preventer of unfair and harmful practices; a recommender of corrective actions and new policies; and a reporter of discrepancies in practices and policies through special and annual reports.

The Ombudsman is appointed by and accountable to the Corrections Ombudsman Board (COB). The Board was appointed and organized in the summer of 1974, and a year later appointed an Ombudsman, who assumed his duties on September 15, 1975. The ten member Corrections Ombudsman Board is composed of two appointees selected by each of the following five state officials: the Governor, the Attorney General, the Chief Justice of the Supreme Court, the President of the Senate and the Speaker of the House. Board members are appointed for four-year terms.

B. The Year's Highlights

The Ombudsman Office focused its primary attention on the Kansas State Penitentiary during the 1981 Fiscal Year (July 1, 1980 - June 30, 1981), while handling complaints from other institutions as well. The Office completed work on 869 complaints which required a total of 5,529 contacts

through interviews, telephone calls, and letters. The top four areas of complaining were "Accuracy of Records," "Medical Care," "Property Loss," and "Custody Status and Parole Eligibility". These four complaint categories represent 350 of the 869 complaints or 40.4% of all the complaints handled during this reporting period.

During the year the Ombudsman issued three special reports. The first regarding the inmate work stoppage from March 16 through March 20, 1981, at the Kansas State Penitentiary. The second report looked into an episode of self-mutilation in segregation units at the Kansas State Penitentiary during March and April of 1981. The third report was a follow-up survey to determine the outcomes of 37 recommendations concerning the Adjustment and Treatment Building at the Kansas State Penitentiary. The 37 recommendations were originally issued by the Ombudsman in two separate reports during 1977 and 1978. The Secretary of Corrections provided written responses to one of these three special reports.

As a result of its complaint handling and special studies, the Ombudsman Office issued nine formal recommendations to the Secretary of Corrections. The Secretary of Corrections provided a written response to one of these nine formal recommendations.

Twenty-two special investigations were conducted during the year at the request of the Joint Legislative Committee on Special Claims Against the State. These investigations regarded claims by inmates and staff concerning the loss or damage of personal property. Also involved were inmate claims regarding permanent disability as a result of injuries received in the course of performing assigned institutional work.

C. The Fiscal Picture

In Fiscal Year 1981 the Ombudsman program was funded 90.2% by the State of Kansas and 9.8% be a federal grant. The proportionately high ratio of state funding has made it possible for the Office to develop into a viable state agency, rather than linger on as a experiment. Indeed, furing Fiscal Year 1982, the Ombudsman Office will be supported entirely by state funds.

The Office's expenditures during the past five fiscal years are as follows:

	FY 1977	FY 1978	FY 1979	FY 1980	FY 1981
Salaries	$25,713	$52,164	$58,329	$75,479	$83,836
Office Facilities and Operations	6,817	9,280	12,857	13,729	14,060
Consultation	500	7,954	- 0 -	- 0 -	- 0 -
Travel and Subsistence	5,920	64	6,041	8,621	9,749
Capital Outlay	1,975	69,848	1,357	1,233	640
TOTAL	50,925	78,584	78,584	99,062	108,285
State Funds	50,925	56,289	66,134	79,385	97,630
Federal Funds	- 0 -	13,559	12,450	19,677	10,655

In order for the Ombudsman Office to accomplish its statutory purposes (KSA 74-7403), it is necessary to make on-site complaint handling services available at all eight state adult correctional facilities. To date, this has not been possible; but progress toward this goal has been achieved. During the reporting period, the Governor and Legislature agreed to create a second Ombudsman Associate position, which will make Ombudsman services at the Kansas State Industrial Reformatory possible during Fiscal Year 1982.

Below are the staffing patterns for Fiscal Years 1981 and 1982, as well as the COB's request for Fiscal Year 1983:

Positions in FY 1981

Field Staff
1. Ombudsman
2. Ombudsman Associate
3. Staff Assistant (part-time)

Support Staff
4. Administrative Secretary
5. Typist

Positions in FY 1982

Field Staff
1. Ombudsman
2. Ombudsman Associate
3. Ombudsman Associate

Support Staff
4. Administrative Secretary
5. Typist

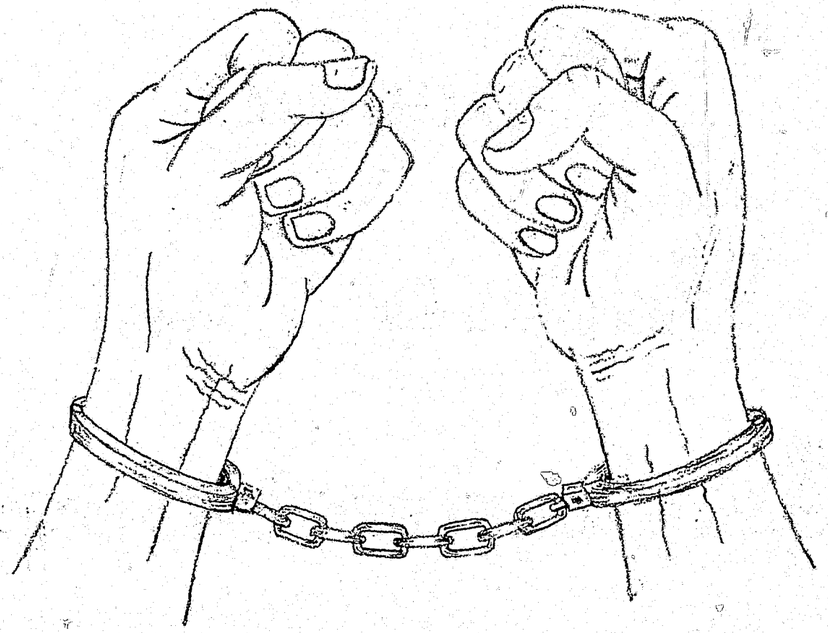
Requested Positions for FY 1983

Field Staff
1. Ombudsman
2. Ombudsman Associate
3. Ombudsman Associate
4. Ombudsman Associate
5. Staff Assistant

Support Staff
6. Administrative Secretary
7. Typist

The remainder of this report is devoted to a description of the work of the Ombudsman program during Fiscal Year 1981 (July 1, 1980 - June 30, 1981) This is accomplished through narrative and statistical presentations.

Special Reports and Recommendations



TOILET FACILITIES FOR THE SEWING ROOM AT KCIW

A. Letter of January 16, 1981 to Ms. Sally Chandler-Halford

B. Letter of January 28, 1981 from Ms. Sally Chandler-Halford

C. Letter of February 9, 1981 to Ms. Sally Chandler-Halford

D. Letter of February 26, 1981 to Secretary Patrick D. McManus

E. Letter of March 10, 1981 from Secretary Patrick D. McManus

CORRECTIONS OMBUDSMAN BOARD

(Formerly the Citizens' Advisory Board on Corrections)

STATE OF KANSAS

OFFICE OF THE OMBUDSMAN FOR CORRECTIONS
503 Kansas Ave., Suite 539
Topeka, Kansas 66603
(913) 296-5295
KANS-A-N 561-5295

Preston N. Barton II, Ombudsman
Executive Secretary
Of The Corrections Ombudsman Board

January 16, 1981

Ms. Sally Chandler-Halford
Director
KCIW
Box 160
Lansing, KS 66043

RE: Toilet facilities for the sewing room at KCIW

Dear Ms. Halford:

I would like to bring to your attention a situation which has existed for several months now in the sewing room at KCIW. Women inmates assigned to that detail must go to the control center, a significant distance away from the sewing room, in order to use the toilet facilities there.

Besides being inconvenient, this situation creates some real concerns. Women needing to use the toilet facilities must go all the way through the control room and, thus, disrupt any visiting which may be taking place and generally make the nerve center of the institution more congested. This traffic in the control center is undoubtedly disconcerning to officers who are preoccupied with a number of pressing matters. An additional severe concern arrises during these winter months when the hill on which the institution is located can become very cold and windy, and passage can become difficult and slippery. There, also, is the concern of persons needing access more rapidly to toilet facilities during times when they may not be feeling well. Such an arrangement is humiliating and depersonalizing for inmates. It also jeopardizes security, safety and health.

I am recommending that toilet facilities be made available within the same building which houses the sewing room facility.

I look forward to your response within a reasonable period of time describing how this condition might be corrected and when. Your attention to this matter will be appreciated.

Sincerely,

Preston N. Barton
Ombudsman

STATE OF KANSAS
DEPARTMENT OF CORRECTIONS

SALLY CHANDLER HALFORD
Director

KANSAS CORRECTIONAL INSTITUTION
FOR WOMEN
P.O. Box 160, Lansing, Kansas 66043
913 727-3553

January 28, 1981

Mr. Preston Barton, Ombudsman
Office of the Ombudsman for Corrections
503 Kansas Avenue, Suite 539
Topeka, Kansas 66603

Dear Mr. Barton:

In response to your inquiry regarding toilet facilities for the sewing room, I will give you some background on the problem. Last June, we developed a supply area for inmate clothing and other articles in the basement of A building in what had been in earlier times old maximum security. Prior to that, supplies were located in various areas, making coordination extremely difficult and for poor efficiency in providing for inmate needs. The only toilet facility in the basement area is located in the supply room, which must be maintained as a secure area. The storekeeper is responsible for this area with an inmate assistant, however, there are many times when he is out of the area handling mail, etc. Inmates in the sewing room initially had access to the toilet facilities in the supply room, however, there were many problems with missing articles, etc. A meeting was held with security and other staff to resolve the problem and the designation of the toilet in the control center/visiting area was the result of that meeting.

The control center is 365 feet from A Basement, less distance than inmates must walk for meals, medication, and other needs and services. There are currently ten inmates in the sewing program, and security reports that the group generally comes to the control center/visiting area after lunch and each inmate will average one other time during the day. The inmates assigned to the maintenance force also use the toilet facility in this building when they are working in the general area. I have enclosed a floor plan of the control center/visiting area; as it indicates, there is no need to go into the control center or the visiting area. They simply give their pass to the control center officer and proceed through the hallway to the toilet and return the same way.

Inmates who are too ill to walk this distance would not be expected to work and those in late stages of pregnancy, if this should pose a problem, would be removed from the assignment and other arrangements made.

I have received no verbal complaints or formal grievances regarding this situation. Medical staff does not view the walk as a medical problem. Security reports that the minor extra traffic in the control center/visiting center does not constitute a problem.

This is not an ideal situation and I am not attempting to present it as such. We have attempted to utilize space as rationally as our joint thinking permits, keeping in mind inmate needs as well as institutional needs. As you are aware, prior to converting the old ceramic shop into the control center/ visiting area, visits took place in the hallway of the administration building, and other scattered areas with no privacy or comfort. At this time the control center was a desk in the hallway of the administration building allowing for little control of traffic. Of course, a multi-purpose building does create extra traffic and the problems that come with it. Our facilities have been adapted to many changes and, to reiterate, are less than ideal.

I remain open to suggestion to this and other problems that may arise.

Sincerely,

Sally Chandler Halford

Sally Chandler Halford
Director

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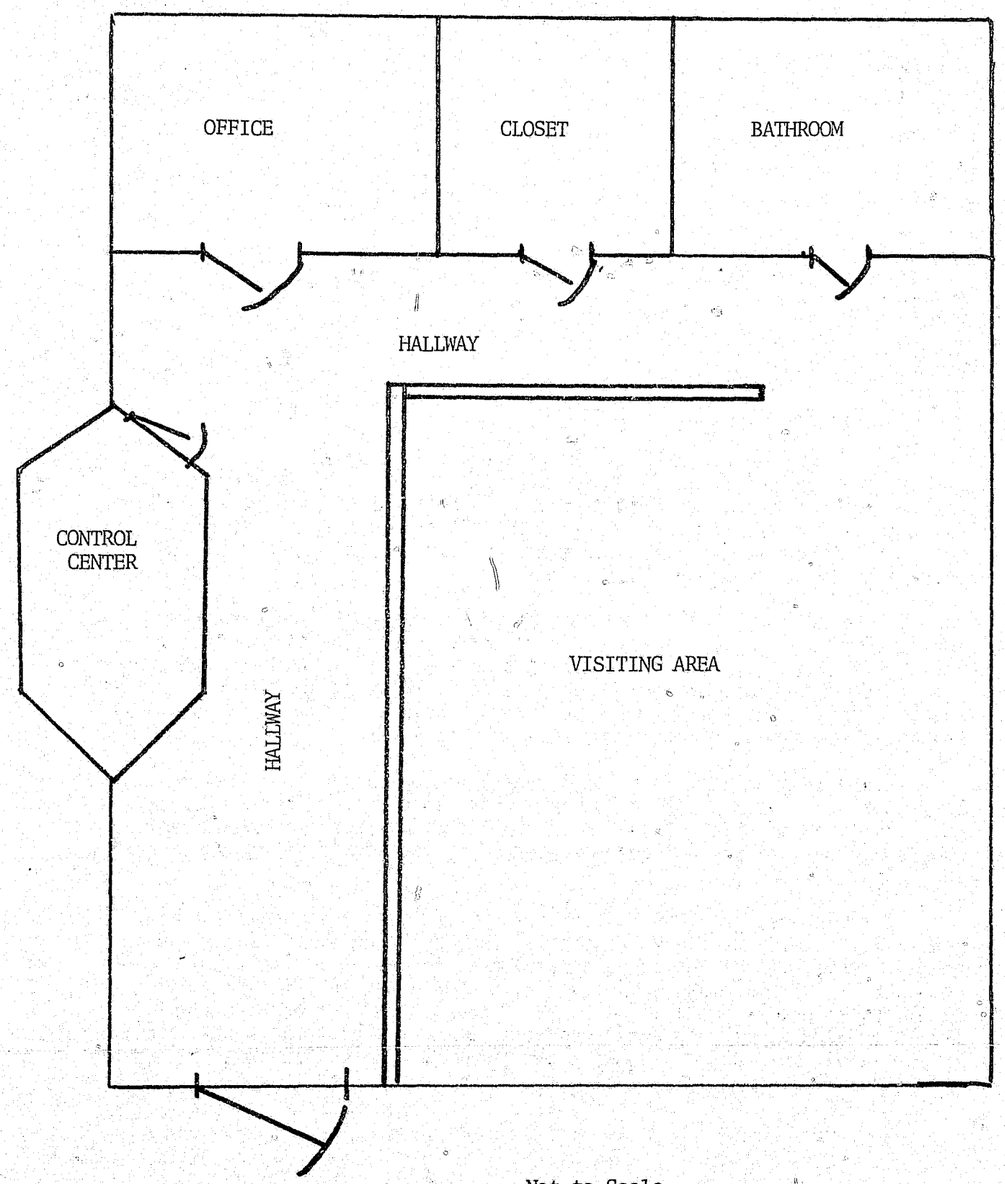

Not to Scale

STATE OF KANSAS

OFFICE OF THE OMBUDSMAN
FOR CORRECTIONS
503 Kansas Ave., Suite 539
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(913) 296-5295
KANS-A-N 561-5295

Preston N. Barton II, Ombudsman
Executive Secretary
Of The Corrections Ombudsman Board

February 9, 1981

Ms. Sally Chandler-Halford
Director
KCIW
Box 160
Lansing, KS 66043

Dear Ms. Halford:

This letter is in reply to your letter of January 28, 1981. I wish to thank you for being so responsive to my letter of January 16, 1981, raising the concern regarding the access to toilet facilities which inmates assigned to the sewing room have at KCIW. It is clear from your reply that not only you but a number of your staff members have given considerable thought to this issue.

I take note of your statement that you have received no verbal or formal complaints regarding the current toilet arrangements for persons assigned in the sewing room. It is just this kind of situation which justifies the existence of an Ombudsman as it provides you, as an administrator, another avenue of communications - one which from time to time provides information which you would not otherwise be privy to.

I find nothing in your response which minimizes the humiliating and depersonalizing aspects of the somewhat formalized method for adults to gain access to a toilet. This arrangement does not seem to be a temporary one as the sewing room has been located at its current facility for a rather long time.

I, therefore, continue to put forth my recommendation that toilet facilities be made available within the same building in which the sewing room is located. This could be accomplished in one of two ways. One way could be to install a new toilet facility within the sewing room. The other option would seem to be a rather uncomplicated one of re-designing the floor plan so as to permit inmates to enter the existing toilet facility in the supply room and at the same time provide a secure area for the supply room.

Again, I thank you for your responsiveness to this issue. If this letter should illicit any new ideas on your part, I would most appreciate hearing them.

Sincerely,

Preston N. Barton
Ombudsman

mp

CORRECTIONS OMBUDSMAN BOARD

(Formerly the Citizens' Advisory Board on Corrections)

STATE OF KANSAS

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Topeka, Kansas 66603
(913) 296-5295
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Preston N. Barton II, Ombudsman
Executive Secretary
Of The Corrections Ombudsman Board

February 26, 1981

Mr. Patrick D. McManus
Secretary of Corrections
535 Kansas Avenue - Room 200
Inter Office Mail

RE: Toilet facilities for the sewing room at KCIW

Dear Mr. McManus:

I would like to bring to your attention a situation which has existed for several months in the sewing room at the Kansas Correctional Institution for Women. Female inmates assigned to that detail must go to the control center, a significant distance away from the sewing room, in order to use the toilet facilities there.

Enclosed is a statement of this problem and my recommendation to Ms. Sally Chandler-Halford, Director of KCIW. I am also enclosing her thoughtful and timely response to that concern.

My recommendation is that toilet facilities be made available within the same building which houses the sewing room facility. I hope you will act upon this recommendation favorably. I await your reply.

Sincerely,

Preston N. Barton
Ombudsman

mp

C: Ms. Sally Chandler-Halford, Director, KCIW

Enclosures: 1) Letter of January 16, 1981 to Ms. Halford
2) Letter of January 28, 1981 from Ms. Halford
3) Letter of February 9, 1981 to Ms. Halford

KANSAS DEPARTMENT OF CORRECTIONS

JOHN CARLIN — GOVERNOR • • PATRICK McMANUS — SECRETARY

535 KANSAS AVENUE • TOPEKA, KANSAS • 66603
• 913-296-3317 •

March 10, 1981

Mr. Preston N. Barton, Ombudsman
Corrections Ombudsman Board
503 Kansas Avenue - Suite 539
Topeka, Kansas 66603

Dear Mr. Barton:

Thank you for your recent correspondence regarding toilet facilities for the sewing room at KCIW. I have reviewed the correspondence relative to this matter and also visited the institution to gain firsthand knowledge of the relative seriousness of the situation.

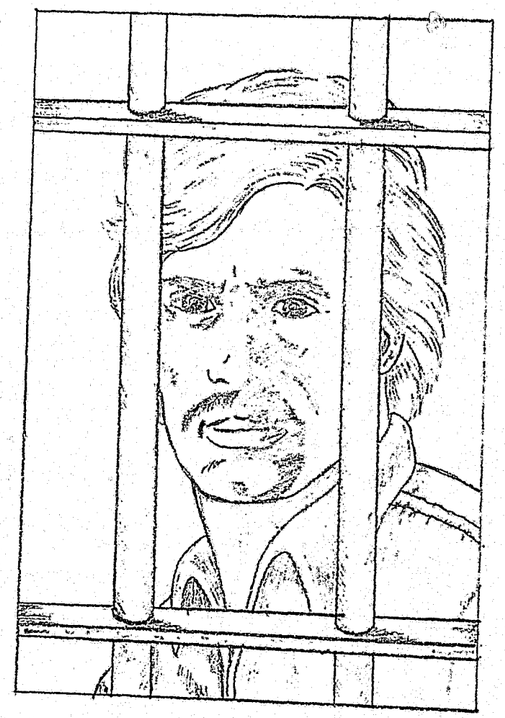
It is my conclusion that, while the present arrangements may cause some inconvenience at times, it is not serious enough to warrant the expense of physical changes in the building. We will continue to monitor the situation to see whether it becomes a larger problem than I currently judge it to be.

We continue to value your suggestions even when, as in this case, we may disagree on the solution. We look forward to continuing our work together toward improving corrections in Kansas.

Sincerely,

PATRICK D. McMANUS
Secretary of Corrections

PDM:dja



REPORT ON THE KSP INMATE WORK STOPPAGE AND LOCKDOWN
FROM MARCH 16 THROUGH MARCH 20, 1981

Background Information

On Thursday, March 12, 1981, the Kansas State Penitentiary issued a new policy regarding the manner in which inmates would collect items which they have purchased from the inmate store. Representatives from the Ombudsman Office were present at the institution that day and heard many complaints from inmates regarding this change of policy. There were discussions of boycotting the store and of needing to meet with the Director of the institution.

A meeting did take place between a small group of inmates, the Director and other members of administration on the following day (March 13).

The First Day - Monday, March 16, 1981

Late in the day on Monday, March 16, 1981, we learned, by chance, a lockdown had been imposed on the Penitentiary in the morning. It was reported that there was a lockdown of inmates inside the walls, in response to the majority of inmates who had not gone to their work details after the morning meal. Two inmates, considered leaders in the work stoppage, were put in the Adjustment and Treatment Building (segregation). We were informed that, all things remaining equal, the institution would remain locked down until Thursday morning, when inmates would be allowed out for the morning meal and given the opportunity to go back to work.

Although the Ombudsman Office staff was not represented at the Penitentiary on this first day, Monday, it was represented during the remainder of the week.

The Second Day - Tuesday, March 17, 1981

The Ombudsman Office staff spent most of its time this day in the Adjustment and Treatment Building (A&T) and the Holdover Unit.

The night before, inmates in A&T had set fires, caused water to flood and in other ways disrupted any semblance of normal routine. These problems occurred on three of the six runs in A&T.

When we talked to inmates in the A&T Building we were informed that there was a good deal of anger over the fact that they had lost their store privileges because of activities on the part of inmates in the rest of the institution in which these inmates in maximum security had not participated.

Additionally we spent some time in the Holdover Unit. This unit holds newly committed inmates who by law are segregated from the rest of the population until such time as they can be transferred to the Kansas Reception and Diagnostic Center for psychiatric evaluations. These inmates, also, were suffering from feelings

of injustice as they felt they too were being punished for a work stoppage for which they had no responsibility, since they were segregated from the rest of the population. They too were not allowed telephone calls. They received the same two meals a day as the general population.

There were 60 inmates being held in this unit with one correctional officer assigned to control them. (From time to time an additional officer would be assigned to assist when available - usually a new officer who was in training.) This problem was resolved the next day by moving these inmates to another housing unit which did not represent this kind of control problem.

The Third Day - Wednesday, March 18, 1981

During this day the Ombudsman and Ombudsman Associate walked some of the runs of the cellhouses talking with inmates to ensure they understood what was happening and to get a better understanding of how the situation was perceived by the general population. In conjunction with this, a number of individual complaints were brought to our attention, some of which we accepted and worked on with staff. We found that a number of prisoners were unaware of the reason for the lockdown. A few did not even know that there had been a work stoppage. Most of the inmates, however, were aware of the work stoppage but attributed a number of different reasons for the cause of the work stoppage. (These reasons and others which we learned on subsequent days will be summarized later in this report.)

The Fourth Day - Thursday, March 19, 1981

The administration put the Penitentiary on the usual work day schedule and served the morning meal in the dining hall. After the meal, however, inmates did not report to work but returned to their cellhouses. There was about a half an hour in which there was some doubt that inmates were going to return to their cellhouses. Approximately 100 inmates milled around between the cellhouses.

Once in the cellhouses, however, some inmates became unruly. This was a particular problem in "C" cellhouse, in which most of the inmates were not locked into their cells. Adding to the problem was a small fire in "C" cellhouse, which was quickly put out. The many inmates who did want to get into their cells were unable to do so, because the officers could not get to them to let them in. A number of items, some heavy, were being thrown down from the fifth tier at staff who were down in the front of the cellhouse.

At approximately 9:30 a.m., two specially trained, seven-man CERT Teams (Correctional Emergency Reaction Teams) moved into "C" cellhouse. They were backed up by a small squad of specially equipped correctional officers, and a police dog and its handler. The CERT Team members were armed either with batons or shotguns and were protected by bullet proof vests, helmets, face shields, and gloves. Approximately two warning shots were fired. After the teams had secured their positions on the ground floor of the cellhouse, they then proceeded to go tier by tier locking inmates into whatever cells were available. Later in the morning, inmates who were in the wrong cells were transferred to their own cells.

The CERT Teams then moved on to "B" cellhouse where they assisted the cellhouse staff in locking up inmates rather rapidly. There were only very few inmates who had not as yet locked down in that cellhouse. The CERT Teams left the institution sometime before 10:00 a.m., having been inside the walls of the Penitentiary for approximately a half an hour.

There was one allegation of an inmate having been hit with a BB or shot from a shotgun blast. This inmate was interviewed by a staff member of the Ombudsman Office. Later he was examined by institutional medical staff. The determination was that this was not a shotgun wound. It was a superficial puncture with no apparent bleeding and no shot or metal to be found.

Later in the day the CERT Teams, unarmed, returned inside the walls to take 22 inmates out of their cells and confine them in the A&T Building. These inmates had been identified as active participants in the work stoppage and other disruptive behavior. One of the CERT Teams was responsible for removing inmates from their cells, hand cuffing them and securing their personal property, while the other CERT Team was responsible for escorting the inmates from their cells to the A&T Building, where they were then strip-searched for contraband. This was carried out without incident. Ombudsman Office representatives worked with each of the two teams to observe these operations.

The Fifth Day - Friday, March 20, 1981

The inmates in all but "C" cellhouse were allowed to go to the dining hall for the morning meal. The vast majority of inmates proceeded from the dining hall to their work details.

The Ombudsman and Ombudsman Associate walked several of the runs of "C" cellhouse during the morning talking to those inmates who were still locked down. The purpose for this was to ensure that they understood what was going on and to listen for their perceptions of the present situation. Counselors in "C" cellhouse were performing a similar function and, at the same time, were getting names of those inmates who either intended to go to work or intended not to go to work.

"C" cellhouse was allowed out to the dining hall for the noon meal along with the rest of the population. It appeared that the vast majority of inmates from "C" cellhouse, as well as from the entire institution, went to their work details for the afternoon.

Implementing the New Policy - Friday, April 10, 1981

On Friday, April 10, 1981 the new inmate store procedures were fully implemented. There were the usual problems which come with any major procedural change, but no serious incidents were observed by the Ombudsman staff members who were observing the new procedures. Continued observation of this procedure is planned by the Ombudsman Office.

Summary of the Conditions of the Lockdown

The conditions of the lockdown known to us are as follows:

1. Inmates remained locked in their cells or dormitory areas for 24 hours a day.
2. Two meals a day were delivered to inmates in their cells.
3. Sick call was not held during this period of time.
4. Inmate access to institutional staff, particularly Unit Team members, was very limited in the three general population locked cellhouses.
5. Those inmates in locked cellhouses (as opposed to dormitory areas) did not have the opportunity to shower during this time.
6. No visits were permitted, except those with attorneys and persons who traveled long distances from out of state.
7. No phone calls were permitted.
8. Because of the duration of the lockdown, it turned out that inmates did not have the opportunity to purchase items from the inmate store during the week of the lockdown.
9. Evening programs, including college classes and inmate activity groups, were cancelled.

Summary of Inmate Complaints

This incident began with inmate protest concerning the new inmate store policy. Instead of personally going to the store to present their orders and then collect their items, inmates under the new policy would have their purchased items delivered to their cellhouses. Complaints regarding this new procedure included:

1. Inmates could not trust that the items they were paying for would in fact be included in their orders when they were actually delivered.
2. If an item requested for purchase was not available, the inmate would not be present to negotiate with the store personnel which item he would prefer to have substituted for the item out of stock.
3. The two refrigerated items - ice cream and chilled pop - would not be made available.
4. Items such as potato chips and pastries would very likely get crushed in the delivery procedure from the store to the cellhouse.
5. There was no formal procedure established to rapidly rectify complaints from inmates regarding discrepancies between their orders and the items they actually received.
6. The new policy imposes limitations on the purchase of certain items. The limitations were seen by some inmates as unreasonable.

It is our understanding that the administration's reasons for instituting this new store policy were the following:

1. To avoid requiring inmates to stand in long lines during inclimate weather in order to get to the store.

2. To avoid the opportunities which inmates had to be robbed, as they carried their store goods from the store to their cells.

The prison administration did agree - before the incident began - to make ice cream available through a different procedure. Making ice cream available was in fact implemented on April 13, 1981.

As the week of the lockdown progressed, the list of inmate complaints became longer. Indeed it got to the point where a number of inmates were denying that the work stoppage was in any way related to the change in the store policy and instead held forth their particular complaint as the primary cause. Although not intended as an exhaustive list, the complaints we heard included the following:

1. The poor quality of food which is served in the main institutional dining room.

2. The poor quality of medical services provided and the negative attitude in which these services are made available by some of the medical staff.

3. Inmates who have work details are paid from 30¢ to 90¢ a day. This has been a fixed rate for the last several years and has failed to account for inflation, which has definitely increased prices at the inmate store.

4. Morning yard was stopped over a year ago for the stated purpose of renovating a building in the area. Although the renovation had been completed some time ago, morning yard is still not provided.

5. Fines, as punishment resulting from disciplinary board action, are being used excessively instead of using other punishment measures such as restrictions and disciplinary segregation.

6. Not enough jobs are made available, so that inmates who would like to work can earn money to purchase items at the inmate store.

7. The institution is slow in crediting money to inmate accounts, so inmates are unable to spend their money at the store.

Commentary

No one was seriously injured throughout the entire week. The week began with an effort on the part of some inmates to have a peaceful demonstration against the new store policy. When events began to get out of hand on Thursday, the administration used force to regain control of the institution. Order was restored and sustained.

Preston N. Barton II
Ombudsman

May 12, 1981

STATE OF KANSAS
DEPARTMENT OF CORRECTIONS

Patrick D. McManus
Secretary

R. A. Atkins
Director

Area Code; 913 - 727 - 3235

KANSAS STATE PENITENTIARY
P. O. Box 2
Lansing, Kansas 66043

May 18, 1981

Mr. Preston N. Barton II
Ombudsman
504 Kansas Avenue---Suite 539
Topeka, Kansas 66603

Dear Mr. Barton:

The following are my comments on your report on the KSP inmate work stoppage and lockdown.

In your background information paragraph you do not set forth the background going back through the summer of 1980 in which the inmate groups within our forum system were advised of our intention to convert the entire institution to a bagged delivery system for canteen items. It is probably pertinent in this paragraph to indicate that 40% of all inmates at KSP were being serviced by a bagged system prior to this incident. The details with regard to that are set forth in our report, a copy of which was made available to you.

Your background information does not reflect the inmate activity meetings which occurred on Saturday night, March 14th. Information on those meetings are also contained in our afteraction report.

With regard to the second day and the problems in A & T, your report fails to note that at the very time that certain inmates were disrupting normal routine by flooding the A & T structure, that store items were being distributed by the institution to those inmates who were not disrupting the institution.

With regard to the third day, I find it not unusual at all that some prisoners claimed to be unaware that there was a work stoppage or a lockdown. There were quite a few million people from 1938 to 1945 who were unaware that a world war was going on. I had specifically directed the staff to "stand down" on Monday and to attend to administrative matters.

With regard to the fourth day and the entry of the CERT teams into C Cellhouse, your report says "Approximately two warning shots were fired." There is no approximation involved here. Precisely two shots were fired--no more, no less.

I have no comment to make on any other portion of your report with the exception of your commentary. While inmates may perceive that it is possible to conduct a peaceful demonstration within a maximum custody institution, it is our position that normal operations are peaceful and that anything else is less than peaceful. In effect, no one in this institution has the right to disrupt the operation of the institution in any fashion and such disruption is basically not peaceful. The inmates' perception of peaceful is that violence is not specifically intended to result from their illegal activity. In any type of demonstration the potential for violence exists, hence to consider a planned demonstration peaceful is to pray alot in the fond hope that things won't get out of hand.

Sincerely,

R. A. ATKINS
DIRECTOR

RAA:lm

cc: K. G. Oliver (with basic report)

SELF-MUTILATIONS IN THE SEGREGATION UNITS AT THE KANSAS STATE PENITENTIARY: MARCH - APRIL, 1981

SUMMARY

This inquiry was undertaken due to an increase in the incidents of self-mutilations at the Kansas State Penitentiary. Investigation revealed that, during the month of March and April, 1981, there were 33 incidents of self-mutilation. The majority (30) of these occurred in the Adjustment and Treatment Building (A&T). The remaining three occurred in the Adjustment and Treatment Annex (which then was in A cellhouse). The predominant form of self-mutilation was by cutting and the instruments reportedly used were razor blades.

Nine inmates, who had been identified as self-mutilators, were interviewed during the course of this study. Information obtained included length of sentences, reasons for being in a segregation unit, and personal histories as they related to self-mutilating behavior. Another aspect of the self-mutilation phenomenon which was examined was the group dynamics. There was a degree of interplay and influence noted between some of the self-mutilators although it was rarely admitted. It was found that the inmates were not receiving the full amount of mandated time outside of their cells; consequently, some men were only allowed to leave their cells for approximately ten minutes twice a week when they showered.

This segregated status makes it difficult, if not impossible, for an inmate to take an active role in solving his own problems. He must depend on others. The resulting frustration was cited as a motivation for the self-mutilating behavior and in some cases inmates self-mutilated in order to get access to problem-solving mechanisms.

One means of monitoring inmates in segregation and ensuring they have contact with middle management staff, is through the work of the Administrative Segregation Review Board. However, none of the inmates interviewed who were eligible to be seen on a monthly basis by the Board were, in fact, being seen.

Two previous reports dealing with conditions in the Adjustment and Treatment Building were issued by the Office of the Ombudsman for Corrections. A total of 37 recommendations for changes were presented in the earlier reports; but no recommendations are included in this report. However, there is a restatement of the Ombudsman Office's position in support of using the A&T Building for only short-term confinement.

Appended to the report are three graphic presentations of the findings. Also attached is the August 4, 1981 response from Mr. Robert A. Atkins, Director of the Kansas State Penitentiary. There, however, is no written response from the Secretary of Corrections.

Introduction

During the last two weeks in March, 1981, there was an increase in the number of inmates who were performing acts of self-mutilation in the Adjustment and Treatment Building (A&T) at the Kansas State Penitentiary. The decision was made by the Ombudsman Office to study these incidents to determine if there were any common themes to them or an underlying organizational problem.

During the month of March there were fifteen incidents of self-mutilation by cutting in the A&T Building. Twelve of the incidents occurred during the last two weeks of the month, and seven of those can be attributed to two persons. During the month of April, there were thirteen incidents of self-mutilation by cutting in A&T by four persons. The last occasion was on April 17, when three people cut themselves -- one of them three separate times in less than five hours.

Also in April, there were four incidents of self-mutilation by sticking wires into the abdomen -- two incidents in the A&T Building and two in the A&T Annex. There was also one reported incident of self-mutilation by cutting in the A&T Annex in April.

Ten inmates were identified as having self-mutilated during the months of March and April, 1981, in A&T and the A&T Annex. Names were obtained from Mental Health Personnel and from the daily log which is maintained in the A&T Building. Interviews were then conducted with nine of the ten inmates. The tenth man was unavailable for interviewing because he had been transferred subsequent to his self-mutilation to Larned State Hospital.

Between April 2, and April 7, 1981, Ombudsman Office staff interviewed seven of the inmates who self-mutilated. Two inmates were unavailable at that time due to hospitalization. However, interviews were conducted with these inmates on April 29, 1981. Additionally, consultative interviews were conducted with line and supervisory staff members. A summary of the information obtained from the interviews is presented in this report.

Adjustment and Treatment Building

The A&T Building is a maximum security facility which houses men who are being held pending results of investigations, men who are serving disciplinary time for offenses which occurred inside the institution, men who are considered to be dangerous to themselves and/or others, and men who are in protective custody. The building has three wings: the south and east wings are comprised of single-man segregation cells, and the north wing contains multiple-man cells in addition to single-man cells.

The availability of certain privileges and/or activities is determined, in part, by cell location within the A&T Building. For example, only those inmates housed in the north wing of A&T, normally have an opportunity to work. Also, most inmates cannot have radios or TV's on the east and south wings.

All of the nine men interviewed had self-mutilated in A&T. Two of these men had also self-mutilated in the A&T Annex. Eight of the persons who were interviewed had been housed in segregation cells on the east wing of the A&T Building at the time of the incident(s) of self-mutilation and one was housed on the south wing. Two inmates self-mutilated by sticking wires into their abdomens. Eight inmates self-mutilated by means of cutting themselves. The most common part of the body to be cut was the arm, but two wounds were reportedly made to the Achilles tendon area and one was to the chest. The wounds to the arms which were observed, varied in length from approximately one inch to six inches.

We were told by the inmates interviewed that razor blades were used to inflict the wounds. They said a large number of blades were available in A&T at all times, despite periodic searches by institutional staff. We were told that blades are brought in by inmates transferred into A&T and also by inmate workers who enter the building. In the A&T Annex, however, razor blades are issued since they are not considered to be controlled material.

Adjustment and Treatment Building Annex

Two of the men interviewed had also self-mutilated while housed in the A&T Annex. This housing area is located in A cellhouse and is a segregation unit for some of the inmates in protective custody. All inmates in this housing unit are provided a daily exercise period outside their cells, are allowed to have radios and televisions, and, if selected, have the opportunity to work.

The two men who self-mutilated, did so by means of sticking wires into their abdomens. The wires used were paper-clips which had been straightened out and measured approximately 3½ inches in length. One of these men also self-mutilated by cutting himself in the A&T Annex.

Conditions

According to information provided by the nine men interviewed, the shortest sentence being served was 1 to 5 years and the longest sentence was 30 years to life. The nine persons who self-mutilated in the A&T Building had been in the segregation unit from 3 to 8 months. Four of them were doing disciplinary time, while the rest of them were in protective custody. Of those interviewed, no one had a radio or television at the time he self-mutilated. (Electronic equipment is not allowed on the east wing of the A&T Building for persons in protective custody or disciplinary segregation.) Five inmates indicated that they received correspondence.

With one exception, all of the inmates reported being prescribed medication. Three men were reportedly taking Benadryl, an antihistamine with sedative effects, and four were taking Sinequan, an anti-depressant. Three inmates were getting Maarax for asthma. It is unclear whether or not these medications were actually being taken. At least two inmates told us that they were not taking the medications given them.

Six of the men were getting one to two hours of exercise outside their cells on a weekly basis. KSP General Order No. 4, Change 2 (April 28, 1980)

states: "Inmates held in the A&T Unit will, as a general rule, receive exercise yard privileges of 45 minutes to one hour twice each week subject to their continued good behavior in the unit and subject to scheduling of such exercise by Unit Team...."

The Department of Corrections' Regulations set an even higher standard. Regulation No. 44-7-102 effective May 1, 1980 (and current at the time of this writing) states, in part: "Inmates confined in disciplinary or administrative segregation shall be allowed to have exercise outside the cell for those who so desire, for at least one (1) hour per day at least three (3) days per week unless security or safety considerations dictate otherwise." The regulation further states if limitations are necessary on the normal routine, the reasons for the limitations must be documented on a case by case basis and a specialized exercise plan for use in the cell must be provided for each inmate by a doctor or physical fitness professional.

None of the inmates interviewed were receiving three hours of exercise outside their cells per week. Additionally, there was no documentation as to why the exercise period was not being allowed and no inmate had been given exercises to do in the cell.

Compliance with the regulation is made difficult by the lack of staff. In a report on the Adjustment and Treatment Building at KSP prepared by this Office in 1977, recommendations were made to increase the number of security staff in A&T, as well as the amount of exercise time outside the cell. This has not been done.

Personal Histories of the Self-Mutilators

Three of the men whom we interviewed gave a history of self-mutilation extending back 5 to 10 years. Three others interviewed self-mutilated for the first time between February and April 1981. This behavior is generally seen by correctional specialists as an institutional phenomenon; and all of the men interviewed indicated that they had self-mutilated only while incarcerated.

Motivation

Various reasons were given for the self-mutilating behavior. Some of the inmates said that they self-mutilated because of "depression" or "frustration". Most of the men, however, had more concrete reasons for their behavior. At times the behavior was calculated to bring about a specific result. The desired results were accomplished in some cases. The examples which follow were taken from information obtained in interviews with inmates housed in the A&T Building. (Concrete examples were not provided by inmates in the A&T Annex.)

Two men self-mutilated (at different times) in order to get to the Captain's office to talk about a problem with mail delivery. When these men were taken to the infirmary for treatment of their wounds, they went through the Captain's office and were able to talk to the Captain about their problems. Another man stated that he had a problem getting medical attention. He self-mutilated as a way of getting to the infirmary. While he was in the infirmary being sutured, he explained his problem and it was treated. A fourth man said that he only wanted to get out of his cell for awhile, and did when he was taken to the infirmary.

When asked what efforts to solve problems had been tried prior to self-mutilating, there was a great deal of frustration expressed about getting any attention to their problems or answers to their requests for assistance. All of these inmates were segregated and had less access to staff members than those inmates in the general population. As was stated earlier, six men housed in the A&T Building were getting some exercise outside their cells. The remaining three men, however, were only allowed out of their cells on a routine basis for ten minutes, twice a week, for showers. Due to the lack of ability to move around in the A&T Building, the inmates do not have direct access to counselors and must rely on inmate porters or correctional officers to carry messages. Grievance forms can only be obtained from Unit Team counselors. So this problem-solving mechanism can only be used if an individual can communicate with the Unit Team.

The institution has a mechanism for monitoring those inmates who are in segregation for other than disciplinary reasons. That mechanism is the Administrative Segregation Review Board. The Board is comprised of one person from the security staff, and one person from the clinical staff and one person from the classification or other non-security staff. According to Department of Corrections' Regulation No. 44-14-311, effective May 1, 1980 (and current at the time of this writing), the Administrative Segregation Review Board is supposed to "review, on a monthly basis, the status of each inmate confined in Administrative Segregation and make written recommendation to the facility prison administration for one (1) of the following: (1) Continue in present status. (2) Return to general population. (3) Transfer to other Kansas state institution or facility. (4) Transfer to another institution in another state or a federal institution."

This regulation is not being complied with to the extent that inmates in protective custody in A&T and in the A&T Annex are not routinely seeing the Administrative Segregation Review Board. There was an indication that this noncompliance with the regulation was the result of too few staff members and a very high number of inmates requesting protective custody.

None of the five protective custody inmates interviewed had seen the Board. This can only exacerbate the sense of frustration felt by these men, as they do not have any assurance that anyone will be seeing them on a regular basis to address their problems.

In discussing the conditions in the A&T Building, one staff member spoke of the staff members' frustration due to their own isolation from the rest of the institution and lack of direct access to problem solving mechanisms. This frustration is created even though the correctional staff members are in a segregated situation for periods of only eight hours. Given the fact that the inmates interviewed spend twenty-two hours or more each day segregated from others, it is understandable that their frustration level is high.

Group Dynamics

When asked whether they had been influenced in their behavior by anyone, all of the inmates interviewed denied it. It should be noted, however, that three of the inmates claim to have influenced others to self-mutilate. Seven of the men displayed pride in their behavior, exhibiting their wounds openly like battle scars. This pride was demonstrated by one man when he spoke dis-

paragingly of another man's wounds as "scratches". Pride in being an accepted member of a group is not limited to self-mutilators or even to prisoners. We were told by a correctional staff member that he was treated with more respect by other staff members after he was injured in an assault by an inmate. That injury made him a member of the "club". This behavior can, of course, take more extreme forms. We were told in the course of our interviews, that one inmate asked if he could have the wires which had been removed from his abdomen as "souvenirs"

The inmates are very aware of the self-mutilating activity that occurs--not only who is doing it, but sometimes, why. Some of the inmates only influence others by example, while other inmates take a more active role by actually encouraging self-mutilation and providing the means (razor blades). We were told, by inmates, of a system for passing razor blades from one tier to another in the A&T Building. If an inmate on a lower tier wished to self-mutilate, an inmate in a cell above him could tie a razor blade to a string and toss it over the edge. The inmate on the lower tier would then remove the blade, cut himself, replace the blade on the string and signal the man above to pull the string back up. Only after the blade was secured, would the correctional staff be notifed of the injury incident.

While most of the men saw their actions as private acts, uninfluenced by others, three men stated that there had been a group effort on the night of March 19--while the institution was locked down due to an inmate work stoppage. On that night five men on the east wing of A&T had agreed to self-mutilate as a protest against what they believed to be mistreatment of inmates on the south wing.

Follow-up to the Self-Mutilations

After they self-mutilated, at least eight of the ten inmates were contacted by Mental Health Personnel; and some are being seen on a regular basis by Mental Health representatives. KSP policy since May, 1979, has directed that persons with self-inflicted injuries be interviewed initially by a member of the Mental Health Unit with referral for psychiatric consultation at the earliest available date.

Since they self-mutilated, four men have been moved to a different area where they can have electronic equipment, regularly scheduled exercise outside the cell, the possibility for employment and increased access to staff. Since they moved, they have not self-mutilated.

The Adjustment and Treatment Building Re-Visited

While the subject of this report is inmate self-mutilation, the setting is primarily the A&T Building. Two of the nine men interviewed self-mutilated in the A&T Annex, but they also self-mutilated in the A&T Building as did the other seven inmates interviewed. The report, therefore, focuses much attention on the A&T Building.

The Office of the Ombudsman for Corrections conducted two earlier studies of this unit. The first study was presented in a report, dated March 1977, entitled, "Report on the Adjustment and Treatment Building at the Kansas State Penitentiary". There was a second report, dated June 26, 1978, entitled,

"Inquiry into Inmate Self-Mutilation in the Adjustment and Treatment Building". The first report contained 24 formal recommendations for changes in A&T, and the second report presented 13 recommendations, for a total of 37 recommendations for changes. Some of these proposed changes have been implemented (fully or partially), but the majority of them have not.

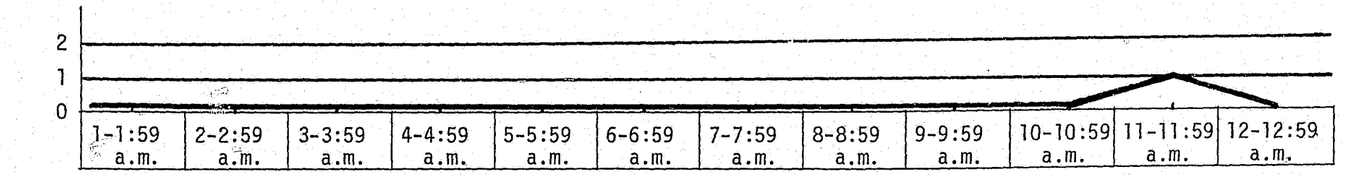
No additional recommendations are being made at this time. The statements made in the previously presented 37 recommendations appear to remain sufficient to address the concerns identified in this report.

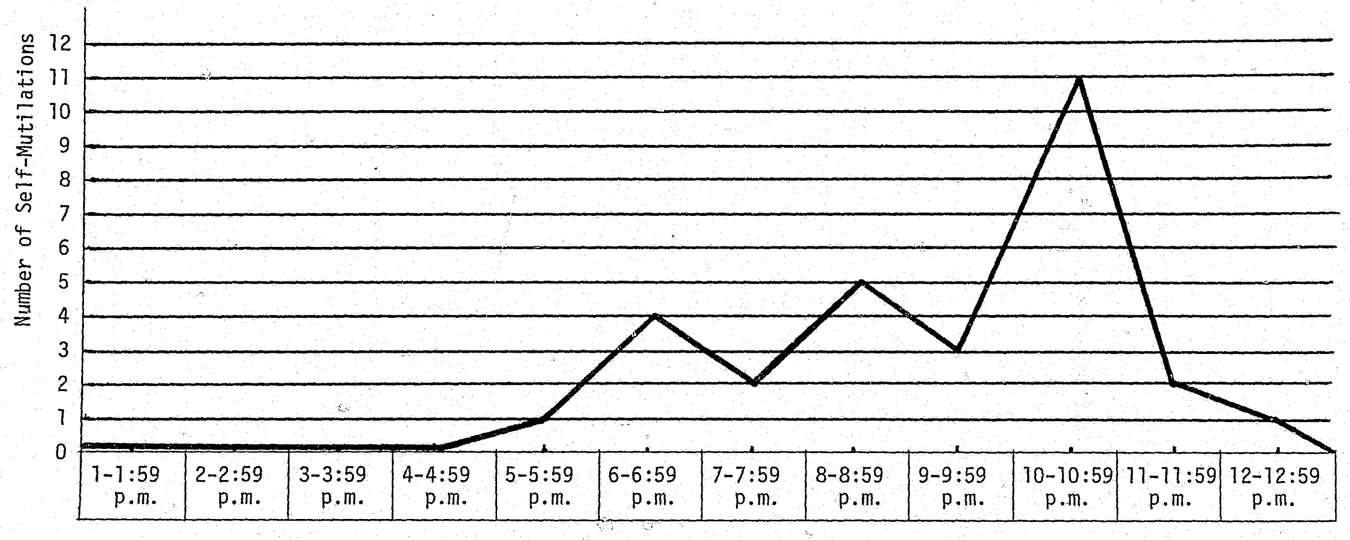
We remain committed to the notion that the A&T Building should be used only for short-term punitive purposes. More appropriate programs and facilities need to be developed for protective custody inmates, psychiatric patients, and any other inmates requiring long term confinement under maximum custody conditions.

Preston N. Barton II
Ombudsman

June 30, 1981

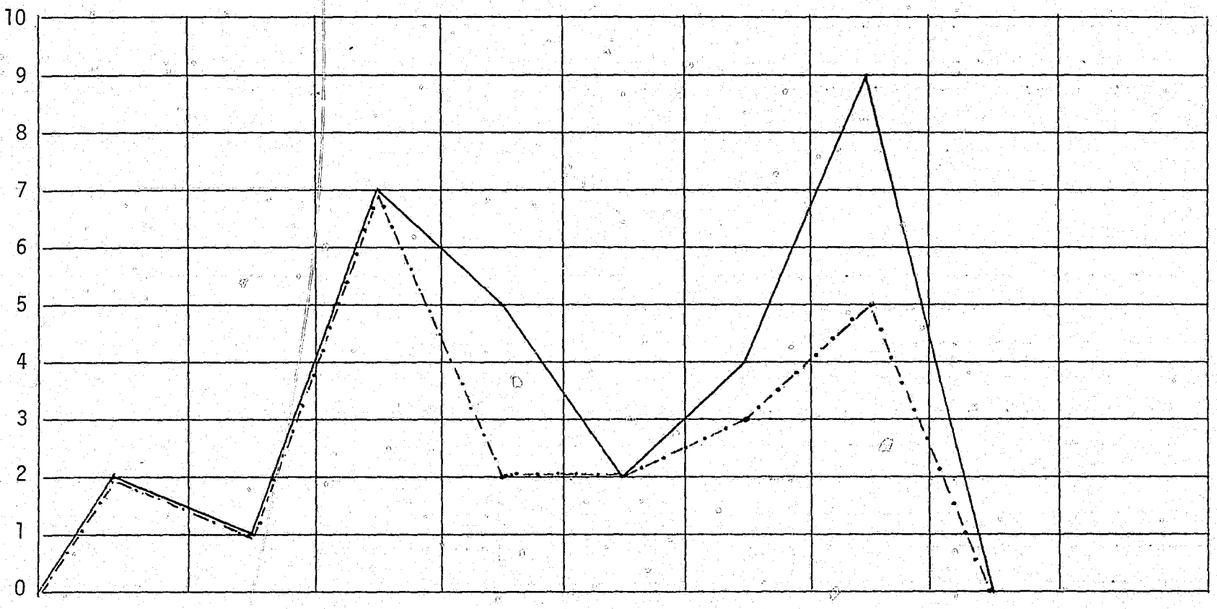
SELF-MUTILATIONS RELATED TO TIME OF DAY*





*Data pertains only to incidents in the A & T Building

Self-Mutilations Related to Date*



Months of March and April, 1981, in 7-Day Groupings

——— Number of incidents of self-mutilation

_ . _ Number of persons who self-mutilated

* Pertains only to incidents in the A&T Building

SUMMARY OF DATA ON INDIVIDUAL SELF-MUTILATORS

Inmate Identification	#1	#2	#3	#4	#5	#6	#7	#8	#9
Number of Self-Mutilations	2	1	3	1	4	8	7	4	2
Location when Self-Mutilated	E wing A&T	E wing A&T	E wing A&T	E wing A&T	E wing A&T	E wing A&T	E wing A&T	E wing A&T and Annex	S wing A&T and Annex
Status*	P.C.	D.S.	D.S.	P.C.	D.S.	D.S.	P.C.	P.C.	P.C.
Sentence**	1-5	30-Life	5-20	1-10	15-Life	18-55	0-27	4-40	10-20
Length of Stay in Unit**	5 mos.	4 mos.	3 mos.	4 mos.	3 mos.	8 mos.	4 mos.	4 mos***	8 mos***
Previous Psychiatric Hospitalizations	yes	yes	yes	no	yes	yes	yes	yes	yes
Exercise Outside Cell	yes	no	yes	yes	no	no	yes	yes	yes
Administrative Segregation Review Board	no	N/A	N/A	no	N/A	N/A	no	no	no
Radio, T.V., or Stereo	no	no	no	no	no	no	no	no	no

* P.C. - protective custody; D.S. - disciplinary segregation
** Information obtained from inmate
*** Combined time spent in A&T Building and A&T Annex

STATE OF KANSAS
DEPARTMENT OF CORRECTIONS

Patrick D. McManus
Secretary

R. A. Atkins
Director

Area Code; 913 - 727 - 3235

KANSAS STATE PENITENTIARY
P. O. Box 2
Lansing, Kansas 66043

RECEIVED
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August 4, 1981

Mr. Preston N. Barton II
Ombudsman
503 Kansas Avenue, Suite 539
Topeka, Kansas 66603

Dear Mr. Barton:

SUBJECT: REPORT ON SELF-MUTILATIONS DURING MARCH AND APRIL, 1981.

Reference is made to your letter of July 14, 1981, which forwarded a draft paper entitled "Self-Mutilations in the Segregation Units at the Kansas State Penitentiary: March - April, 1981" for response by this institution.

We have examined reference report in the light of our research and continuing responsibility for control and/or treatment of difficult mental health cases.

The following general comments are provided:

1. Your report seems to indicate that self-mutilations are "generally seen by correctional specialists as an institutional phenomenon; and all of the men mentioned indicated that they had self-mutilated only while incarcerated." Our research into the literature reveals the following:

   a. (Simpson, 1976) Self-mutilation is common human behavior. Simply defined it is a behavior inflicting physical injury on oneself, regardless of apparent or punitive effect.

   b. Simpson (1976) Self-mutilation doesn't necessarily constitute an act of suicide or direct self-destruction. It is, in many ways, an act of anti-suicide for the cutting is used as a direct, reliable and rapidly effective way of coming back to life from a dead, unreal, or proceeding state. Self-mutilation in this context almost amounts to self-therapy, achieving swift reintegration, repersonalization, and ending a very unpleasant sequence. Gruenebaum and Kluman (1967) have called wrist-slashing a "self-prescribed treatment that does not involve verbalizing feelings in psychotherapy."

   c. Self-mutilation is a superbly economical technique whereby a delicate dermal injury can serve multiple psychological functions in the cutter, while stirring up an inordinate amount of attention from others whose outrage and alarm are usually all out of proportion to the scale of the event.

   d. Phillips and Muzaffler (1961) describe an incidence of 4.3% self-mutilations in a group of psychiatric inpatients. Berter, et al. (1968) studying suicide attempts in hospitalized adolescents, found that self-inflicted injury accounted for 37.8% of all attempts. Ballinger (1971) found that 3.4% of a group of general psychiatric patients had injured themselves in the course of a month.

   e. In prison, self-cutting is, along with hanging, the favored means of attempting suicide (Beigel and Russell (1972). That is not simply due to the relative unavoidability of other methods; it is also a technique to manipulate one's way into better conditions.

   f. Research done by others including Crabtree (1967), offers and and Barglow (1960) confirms the deviant nature of cutters and their apparent motives as to gain attention, to gain prestige in their social group, to reduce tension, control their aggression and to express a need for love and caring.

2. Studying the frequency of self-mutilations witout regard to the persons involved is impossible, hence we have, with your cooperation, identified the inmates involved in March and April. All but one of these inmates have been treated in psychiatric hospitals, some of them repeatedly. Their behavior is previously learned in such settings. They fall into a broad category of sub-normal, autistic, schizophrenic, or brain-damaged children and adults who display a high incidence of self injuring behavior (Dehissavoy, 1961); Frankel & Simmons, 1976; Green, 1967, 1968; and Shodell and Reiter, 1968).

3. The attached statistical analysis covers the period 1 January 1980 through May 31, 1981. Data is correlated to mental health intervention. Please note that in the summary prepared by the Mental Health Unit the conclusion is drawn that despite the dramatic increase in mental health intervention in self-mutilation cases, the Unit Team's alleged failure to maintain adequate communications with inmates, particularly on the second shift (2-10) is cited as being part of the problem. Since I am personally aware of the extent of officer and non-uniformed contact with these inmates during the 0800 to 1600 hour time period, I find it difficult to believe that the deviant behavior is anything other than manipulation when the inmates involved know that the absence of the day shift will result in staff response per policy in the absence of a full administrative and clinical staff.

4. The essence of the problem is best expressed by these comments made to me by the KSP Chief Psychologist:

a. MHU services have been dramatically increased for the A & T population, yet self-mutilation persists. Although there may be a lack of communication between team members and some inmates, each time an inmate mutilates, he receives a great deal more attention than would usually be required for such an episode. So, in essence, our caring attitude may well be one of the factors which encourages an inmate to mutilate for attention and self-gratification.

b. The answer does not lie in the fact that we must do all we can to stop self-mutilation, but rather how to contain this behavior with less damaging impact on staff and inmates.

c. Also, we will be fooling ourselves if we started to believe that by even if we did our best, the problem would go away. In my opinion, with all due respect to all concerned and with all the MH services at the disposal of A & T inmates, self-mutilation is here to stay and will result in more headaches, more research and more lost staff time that might better be used to provide services to others rather than to those who are abusing it in A & T, as the listing below reflects.

SELF-MUTILATORS - MARCH/APRIL 1981

OMBUDSMAN CODE NUMBER	NAME	INMATE NUMBER	TIMES SEEN BY MHU IN 1981
1			24
2			4
3			29
4			12
5			7
6			18
7			15
8			7
9			4

Sincerely,

R. A. ATKINS
DIRECTOR

RAA:lm

1 Incl. a/s

FREQUENCY III

Frequency III deals with the reason for self-mutilation. In 1980 only three reasons were given for self-mutilation. These reasons were: "Upset because of parole date, to get fresh air, and to attempt suicide". Therefore, only 13% of the self-mutilations gave any reasons for cutting and most gave no reason.

In the first six months in 1981 this was not the case. Here 47% of the self mutilizations gave reasons for their cutting. These are: "Nothing better to do, to end it all, cut myself so I could see Unit Team, to get out of KSP, no Unit Team cooperation, don't like Kansas, I am so far from home, tried to end it all, Unit Team is not doing anything about my Form 9s, no medical attention, holding back my mail, my prescriptions are messed up, legal mail problems, I'm sick, so they'll remove wire from my belly, so they will fix my finger, Unit Team is not cooperating, want to be removed from this place, medicine was not refilled, they did not give my asthma medication, wanted medication to help sleep, to get medicine, had a headache, and to abstain from drugs.

Of the 23 reasons for self-mutilizations that were recorded 30% were for medical treatment and 26% of the reasons for self-mutilizations were against the Unit Team. This represents a major increase in the number of recorded reasons for self-mutilizations.

FREQUENCY IV

Frequency IV deals with the number of visits made to A&T by the MHU staff and the Psychiatrist. In 1979 only 21 visits were made to A&T by the MHU staff. 267 visits were made to A&T in 1980; during the first six months of 1981 - 317 visits were made to A&T. This gives a total of 605 visits to A&T in the past 2½ years.

In 1980 there were 23 visits made by a Psychologist or Social Worker to A&T because of self-mutilations. The Psychiatrist also saw these individuals due to their self mutilations.

During the first 6 months of 1981, 49 visits were made to A&T by Social Workers or Psychologists due to self-mutilizations. The Psychiatrist also saw these individuals.

However, the Psychiatrist talked to 85 additional inmates for a total of 108 consultations in 1980. In the first six months of 1981 the Psychiatrist visited 49 inmates who self-mutilated themselves. In addition to these the Psychiatrist visited 21 additional inmates in A&T for a total of 70 consultations.

Enclosure to Response from
Director Atkins

Counseling inmates in A&T for 1980 took an additional 221 visits by Psychologist and Social Workers. Therefore, in 1980, inmates who performed self-mutilations took 19% of the Psychologists, Social Workers and Psychiatrist's time in A&T. During the first six months of 1981, 219 visits were made to A&T for counseling and self-mutilation. Self-mutilating inmates for the first six months of 1981 took 31% of the time spent in A&T. Therefore, there has been significantly more time spent in A&T during the first six months in 1981 than at any other time spent. (See attached Graph for inmates and the number of contacts).

FREQUENCY V

Frequency V deals with the time inmates mutilated themselves. It was found that in 1980 10% of the self-mutilations occured on the first shift. The second shift had the most recorded self-mutilations with a 66% rate of occurance. The third shift had the next highest percentage of self-mutilations with a 23% occurance on that shift.

In 1981 there was not a significant change in this trend. The first shift had only a 4% self-mutilation occurance while the second shift had a 67% occurance rate. Third shift again came in second with a 29% occurance rate for self-mutilations.

SUMMARY

Self-mutilations have become a major problem. Most of these self-mutilation episodes occured in A&T. Also, there has been a significant increase in these self-mutilations since January 1, 1981. With the increased self-mutilations has come an increase in the number of inmates mutilating themselves.

Inmates in A&T appear to be having problems communicating with the Unit Team concerning problems in A&T as well as medical treatment. However, it should be noted that Psychiatric counseling and therapy by the MHU has increased significantly since 1979. In 1979 only 21 visist were made to A&T but in the first six months of 1981, 317 visits were made to A&T to deal with crisis problems and psychological counseling. In the past two years the second shift has had the most occurance of self-mutilations. This is followed by the third shift and then the first shift. In percentages the second shift has approximately 66% of the self-mutilations. The third shift has approximately 29% of the self-mutilizations, while the first shift has approximately 4%.

In conclusion it can be stated that there is an increase of self-mutilizations in A&T, even though Mental Health has increased it's efforts to work with the inmates in A&T. The increase in self-mutilations appear to be influenced by the Unit Team's lack of communication with the inmates. Since the majority of self-mutilations occur during the second shift, careful examination of this shift does need to be considered in identifying potential self-mutilation causes. Therefore, through the study of these statistics it appears that the Unit Team and the second shift in A&T need careful evaluation in potential causes of self-mutilation behavior.

EXAMPLE OF INVESTIGATION REPORTS

Introduction

Except for the first example, the investigation reports presented here have been edited to make the identity of persons and institutions less discernible. The first report is in the form of a letter to the Secretary of Corrections. The second report relates to an external review of an inmate grievance requested by the Secretary of Corrections. This is the first time the Department has requested the Ombudsman Office to be involved in its Internal Inmate Grievance Procedure.

The remaining investigation reports were written for Rep. Ben Foster, then Chairman of the Joint Legislative Committee on Special Claims Against the State. These reports are examples of investigations into claims regarding damaged or lost personal property, or regarding injuries resulting in permanent disability. Each of these examples resulted in a recommendation to the Legislature. The disposition indicated at the end of each example describes the response of the Legislature to the Ombudsman's recommendation.

The reader may be interested in reviewing our study entitled, "Property Loss Study", which provides an extensive description of reimbursement procedures and recommendations for improvements. This report is appendix VII of the *Fourth Annual Report*.

Investigation 1 - Safe Environment During Prison Renovation Projects

March 3, 1981

Mr. Patrick D. McManus
Secretary of Corrections
535 Kansas Avenue - Room 200
Inter Office Mail

RE: Safe environment during prison renovation projects

Dear Mr. McManus:

This letter is a follow-up to our telephone conversation of Friday, February 20, 1981 in which I expressed concern for the persons assigned to work and live in B cellhouse at the Kansas State Penitentiary while that cellhouse is under renovation. I recommended that inmates be removed from B cellhouse during times when renovation work is being done. It, also, was recommended that the Kansas Department of Health and Environment be requested to test conditions in the cellhouse, particularly with regard to noise level and air quality.

It is my understanding that the Department of Health and Environment did, in fact, conduct tests in B cellhouse on Monday, February 23, 1981. It also is my understanding that, after the testing, noise and air pollution was reduced. I would very much appreciate your sending me a copy of the Department of Health and Environment's report of this testing.

This Office is concerned about the conditions in B cellhouse as well as conditions in any other area of the Penitentiary or Reformatory under renovation. I will describe four of these concerns.

Our first concern is for the potentially detrimental effects to both staff and inmates regarding possible hearing and respiratory problems, and physical injuries. A member of the Ombudsman staff experienced some hearing difficulty and discomfort several days after having been in B cellhouse on February 23 and 24, for periods of time considerably shorter than that time spent by many staff members and inmates.

The second concern regards the safety and security for both staff and inmates in B cellhouse. The ability of officers and inmates to communicate with one another is considerably diminished. In the event of an institutional emergency or a medical emergency, response time could be delayed for a significant period of time. This issue is of particular concern in the holdover area of B cellhouse, in which inmates are locked into a "run" on the fifth tier and are unable to reach an officer or another inmate outside their tier for help in an emergency, except by verbal means.

Third, we assess the present situation as making the state vulnerable to valid law suits on behalf of both staff members and inmates. Thus, my recommendations have been made, in part, as an attempt to minimize conditions under which the state could become liable.

Fourth, there is concern for the effects of stress on both staff and inmates created by the considerable noise, flying debris, dust and carbon monoxide in the cellhouse. There is no doubt that the psychological stress caused by these conditions will impact upon both staff and inmates, creating something less than an environment which would be conducive for living and working.

Out of these concerns, it is recommended that:

> Cellhouse staff and inmates are not to be in a cellhouse under renovation, when work is being conducted which presents the health and safety hazards outlined above.

Should Recommendation #1 not be accepted by you, the following recommendations are made:

A. Provide thorough medical evaluations of all staff members and inmates in the cellhouse under renovation. A medical evaluation format needs to be established by health professionals to ensure that persons vulnerable to the hazards (such as noise and poor air quality) be identified. Persons identified as medically vulnerable to existing conditions would then need to be re-assigned for work and living purposes to other areas in the institution.

B. All persons who remain assigned to work and live in a cellhouse under renovation need to be given medical testing particularly with regard to hearing ability and pulmonary functioning. Such data could then be available should law suits be filed, alleging that conditions in the cellhouse adversely affected the health of a staff member or inmate.

C. The Department of Health and Environment needs to be requested to evaluate conditions in a cellhouse at the beginning of each new phase of renovation. The results of such testing would help decide whether or not inmates and staff members should continue to be assigned to that area.

D. A reliable system for emergency communications needs to be established in a cellhouse under renovation. This is of particular concern with regard to inmates who are locked down.

It is my hope that these thoughts will contribute to the timely and uninterrupted completion of the renovation projects at the Penitentiary and Reformatory. I look forward to your reply.

Sincerely,

Preston N. Barton
Ombudsman

C: Mr. Robert A. Atkins, Director, KSP

Note: We did not receive a written reply to this letter. However renovation was stopped, and remained so through the end of this reporting period (Fiscal Year 1981).

3075

Investigation 2 - External Review of Inmate Grievance

As requested by Mr. Patrick D. McManus, Secretary of Corrections, in his letter of May 16, 1980, this Office has reviewed a grievance which an inmate filed on June 11, 1979, appealed on June 25, 1979 and requested external review in a letter dated July 12, 1979. This grievance had been processed through the Department of Corrections' formal Internal Inmate Grievance Procedure. The Secretary requested that we look at the facts to ensure the absence of any possible bias or arbitrariness and to see whether or not any other conclusions could be logically reached.

Our external grievance review involved extensive study of the grievance documents and of the inmate's unit team, institutional and departmental files. Additionally we conferred with the inmate and relevant staff members. There was a total of 17 in-person and phone contacts, and 10 correspondence contacts, with 5 different persons. During this review we noticed administrative discrepancies in the inmate's files which appeared relevant to his concerns, although not explicitly mentioned in his grievance. These are identified in this report as "observed discrepancies".

In reading the inmate's grievance and in talking with him, we find that we must work very hard at understanding him. (And he worked hard at helping us understand him.) To ensure valid communications, we will first state our understanding of his grievance, appeal and request for external review.

Tracking the Grievance Through the Internal Procedure

The Grievance (June 12, 1979)

The inmate felt that he would not get "minimum custody II" and thus would not get transferred to a minimum security facility or be eligible for consideration for work release. He also reflected that his chances were not good in receiving a parole, when he was to see KAA in December, 1979. The inmate claimed that his chances had been ruined because of statements in his file that he would try to hurt his wife or her lover. Specifically, his complaint is twofold:

1) Two staff members had "falsely made" such statements. He wants the alleged statement that he would hurt his wife and her lover to be removed and/or proven.

2) He is opposed to the State of Kansas and its employees inquiring into the relationship between him and his wife. Along these lines he feels that his wife is controlling his life through the prison administration.

The Appeal (June 26, 1979)

In his appeal to the Secretary of Corrections of June 26, 1979, the inmate complains that his grievance was investigated by one of the people about whom he was complaining. He questions why the investigation was not conducted by a different employee.

Request for External Review (July 12, 1979)

There appears to be only one new complaint stated in his letter of July 12, 1979, requesting external review of his grievance. He states his disbelief that the Office of the Secretary of Corrections conducted an investigation into his complaint before issuing an answer to his appeal.

Director's Answer to Grievance (June 14, 1979)

The inmate's grievance was determined to be "unfounded". This determination was based upon the following stated facts:

"1) The circumstances involving you, your wife and the child are valid concerns of the ... staff as well as the KAA.

2) You have been repeatedly counseled in the matters of custody, work release and other matters.

3) Your current attitude is vindictive and vengeful, which is supported by mental health tests.

4) Your grievance is premature. You have no automatic right to minimum custody, or work release."

Secretary's Answer to Grievance Appeal (no date provided)

The inmate's appeal of the institution's response to his grievance was answered in the following manner: "Following an investigation into your grievance, we have found no evidence which would differ from the action taken by the Director."

Review of Records

Special Progress Reports

In reviewing his records, we find two sets of "Progress" and "Special Progress" reports in preparation for his December, 1979 parole hearing. The first set of reports is dated October 4, 1979, and the second set is dated November 6, 1979, which has additional information under the heading "Unit Team Summary". This added information deals primarily with his relationship with his wife and other persons outside the institution. Also, the November 6, 1979 "Special Progress Report" has an attached one page "mental health summary", dated November 2, 1979.

The "mental health summary" describes what was perceived by the interviewer as the inmate's attitudes. In a discussion about his wife leaving him, he is quoted as saying, "she would suffer the consequences".

The summary concludes with the following sentence:

> My opinion of ... (the inmate) based on these two interviews and my experience with violent inmates is that he will probably be dangerous to his wife and her child upon his release.

The November 6, 1979 "Special Progress Report" makes reference to the inmate's wife having expressed fears for her safety "if" he were released. The report goes on to say "Whenever the subject of his wife is mentioned, he becomes violently upset, emotionally," Throughout his file there are numerous references to threats and physical beatings directed by the inmate toward his wife.

The accompanying "Progress Report" states that he has accumulated two Disciplinary Reports. The first was on March 3, 1973 and the second was January 6, 1976: both of which occurred during prior incarcerations. His present sentence began December 15, 1977.

The first Disciplinary Report describes the rule violations as "disturbances" and the disposition as "unknown". This reportedly occurred at a minimum custody facility on March 10, 1973. A search of his file shows that the March 10, 1973 incident was actually reported in the form of an "Incident Report," describing a situation in which the inmate was "talking to girls" on February 27, 1973. In a letter dated March 16, 1973, a staff member makes it quite clear that no disciplinary report was written. He ends the letter by stating: "I trust that his incident report will be taken quite lightly".

Under the heading "Psychiatric/Psychological", the inmate is described in the "Special Progress Report" of November 6, 1979 with the following sentence:

> ... (the inmate) is an immature, angry and poorly endowed (intellectually) young man who has a tendancy to perceive his human environment in threatening and destructive ways.

Credit for this sentence is given to the Kansas Reception and Diagnostic Center's (KRDC) psychiatric report of October 9, 1972. On the same page the section entitled, "Unit Team Summary," is begun with the identical sentence. The inmate, however, has had two psychiatric evaluations since the October 9, 1972 evaluation from which this sentence has been quoted. The report of the second evaluation is dated October 6, 1975 and the most recent report is dated May 16, 1978.

That the inmate possibly can be an unpleasant person is documented through his own writing. His letters appear angry and confused. They are indeed self-defeating. He uses vulgar words and is insulting. In his letter seeking the Secretary's assistance in providing external review to his grievance, he is insulting to the Secretary. It is noted that most of the material reviewed for the report is over a year old and should not be used to assess the inmate's current attitudes and behavior.

The Inmate's Complaints	Determination	Recommendations to the Secretary
1. A statement was "falsely made" by two staff members that the inmate would try to hurt his wife or her lover.	1. No written record of such a statement attributed to either man could be found.	1. None
2. His wife is controlling his life through the prison administration.	2. There are numerous statements throughout the inmate's files (both institutional and Departmental) indicating he has beaten his wife frequently. With one exception, the only source cited for this information is his wife. There is no indication that any attempts have been made to corroborate or invalidate her statement. On one occassion the inmate is quoted as a source of this information. This quote appears in the Mental Health Summary, dated November 2, 1979. The quote, however, is not explicit and is open to interpretation. In spite of the lack of documentation it appears that this information has been actively considered in decision making regarding the inmate.	2. Corroborating documentation needs to be provided for these statements. (This had been agreed to at the institutional level; however, that was before he was transferred.)
3. Issues regarding his marriage and family are no concern of the institution.	3. The Kansas Legislature has assigned rehabilitation as a mission of the Department and the institution. Within this rubric it is appropriate and necessary for officials and mental health professionals to address these issues. Additionally, within the institution's implicit security mission, it is appropriate that these issues be addressed. As the issues involve a possible felony (physical harm), the State has an obligation to consider this.	3. None

The Inmate's Complaints	Determination	Recommendations to the Secretary
3. (continued)	There are written statements by qualified and licensed mental health professionals indicating this is an area of valid concern.	
4. He believes official statements concerning his marriage have hurt his chances for possible consideration for minimum custody, work release and parole.	4. Admission to these programs is not a right but is part of a rehabilitation plan. Entrance into them is a discretionary decision assigned by the Legislature to the KAA, or the Department and subsequently delegated to the institution. As expected, it does appear that such statements have effected his acceptance to these programs.	4. None
5. One of the persons against whom he complained, was responsible for investigating the grievance for the institutional Director's response.	5. This in fact did happen. Full and credible implementation of the Department of Corrections' Internal Inmate Grievance Procedure would be greatly enhanced if this were not practiced at the institutional level. However, having a grievance handled by a staff member who is also considered a part of the complaint is an inherent possibility of any internal grievance procedure, which is relatively easy to avoid in a large institution. Nevertheless, the institution's directness and openness regarding the manner in which grievances are handled is commended. This sense of accountability provides a degree of reliability for Department and external reviews.	5. None
6. The statement of the Office of the Secretary of Corrections that it conducted an investigation into the grievance is untrue.	6. There is no way to determine from his files whether or not this is a valid complaint.	6. a) The inmate should be informed of the scope and means of the Secretary's investigation. b) In the future, information about the scope and means of investigations should be routinely provided persons receiving responses to grievance appeals.

Ombudsman Observed Discrepancies	Recommendation to the Secretary
1. Progress Reports of October 4 and November 6, 1979, both present a 1973 Incident Report as a Disciplinary Report, "disposition unknown."	1. Remove all mention of this non-existent Disciplinary Report from his files.
2. A second Disciplinary Report (1976) listed in the Progress Reports of October 4 and November 6, 1979 is from a prior period of incarceration and does not appear relevant to these Progress Reports. More recent rule infractions are omitted, if there are any.	2. Revise Progress Reports of October 4 and November 6, 1979 to reflect relevant disciplinary information.
3. In the October 4 and November 6, 1979 Progress Reports, a quote from a 1972 KRDC Report is used twice in the November Report. This quote from the seven year old report reflects negatively upon the inmate. Two KRDC evaluations were conducted subsequent to the one cited, the most recent having been done in 1978.	3. Revise Progress Reports of October 4 and November 6, 1979 to reflect more chronologically relevant psychiatric evaluation material.
4. In the November 6, 1979 Progress Report, no supporting documentation, information or examples are given to the following sentence: "His institution behavior record has been unsatisfactory."	4. Revise Progress Report of November 6, 1979 to either provide specific supporting data for the assessment that "His institution behavior record has been unsatisfactory" or to remove that statement.

Preston N. Barton II
Ombudsman

September 8, 1980

Disposition: Unknown - no written response to these recommendations was received from the Secretary of Corrections.

2400

Investigation 3 - Officer Allegedly Conspires to Steal TV Set

Dear Rep. Foster:

This report is in response to your letter of November 5, 1979 asking that we investigate the property loss claim of an inmate at a state prison. He is represented by Legal Services for Prisoners, Inc.

Claim

The inmate's claim is for $154.00 for the loss of an RCA black and white television. He maintains the television was stolen on July 28, 1979 when an officer let two inmates into his cell. The claimant discovered the loss the same day when he returned to his cell with another inmate. This inmate allegedly observed the claimed items missing from the cell. He also signed a statement claiming an officer was paid to open the claimant's cell door, so the two inmates could steal the property.

Institutional Findings

In its letter of December 5, 1979, the institution verified that the inmate owned and had properly registered the claimed television. The television is missing. However, the circumstances of the loss are not known. It reported that the officer, who allegedly opened the cell door, denied letting anyone other than the claimant into the cell.

Ombudsman Office's Findings

The Ombudsman Office investigated the state's responsibility for the loss. The basis of the inmate's claim is the signed statement by another inmate. However, this inmate told us the statement is false. He signed a blank piece of paper for the claimant. He did not observe the items missing, and knew nothing about the officer opening the cell door.

Recommendation

It is recommended that this claim be denied. While the television was properly registered and is missing, there is no proof that an officer is responsible for the loss.

I trust the above information will help the Claims Committee reach a determination in this matter. If further information is needed, please let me know.

Sincerely,

Preston N. Barton
Ombudsman

December 3, 1980

Disposition: Not Rectified (Claim denied by Claims Committee) *2034*

Investigation 4 - Evidence not Returned

Dear Rep. Foster:

This report is in response to your letter of April 30, 1980 asking that we investigate the property loss claim submitted on April 15, 1980 by an inmate at a state correctional institution.

Claim

The inmate's claim is for $50 for the loss of five eight track tapes. He maintains these tapes were confiscated on September 15, 1979 along with his tape player and headphones from another inmate for evidence in a disciplinary action against that inmate. The other inmate was charged with having property which was not registered to him. After the disciplinary action was completed, the claimant was required to send the confiscated property home. However, the five tapes allegedly could not be found.

The inmate does not have any proof of the value he is assigning to the tapes. He maintains there were two double tapes purchased for $12.95 each and three single tapes purchased for $7.95 each. He rounded the total of $49.75 to $50.

Institutional Findings

The institution provided an investigation report dated September 20, 1980. It verified that the inmate had properly received three tapes in December, 1978 and two tapes in March, 1979. It also verified that the inmate had sent home the tape player and headphones. The issue of the tapes having been confiscated from another inmate was not addressed in the report.

Ombudsman Office Findings

We obtained a copy of the disciplinary report dated September 15, 1979 written on the inmate who had the claimant's property. The report states that three eight track tapes, a radio (tape player), and headphones, which belonged to the claimant, were found in the inmate's cell. A tape belonging to a third inmate was also found. All the items were to be tagged and turned in with the disciplinary report. Thus, there is a record of staff taking possession of three of the five tapes the inmate is claiming. Since he was required to send the other confiscated items home, the claimant should have been allowed to send the three tapes home. This is in accordance with Department of Corrections regulation 44-5-115(2) which was in effect at the time.

Recommendations

We recommend that the Committee approve reimbursement for three of the five eight track tapes the inmate is claiming were lost. There is a record showing that three tapes were confiscated by staff. According to Department of Corrections regulations, the inmate should have been allowed to send these tapes home, as he did the other confiscated property.

If the Committee approves reimbursement, we recommend that the amount be set at $29. This is a total of the average price of two double eight track tapes ($11 each) and of one single eight track tape ($7). We obtained these averages by contacting a local retailer.

I trust this information will help the Committee reach a decision. If I can be of further assistance, please let me know.

Sincerely,

Preston N. Barton
Ombudsman

December 3, 1980

Disposition: Not Rectified (Claim denied by Claims Committee) 2404

Investigation 5 - Cell Door Malfunctions

Dear Rep. Foster:

This is a report of our investigation of the property loss claim submitted on March 13, 1980 by an inmate at a state correctional institution. We are forwarding his claim form to the Committee for registering.

Claim

The inmate's claim is for $746 for property stolen from his cell on January 12, 1980. He maintains the property was stolen because staff opened his cell door when he was not in the cell, and left the door open the entire morning. Thus, inmates had direct access to the claimant's property. When staff discovered the error later the same day, the property that remained in the cell was inventoried and listed on an inmate personal property record. According to the inmate, he discovered the loss when he received his property on January 15, 1980 in a different cellhouse where he had moved on January 11, 1980. He did not sign the property record because much of his property was missing. The inmate submitted an inmate grievance to the Institutional Director on January 17, 1980 complaining about the loss.

When the inmate submitted his grievance, he claimed the following items were missing and assigned these values:

1 - Rapsody AM/FM cassette player - $54.00
40 - Cassette tapes - $320.00
1 - Remington electric razor - $30.00
1 - Hot pot - $10.00
1 - Pair of Justin work boots - $90.00
1 - Levi Jean Jacket - $20.00
1 - Pair of Levi jeans - $10.00

unspecified amount - Food beverage items - $80.00
1 - Sweatshirt - $10.00
1 - Pair shower shoes - $2.00
1 - Pair tennis shoes - $15.00
unspecified amount - Underclothes - $25.00
unspecified amount - Leather working tools - $80.00

Total assigned value - $746.00

Institutional Findings

After conducting an investigation, the institution answered the inmate's grievance #1051 on February 22, 1980. It states that the items he listed on the grievance were registered to him and they could not be found. The grievance answer did not explain how the items were lost.

Ombudsman Office Findings

In order to verify the circumstances of the loss, we reviewed the investigation reports prepared by staff in response to the grievance. We are not enclosing copies of these reports because they contain confidential information about other inmates. The reports state that the cell was searched by staff on the evening of January 11, 1980 after the inmate went to a different cellhouse. After staff finished, no one was told to pack the property. The next morning an officer opened the cell doors so the inmates could go for breakfast. The officer did not know that the claimant had been moved. When the officer opened the claimant's door about 7:15 a.m. the locking mechanism broke and the door remained open. The officer got an inmate locksmith to work on the door which was fixed about 9:15 a.m. The door was then locked closed. During this time the officer was trying to locate the claimant. Thus, inmates had direct access to his cell for about two hours.

After the officer found that the claimant had been moved, he took the property still in the cell and placed it in a locked office in the cellhouse. He did not have time to inventory the property because there were only two officers covering the cellhouse. The property was not inventoried until after the next shift of officers came on duty at 2:00 p.m.

While we believe the state is clearly responsible for the inmate's property being stolen, we ran into problems verifying the items which were taken and their values. In contrast to the grievance answer, we found that only some of the claimed property are items that the institution routinely records as being in an inmate's possession. According to the investigation reports the following items were registered as belonging to the inmate.

1 - Set of leather tools
1 - Rapsody AM/FM cassette player
1 - Remington Electric Shaver
1 - Hot Pot
40 - Cassette tapes

Of these registered items, the inmate could only document the purchase price of the cassette player. He provided a receipt showing it was purchased for $42.96 in February, 1979 (instead of $54.00 as claimed.)

We consider the $30 value he assigned to the Remington shaver, purchased for him in 1978 to be a reasonable amount for reimbursement. We also consider the $10 value he assigned to the hot pot to be a reasonable amount. The $320 he is claiming for 40 cassett tapes seems high. The inmate maintains that most of these tapes cost at least $8. He claims, as was verified by the institution, that they were acquired during the year preceding the loss. We were told by a Topeka record and tape retailer that an average cassette tape currently sells for about $7. If this $7 figure is used, the purchase price of the 40 tapes would be $280. If the Committee approves this claim, we recommend that the inmate be reimbursed $362.96 for these items. This total includes the $7 per tape figure.

The remaining registered property is a "set" of leather tools which the inmate claims are worth $80. He admitted that he guessed at that figure. The property record does not identify what tools were included in this set. Some of his tools were returned to him. He was unable to provide us with an itemized list of the missing tools. He also has no proof of the value of the missing items. Without this information, we cannot recommend reimbursement for the leather tools even though we believe some were stolen.

Although the remaining claimed items are not routinely registered, the inmate was able to provide documentation of ownership for some of the items. He purchased the claimed Levi jeans in April, 1979 for $11.55 instead of the claimed $10. He purchased underclothes in February and March, 1979 for a totol of $33.50 instead of the claimed $25. The tennis shoes were purchased in January, 1979 for $13.77 instead of $15 as claimed. He could not document the purchase of the Justin work boots ($90), the Levi jean jacket ($20), the sweatshirt ($10), the shower shoes ($2). If the claim is approved, we recommend that he be reimbursed $58.82 for the documented items.

The remaining claimed property is an unspecified amount of food and beverages valued at $80. The inmate told us he kept a large supply of such items in his cell, and had just purchased $25 worth that week at the inmate canteen. We believe the value he is assigning to this type of item is unreasonable. We suggest that $25 for the items just purchased would be more reasonable. We have verified that on January 8, 1980 (three days before he transferred to a new cellhouse) he made purchases totalling $25 at the inmate canteen.

Recommendations

We recommend that this claim be approved because the inmate's property was not packed when he transferred to a different cellhouse and because the door of his previous cell, in which his property remained, malfunctioned and stayed opened. Thus, inmates had direct access to his property for about two hours. If the Committee approves this claim, we recommend that he be reimbursed $362.96 for his registered property, and $48.82 for his non-registered documented property, and $25 for lost food and beverage items - a total of $446.78

I trust that this information will help the Committee reach a determination in this matter. If further information is needed, please let me know.

Sincerely,

Preston N. Barton
Ombudsman

December 5, 1980

Disposition: Fully Rectified (Claimant was reimbursed $446.78) 2877

Investigation 6 - Documents Falsified by Claimant

Dear Rep. Foster:

This is a report of our investigation of the property loss claim submitted on May 12, 1979 by a person, who was then confined in a state prison and has since been released by court order. He has not contacted us since release so we are unaware of how to reach him.

Claim

The claim is for $33.41 for the loss of a Panasonic fan, an ear plug, and an extension cord. He maintains these items were in his cell when he was transferred from one cell house to another on March 15, 1979. He alleges that his property was packed by an officer, and the claimed items were missing when his property was given to him on March 25, 1979.

Findings

The institution reported in its letter of August 7, 1979 that there was apparently no recorded inventory made of the inmate's property when he was transferred, and there was no record that he received his property.

When the Ombudsman Office interviewed the inmate, he provided the original property inventory sheet which, although not dated, had an officer's signature. He later provided the Ombudsman Office with a copy of the inventory sheet. Both of these inventory sheets had the officer's original signature. The inmate could not have two original signatures unless he signed the officer's name. The signature on the sheets appears very similar to the way the inmate wrote the officer's name on correspondence. It does not look like the officer's signature, which we obtained. The officer did not remember packing the inmate's property.

Recommendation

It is recommended that this claim be denied because the claimant provided falsified documentation.

We trust the above information will help the Claims Committee reach a determination in this matter. If further information is needed, please do not hesitate to let us know.

Sincerely,

Preston N. Barton
Ombudsman

September 8, 1980

Disposition: Unfounded (Claim denied by Claims Committee.) *1661*

Investigation 7 - Property Missing from Storage

Dear Rep. Foster:

This report is in response to your letter of September 10, 1980 asking that we investigate the property loss claim submitted by an inmate at a state prison.

Claim

The inmate's claim is for $445.95 for property allegedly stolen from a storage room in a cellhouse on August 19, 1978. He is claiming the following property was stolen: a television, a fan, an AM/FM radio, and a locker box containing one hundred thirty-eight canteen items.

Ombudsman Office's Findings

The inmate complained to us about this loss on two previous occasions. After we discussed with him our preliminary findings he chose not to submit a claim at those times.

In reviewing the claim he has since submitted, we found that the number of claimed items and the amount of the claim have increased from when he originally complained to us. The most notable item which have been added is the radio. The other items which have added are canteen items.

When we checked on the television listed on the claim, we learned that the inmate had signed an affidavit on May 31, 1980 authorizing the prison to destroy the television. Based on this affidavit the television was destroyed.

Recommendation

It is recommended that this claim be denied. Our findings show the inmate inflated the claim, and claimed a television was lost which he had authorized be destroyed.

We trust this information will aid the Committee in reaching a decision. If additional information is needed, please let me know.

Sincerely,

Preston N. Barton
Ombudsman

September 16, 1980

Disposition: Unfounded (Claim denied by Claims Committee) *2690*

Investigation 8 - Basketball Injury

Dear Rep. Foster:

This letter is in response to the Committee's request at its May 29, 1980 hearing for us to investigate the personal injury claim submitted by a Department of Corrections' inmate. In this report we identify the claim as presented by the claimant, the Department of Corrections' findings, and this Office's findings. This report addresses the validity of the claim. It does not address the amount of possible reimbursement because the percentage of permanent disability is still being computed.

Thus far, in conducting this investigation we have made 15 telephone contacts, 31 personal contacts, and 44 letter contacts, for a total of 90 contacts.

Claim

The claimant maintains he injured his left wrist on July 4, 1977 while playing basketball with other inmates on a concrete court He was pushed backward and fell on his left wrist. Later that day he reported the injury to a correctional officer and asked for treatment.

He claims the medical staff "... neglected to provide adequate medical attention for a broken hand (wrist), resulting in a non-united navicular fracture." He contends that two x-ray's of his wrist were taken at the institution on July 6, 1977 by the institutional dentist. He claims the Department of Corrections records are incorrect - that an x-ray was not taken and read by Dr. A, a private physician at a local hospital on July 18, 1977 as is the Department's position.

The claimant contends that his wrist was fractured from the fall and that it was treated as a sprain because he was an inmate at the institution. After being released on parole on November 21, 1977, he was examined by Dr. B on April 14, 1978. In his initial evaluation Dr. B stated, "From his (the claimant's) description, I certainly wonder about a scaphoid fracture that has been missed."

Dr. B's report contained two additional pieces of important information. He indicated that the claimant's past history included a laceration to the base of his left thumb. Dr. B was "... rather vague on that account as to

what was really wrong and whether or not any nerve was cut and whether it was mainly just some tendon repair that was carried out." Dr. B also indicated that the claimant was wearing a "short night splint on his right wrist" when examined. When this Office contacted Dr. B, he reviewed his records and could find no additional information about the right wrist. He believed his report is accurate. When we questioned the claimant about this, he strongly maintained the splint was on his left wrist during the examination.

The claimant was referred by Dr. B to Dr. C who examined the claimant on April 18, 1978. Dr. C found on his initial evaluation, "Fall on the hand about 9 months ago sustaining trauma to the wrist. Initially was diagnosed as a wrist sprain. He has continued to have pain and discomfort about the left wrist ... X-rays show what appears to be an old navicular fracture, non-united. Recommended is surgical correction."

Dr. D performed surgery on the claimant's left wrist on August 29, 1978. A silastic navicular implant was placed in his wrist.

The claimant is claiming the inadequate medical treatment at the institution caused him to lose his job on parole and he "... sustained a functional and bodily disability of approximately 15%." He is asking for $278.75 for medical expenses, $2,880.00 for lost earnings, and $6,552.00 for 15% disability - a total of $9,710.75.

Department of Corrections' Findings

In his enclosed letter of January 2, 1980, Secretary of Corrections Patrick D. McManus stated that there is insufficient evidence to support the claim. He maintained that, "Following the injury in July, 1977 (the claimant) received adequate medical care at (the institution) including an x-ray of the injury by (Dr. A) which reported negative findings. This x-ray report, when considered in conjunction with the results of the physical examination conducted by (an institutional physician) in November, 1977, would seem to refute (the claimant's) claim that he was suffering from a disability of severe injury at the time of his departure from (the institution) on November 21, 1977."

Ombudsman Office's Findings

The Ombudsman Office investigated the record of medical treatment the claimant received at the institution, and his employment and medical records on parole.

A dental x-ray was found in the claimant's medical chart at the institution where he is presently confined. It was in an envelope dated July 6, 1977. There is no mention in the medical notes of this x-ray having been taken, of it being read, or of the findings. The claimant told us he was present when an institutional physician read the x-ray. The physician said there was no fracture. The claimant maintains two dental x-rays were taken. (As will be shown, the former institutional dentist's description of the general procedure would support this.) We, however, have been able to find only one x-ray taken with the dental x-ray machine. The Department has no record of the number of x-rays taken or that any were even taken.

In response to our request, the Department of Corrections had the dental x-ray read by a private radiologist. In his enclosed report of September 4, 1980, the radiologist stated that the x-ray film was of "moderately good quality." He reported the unlabeled intra oral film of (the claimant's) wrist, "... shows a comminuted fracture of the scaphoid bone with the fragments in contact and in good position."

To better understand how dental x-rays were used at the institution, the Ombudsman Office obtained a detailed letter of July 20, 1980 from the individual who was the dentist at the institution at the same time of the claimed injury. He explained the practice of the physicians at the institution was to have him take x-rays with the dental x-ray machine of parts other than the mouth as a screening mechanism. He was often asked to take more than one x-ray at different angles. He stated that if the x-rays were negative the physician continued to observe the patient to determine the need for further consultation or treatment.

The medical staff at the institution did continue to observe and treat the claimant. According to the medical records, he was sent out of the institution and x-rays were taken by Dr. A at a local hospital on July 18, 1977. Dr. A's findings were, "Negative left wrist."

The Department of Corrections also had this series of x-rays sent to the radiologist. He found a fracture of the scaphoid bone of the left wrist which was visible on only one of the multiple views. He pointed out that fractures of this type heal very poorly regardless of the treatment and many go on to aseptic necrosis.

It appears that the medical staff at the institution treated the claimant's wrist as if it were a sprain. There is nothing in the record to show that staff identified an existing fracture. In contradiction to the claim, x-rays were taken at the local hospital. However, Dr. A who read the x-ray's did not observe a fracture. Thus, the medical staff at the institution, following Dr. A's findings, provided on-going treatment for a diagnosed sprained wrist.

The Ombudsman Office investigated to determine if the claimant may have re-injured his left wrist while he was on parole. We also checked on his allegation that he lost his job on parole due to the claimed injury at the institution.

We found in reviewing the claimant's parole officer's case notes that he phoned his parole officer on March 20, 1978 reporting that he had been temporarily layed off his job due to his injured hand (wrist). He also told the parole officer for the first time that he was suing the state for malpractice. In the same call, the claimant reported he had bought a motorcycle.

The claimant's employer reported that the claimant did not show up for work one day. The claimant called in later saying he had fallen down the stairs to his apartment and would not be able to work that day. The employer stated that the claimant visited him the next day after seeing a

doctor and informed the employer he would be unable to return to work for six weeks because he had injured his arm (wrist) while working for the state. The employer later overheard one of his employees state that the claimant had had a motorcycle accident, instead of having fallen down the stairs. The employer reported that the claimant was a very good worker. The claimant did not return to work for the employer.

Dr. B's statement that the claimant had a splint on his right wrist instead of his left wrist supported the likelihood of the claimant having been re-injured. When we questioned Dr. C about this, he reported that he had no record of the claimant sustaining another injury. According to Dr. C, "... the x-ray appearance of the non-united fracture would tend to indicate that it had been present for several months." Neither Dr. C nor Dr. D made a note of the claimant having a splint on his right wrist. Based on Dr. C's statement it does not appear the wrist was re-injured in such a way as to effect the resulting disability.

Conclusion

After the claimant injured his wrist at the institution on July 4, 1977 the medical staff provided treatment based on a diagnosis that the wrist was not fractured. At least one dental x-ray was taken of the wrist at the institution two days after the injury. Although medical staff failed to record the existence of the dental x-ray and their findings from reading it, the claimant reported that he heard staff say there was no fracture. Two weeks after the injury a series of x-rays were taken at a local hospital and were read by Dr. A. His report to the medical staff at the institution indicated there was no fracture. We found that both the dental x-ray and one view of the x-rays taken at a local hospital show the wrist was fractured.

While we cannot predict what would have happened if the claimant would have been treated for a fracture, we do know that the fracture failed to heal properly and surgery was required. Although the exact percentage of disability has not been determined, we also know that the claimant is partially permanently disabled as a result of the fracture that was treated as a sprain.* Thus, it is recommended that the claim be approved.

If the claim is approved, we suggest the amount of reimbursement be calculated by the Division of Worker's Compensation in compliance with the Committee's rules.**

I trust the above information will help the Claims Committee reach a determination. If further information is needed, please let me know.

Sincerely,

Preston N. Barton
Ombudsman

October 20, 1981

* It was later determined that the claimant has a 25% permanent loss of use of his left wrist.

** Mr. William Morrissey, Assistant Director, Division of Worker's Compensation, calculated that the claimant would be reimbursed $6,618.39 plus any medical expenses, if this were a Worker's Compensation claim.

Disposition: Partially Rectified (Claimant was reimbursed $278.75.) 2433

Investigation 9 - Negligence by Medical Staff Claimed

Dear Rep. Foster:

This report is written in response to your letter of February 26, 1980 asking this Office to investigate an inmate's personal injury claim. When the inmate submitted this claim on June 22, 1979, his claim form stated that he had filed a civil case in District Court. Based on this information the Committee continued the claim until the case was resolved. The case was dismissed on July 12, 1979 at the request of the inmate. The inmate was confined in a Department of Corrections' Institution when the injury allegedly occurred. He is presently in a different Department of Corrections' Institution.

Our investigation involved an examination of how and when the injury occurred, a determination of the extent of the injuries, and a review of the treatment which was provided. In conducting this investigation, we made nineteen telephone contacts, fourteen letter contacts, and nine personal contacts for a total of forty-two contacts.

Claim

The inmate's claim is for $2,000 for the 5% permanent disability he allegedly incurred after injuring his right elbow at the institution. He maintains this disability is the direct result of the negligence of the institutional clinical staff in their diagnosis of his injury. He states that this 5% figure was given to him by an institutional physician.

The inmate states in his claim form that the injury occurred on August 20, 1977 when he fell while walking in his cellhouse and landed on his right elbow. He explained that he was leaving his cell when he simply fell. He reportedly went to sick call on August 21, 1977 and was examined by an institutional physician, who diagnosed the injury as a pulled muscle. No prognosis or medication was issued, according to the inmate. On or about April 1, 1978, the inmate again went to sick call. He was examined by a different physician who again reportedly diagnosed the injury as a pulled muscle. The inmate states in his claim form that he was sent by the institution to a private specialist, who diagnosed the injury as an old fracture of the right arm, which could have easily been corrected at the time of its occurrence. However, due to the fact that it had healed improperly it required surgery to correct it which was performed in June, 1978.

Institutional Findings

The institution provided a letter dated April 3, 1980. The medical record shows that the inmate complained on August 16, 1977 he had fallen out of bed and hurt his right elbow. The record states that no obvious

swelling was noted. The inmate was given an ace bandage, tylenol and set up for a re-check. The next day, August 17, 1977, the inmate was seen and complained only about being nervous. He was placed on psychotropic medication.

According to the institution, the record shows that after the inmate complained on January 7, 1978 an x-ray was taken on January 21, 1978. An orthopaedic surgeon was consulted which resulted in diagnosis and "... initial treatment of a probably old fracture of the lateral epincondyle of the humerous with aseptic changes. This resulted eventually in surgery on June 7, 1978." According to the institution, an institutional physician may have offered an opinion of the percentage of disability to the inmate as a general practitioner, but this determination is always made by a specialist. The record did not include a formal judgement of percentage of disability.

Ombudsman Office Findings

We were unable to verify how and when the inmate fractured his right elbow. He states in his claim form that he injured it on August 20, 1977. and sought medical attention the next day. The medical record at the institution shows him complaining on August 16, 1977 that he had fallen out of bed the night before and injured his elbow. He remained at the institution approximately two weeks after initially reporting the injury and did not complain a second time.

The medical record states that he did not complain again to the clinical staff about his elbow until January 11, 1978. On that date he was seen by a registered nurse. No swelling was noted. The inmate told the nurse he had the problem approximately six weeks. He was told to return that Friday to be seen by an institutional physician. He was seen by the physician on Friday, January 13, 1978 at which time it was decided that no treatment was indicated, but the elbow would continue to be observed.

The next entry in the medical record, dated January 19, 1978, contains crucial information. It is noted that the inmate continued to complain about persistant pain in his right elbow. It then states, "please check x-ray film in dental unit for (next word is illegible) bone pathology." While the remainder of the entry is difficult to read, it appears to state that the dental x-ray film revealed a type of fracture. This information was reported to an institutional physician who advised that the inmate should be referred to a radiologist, for a possible fracture, and the appointment should be made for that week.

It appears the inmate's elbow was x-rayed on January 19, 1978 with the dental x-ray machine. As explained in our report on claim #966 of another inmate, the dental x-ray was used at the institution as a screening tool. In this instance a fracture was found and an appointment was made.

The dental x-ray is not in his medical record at the institution where he is currently confined. However, there is a full size x-ray in his record, dated January 19, 1978, labeled ("Inmate's name and institutional number) Elbow." It is believed that this x-ray was taken outside of the institution

and read by private physician. The private physician's enclosed x-ray report, dated January 20, 1978, states "Old fracture of the lateral epicondyle of the right elbow. I see no evidence of new injury."

After receiving the private physician's report on January 25, 1978, the clinical staff at the institution sent the x-ray to be read by a private orthopaedic specialist. The specialist submitted the enclosed letter dated January 26, 1978, to the institution. He reported that the inmate, "... has what is probably an old fracture of the lateral epicondyle of the humerous with aseptic changes. Obviously, there is no way to be certain that he doesn't have a chrondroma, but with the history of the injury and the present x-ray findings, it is most likely a non-united epicondylar or condylar fracture."

The private orthopaedic specialist examined the inmate and decided surgery was needed. It was performed on July 7, 1978. A bone graft was done to the loose lateral condyle. The inmate was seen for follow-up treatment by the specialist through October, 1978. The specialist wrote the institution on October 26, 1978 stating that the inmate had "motion from normal flexion to 20^0 loss of full extension. He has a good rotation and he makes a good fist. The patient may resume his near normal activity as possible."

The inmate presently cannot fully extend his right arm. While it is believed he has a permanent partial disability, this figure has not been obtained.

Summary

The inmate claims he should be reimbursed $2,000 because the clinical staff at the institution was negligent in their diagnosis of a fractured right elbow he allegedly received while confined there. Because of this negligence, he maintains that he has a 5% permanent disability.

While the record shows that the inmate fractured his right elbow, the date and circumstances could not be verified. He may have fractured it before arriving at the institution, on the date he claims, or at a later date. The inmate is not claiming the state is responsible for the injury. He simly fell either out of bed or while walking. He has provided different versions at different times.

The issues to be evaluated are if medical treatment was made available to the inmate as he requested it, and then if this medical treatment was adequate. This Office is unable to evaluate the second issue, which is a medical malpractice determination.

If the institution medical records are accurate, they show that the inmate first complained about his elbow on August 16, 1977. Treatment was provided. He did not complain again about his elbow until January 11, 1978. Surgery was needed to correct the "old" fracture which was performed on July 7, 1978. All of the inmate's medical treatment has been paid for by the state of Kansas.

Recommendation

We do not believe the inmate has a valid claim as treatment was made available as requested. The Committee may wish to rule on the adequacy of the medical treatment which was provided.

I trust this information will help the Committee reach a determination in this matter. If additional information is needed, please let me know.

Sincerely,

Preston N. Barton
Ombudsman

December 9, 1980

Disposition: Unfounded (Claim denied by Claims Committee.) 2045

Investigation 10 - Injured on the Job

Dear Rep. Foster:

This is a report of our investigation of the personal injury claim submitted on August 10, 1979 by a fomer Department of Corrections' inmate for $4,500. The claimant was an inmate at a state correctional institution when he allegedly injured his thumb. He later was transferred to a correctional facility and is currently on parole. We were referred to the claimant by a Department of Corrections' staff member.

Our investigation involved an examination of the accident, a determination of the injuries that resulted from the accident, and an inquiry into the amount of possible compensation. In conducting our investigation we made 3 personal contacts, 30 letter contacts, and 50 phone contacts for a total of 83 contacts.

Claim

The claimant maintains he injured his thumb in the latter part of 1973 or the first part of 1974. He was working on a motor in a garage at the institution when his wrench slipped and his hand struck the motor. He claims his right thumb was knocked out of joint. He says he went to the institutional infirmary the same day for treatment. Because he was not sure of the date of the accident, he suggested that the medical record would show when he first sought treatment. We were unable to find this in his record.

The claimant reports that after this accident his thumb dislocated very easily. He indicates this happened several times while working at the institution and then at the facility to which he was transferred. He also states that a knot grew on his thumb sometime after the initial accident.

The claimant reports that he was examined by the medical staff at the institution and also was examined by several physicians while he was at the facility. However, he claims proper medical treatment was not provided. After being released on parole he was examined by a private physician, who found that the claimant had, "...definite evidence of degenerative arthritis involving the metacarpophalangeal joint and advised (the claimant) that this be treated by an arthrodesis. This surgery was carried out on July 26, 1979." The private physician states in a letter of October 29, 1979 that, "He (the claimant) does have some permanent partial disability, after a successful arthrodesis of the metacarpophalangeal joint, which I would estimate at 50% of the thumb, which would translate to 25% of that hand."

The claimant relates that he is asking to be reimbursed for the losses he has incurred due to this injury. He asked for $4,500 on his claim form which is an estimated amount that includes his medical expenses, travel expenses in going to his doctor appointments, an estimation of his lost wages following the surgery (he was then self-employed) and his permanent partial disability.

Department of Corrections Findings

The institution provided two letters which address the accident and the medical treatment the claimant received. The facility provided a report of the treatment the claimant received while there.

In its letter of January 11, 1980, the institution reports that no record could be found of the accident when the claimant allegedly injured his thumb.

In a letter of November 9, 1979, the institution states, "There is no reflection of any injury sustained to the right thumb while (the claimant) was incarcerated at the (institution), making this writer think the sesamoid bone could either be of congenital or spontaneous origin, rather then traumatic." In talking with the institution, we clarified that the claimant's medical record shows that he complained about his thumb, but the record does not show that he reported he had been injured. In reviewing the medical record, we found the first mention of the right thumb was on February 25, 1975 when the claimant complained about a growth on his thumb.

The institution sent the claimant to a private orthopedic specialist on April 21, 1975 to have the right thumb examined. The claimant had complained of pain and a knot on the thumb. In a letter dated April 23, 1975 the specialist reported, "...a mild degree of prominence of the bony structures on the outer side of the thumb metacarpophalengeal joint ... at least at the present time there is no evidence of abnormal instability of degenerative arthrosis of the joint."

On September 22, 1975, five months after this examination, the claimant was transferred. The facility to which he was transferred, provided a letter dated November 13, 1979 which lists the dates the claimant was examined and treated by several doctors. His thumb continued

to dislocate extremely easily causing him severe pain. His last examination while at the facility was on October 4, 1978. This was to obtain a referral to a neurologist. A referral was made and he was scheduled for an appointment on November 11, 1978. The facility explains that this appointment was to obtain an assessment of the injury and an estimate of the cost for surgery. On November 3, 1978, eight days before the appointment, however, the claimant was released on parole. His sentence had been reduced in August, 1978 by the sentencing judge in accordance with KSA 21-4603.

Ombudsman Office's Findings

The Ombudsman Office investigated the circumstances of the accident, the treatment provided the claimant while incarcerated, and the extent of permanent disability.

We obtained a letter dated September 9, 1980 from the claimant's supervisor in the institutional garage. The supervisor verified the claimant's version of the accident. The supervisor was working with the claimant on the motor when the claimant's wrench slipped and the thumb was injured. The supervisor, who has since left the institution, thought the accident occurred in February, 1975.

In reviewing the Department of Corrections records, we found that the facility sent a memo dated August 3, 1978 to a Department of Corrections physician at another institution concerning the claimant's right thumb. The facility also sent an x-ray of the thumb and the medical file seeking advice "... on the best manner to proceed to correct this deficiency." It stated that the claimant was near a possible release through KSA 21-4603 and he was very concerned about his thumb as he planned to be a plumber upon release. The facility subsequently submitted a memo dated November 6, 1978. The facility asked that the x-ray be placed in the claimant's medical file as he had been released on parole.

It appears that the Department of Corrections was aware as early as August 3, 1978 that the claimant's thumb had not healed properly and required an operation. Three months passed before he left on parole and this operation was not done.

In order to clarify the claim, we obtained the following information. We contacted the private specialist's office, where the claimant was sent while confined at the institution, and learned that his record shows he reported the injury occurred about a year prior to the examination. This would have been the first of 1974 as the claimant stated on his claim form. We also contacted the physician who treated him after being released on parole. The physician believed the claimant's degenerative arthritis was the result of an injury. According to the physician, once the thumb was injured it dislocated easily because the joint was unstable. Consequently, arthritis developed.

Amount of Reimbursement

If the Committee approves this claim, we recommend that the claimant be reimbursed $3,748.95. This would be in accordance with the Workers' Compensation Law as specified in the Committee's rules.

A letter of October 6, 1980 from Mr. William Morrissey, Assistant Director of the Division of Workers' Compensation, gives the amount of payment for permanent partial disability based on the accident having occurred in February, 1975. After Mr. Morrissey did his calculations, we verified the date of the accident to be early 1974 not February, 1975, as we had previously believed.

Mr. Morrissey told us that if early 1974 is used as the accident date the amount of maximum compensation would be reduced from $95.20 per week (the figure he used in his letter) to $56.00 per week. The amount of payment for permanent partial disability using the $56.00 figure is $2,268.00.

Mr. Morrissey explained to us that under Workers' Compensation Law all medical expenses are paid in addition to payment for permanent partial disability. The claimant provided us with the following medical bills:

Anesthesia	-	$ 150.00
Hospital Care	-	886.15
Physician	-	574.00
Total	=	$1,610.15

The claimant also provided us with documentation which shows the medical insurance he obtained after being paroled paid $110 toward these bills and $20 directly to him - a total of $130. Subtracting this $130 figure from $1,610.15 leaves $1,480.15 for medical expenses. Adding the $2,268.80 calculated by Workers' Compensation formula with the $1,480.15 for medical expenses totals $3,748.95.

Recommendations

We recommend that the claim be approved. We verified with the claimant's former supervisor at the institution that he injured his thumb while working on his assigned inmate job. Once the thumb was injured, it was easily reinjured while he was incarcerated. Degenerative arthritis developed which resulted in the thumb being treated by an arthrodesis. This was done shortly after he was released on parole. Because he was on parole, he had to pay for his medical treatment. He now has permanent partial disability for 50% of the thumb or 25% of that hand.

If the claim is approved, we recommend that he be reimbursed $3,748.95. As previously explained, this is a total of the payment for permanent partial disability, using the Workers Compensation formula, and his verified medical expenses.

I trust the above information will help the Committee reach a determination. If further information is needed, please let me know.

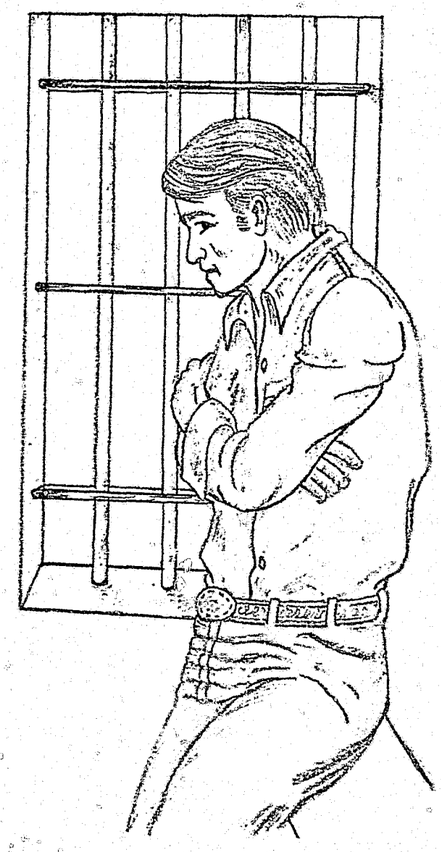
Sincerely,

Preston N. Barton
Ombudsman

December 1, 1980

Disposition: Fully Rectified (Claimant was reimbursed the $4,500 he claimed, instead of the $3,784.95 which was calculated using the Worker's Compensation formula.

1831



EXAMPLES OF COMPLAINTS

In each of the following complaint examples an attempt has been made to avoid identifying the individuals and institutions involved. In addition to omitting names, all complainants and correctional staff members are to be referred to in the masculine gender or are given fictitious names. Additionally, all representatives of the Ombudsman Office are to be referred to as the Ombudsman. With these exceptions, the information provided in each example is factual. Definitions for the terms used for complaint and disposition categories can be found in "Definitions of Complaint Handling Terms", pages 99 - 102.

Example 1 - Medical Complaint

After examining the facts and finding a complaint valid, the Ombudsman tries to obtain consensual resolution. If this is not possible, the Ombudsman makes formal recommendations to rectify the problematic situation. In some instances, the staff member to whom the Ombudsman makes his recommendations refuses to accept it, but a short time later the corrective action recommended is implemented.

In this particular example, the Ombudsman had found that the confidentiality of medical records was not being maintained during the sick call procedure at one of the institutions as required by Department of Corrections' regulation. This regulation states, "Confidentiality requires that medical records be available to only those who have a clearly defined need to know. In no case shall they be available to other inmates."

The Ombudsman found the sick call procedure to be in direct contradiction to this regulation because an inmate, assisting the physician during sick call, had direct access to the written prescriptions and to the medical files. Also, the communication between the inmate patient and the physician was not confidential as the inmate had no choice but to describe his medical complaint in front of non-medical personnel, including a correctional officer and the inmate assistant.

In order to correct this discrepancy, the Ombudsman recommended to the physician that no inmate at any time handle or have access to the medical files or any medical records including the prescription. He, also, recommended that only medical staff members be present when an inmate is examined. The physician refused to accept or even consider these recommendations.

Because of the physician's strong stand, the Ombudsman was very pleased to learn a few days later that the sick call procedure had been altered and the Ombudsman's recommendations had been implemented. Under the new procedure, an inmate no longer assists the physician. The physician conducts the sick call with only the inmate patient and a medical staff member present. This corrective action was taken without the Ombudsman having to make this recommendation to any other staff member.

Disposition: Fully Rectified 2726

Example 2 - Medical Complaint

The Ombudsman started his day at an institution by receiving a note from an inmate stating that he had hepatitis and had not been isolated. The inmate also complained that he was having severe pain and could not get medicine to kill the pain. The Ombudsman immediately went to see the inmate.

When he entered the inmate's cellhouse, he was greeted by the officer in charge, who expressed concern that the inmate had hepatitis, but had not been isolated. The Ombudsman told the officer that he was there to talk with the inmate about this.

The inmate explained that earlier the same week he had complained to the institutional staff about pain in his liver area. According to the inmate, a blood test indicated he had hapatitis. He had received medication, but wanted it to be stronger.

The Ombudsman learned from the medical staff that the inmate had not been diagnosed as having hepatitis. The blood test results would not be available for two weeks. However, the inmate's symptoms did not appear to be that of hepatitis, but rather some other liver problem. The physician had determined that the inmate did not need to be isolated. The inmate was scheduled for another liver test the next day. His medication would be re-evaluated when the new test results were obtained. The staff member gave the Ombudsman permission to discuss this information with the inmate.

The Ombudsman confronted the inmate with these findings. The Ombudsman also informed the cellhouse officer that the inmate had not been diagnosed as having hepatitis. Two weeks later the Ombudsman learned that the test results confirmed the inmate did not have hepatitis. The inmate, however, had not been informed of this. Following the Ombudsman's recommendation, a medical staff member informed the inmate and the cellhouse officer of the test results. The Ombudsman believed it was crucial that the cellhouse officer be informed of the inmate's accurate medical condition in order to squelch the false rumor the inmate had spread.

Disposition: Unfounded 2916

Example 3 - Inter-Institutional Transfer Complaints

To inmates and line staff the central office of the Department of Corrections is a bureaucratic entity many miles down the road in Topeka, the capital of Kansas. The central office and the institutions are sometimes seen as being totally separate when in reality they are all part of a large system. This sense of working independently, instead of jointly, increases problems. The following case example demonstrates such problems.

An inmate at one of the institutions was afraid for his life if he remained in Kansas. Institutional staff believed his concerns were legitimate and submitted a recommendation to the central office, dated December 18, 1979,

asking that the inmate be transferred to an institution in another state. After seven months had passed and the inmate had heard nothing, he contacted the Ombudsman.

In reviewing the Department of Corrections' central records, the Ombudsman found that a request for additional case materials had been sent back to the institution two months after the recommendation had been received. The central office staff member, who had submitted the request, had heard nothing from the institution but had not attempted to find out why.

The institutional staff member who had been working with the inmate and had made the recommendation for the transfer knew nothing of the request for additional materials. He assumed the recommendation was being processed. Within a week after the Ombudsman's intervention, the case materials were sent to the central office and a letter was immediately sent to another state asking if it would accept the inmate.

At this point the Ombudsman had fully rectified the breakdown in communication between the institution and the central office. Whether or not the Kansas Department of Corrections transferred the inmate to another state was a discretionary decision. The complaint was closed. The Ombudsman, however, decided to monitor the case to ensure that, when a decision was made, the inmate would be informed of it. This turned out to be a wise move, as another breakdown in communications occurred.

Five months after the Kansas Department of Corrections wrote the other state, a response was received. The other state turned down the transfer request. This information was immediately sent to the institution, but to a staff member other than the counselor who had been working directly with the inmate. The counselor told the Ombudsman he had not been informed of the outcome three weeks after it had been sent to the institution. At the Ombudsman's request, the counselor verified the outcome and informed the inmate. A second complaint opened on the Ombudsman's initiative was fully rectified. A year had passed from when the recommendation had been made by the institution to when the inmate was told of the outcome.

Disposition: Complaint #1 - Fully Rectified 2437
Complaint #2 - Fully Rectified

Example 4 - Complaint Against Staff

An inmate wrote the Ombudsman saying he had been unable to get an answer to his numerous inquiries regarding the status of his inter-state parole plans. He had been repeatedly and recently informed by institutional staff members that they had no knowledge of the progress of his request to parole to another state. Furthermore, he claimed he had been told it was not the responsibility of institutional staff to have this information.

By contacting the central office of the Department of Corrections, the Ombudsman learned that Kansas had received notification 28 days earlier that the other state had rejected this inmate's parole plan. The central office had mailed this information to the institution 18 days earlier.

The Ombudsman immediately notified the institution. An institutional staff member located the misplaced paper work and verified the Ombudsman's information. It was two days later when institutional staff passed this information on to the inmate. At that time the institution immediately made plans to assist the inmate in developing a new parole plan in another area. As a result of our intervention the inmate was informed of his parole status; but, regrettably, it was 30 days from the time Kansas received notification of the action taken by the other state before the inmate was informed of this action.

Disposition: Fully Rectified 2861

Example 5 - Parole Complaint

During Fiscal Year 1981, there has been a mounting problem regarding the processing of parole plans. Inmates have been frequently told they can parole from prison but only after they have secured approved employment. The procedure for approving a job, as exemplified in this case, is so lengthy that inmates can lose the job by the time the paper work has been processed; and then, have to begin the process all over again.

During the middle of February, 1981, the Ombudsman was contacted by a community agency which was thoroughly frustrated in its efforts to assist an inmate in securing a job, which would enable him to be paroled from a state institution. It had been August, 1980, when this inmate was informed that he could leave on parole once a parole plan had been approved. His first plan involving parole to another state had been denied in December, 1980. Now, five and a half months later he was still in prison.

The referring community agency and the institution had assisted the inmate in obtaining a job a month earlier. The prospective employer, however, was now saying he would not continue to reserve the job for this inmate and, thus, the parole plan was denied.

In view of the lengthy delays this inmate had experienced, the Ombudsman made a series of phone calls suggesting that the inmate be transferred from the institution to a work release center located in the community to which he wished to parole. Rather than going through the entire work release program, which is approximately three months, it was further suggested that the inmate remain at the center only as long as it was necessary for him to find a job, a residence and a sponsor. This idea was accepted and several officials within the system worked diligently at implementing the plan.

While this particular individual's situation was corrected, the procedural problems causing it were not effectively addressed and continued to exist.

Disposition: Fully Rectified 2992

Example 6 - Medical Complaint

The Ombudsman received a call from Mrs. Smith, an inmate's mother who was afraid that her son could not survive in prison. She tearfully explained that her son, John, had recently entered the corrections system and was to be transferred the next day to a long term institution. John had a history of severe physical and emotional problems. He was serving a 1 to 10 year sentence. It was his first time in prison. All Mrs. Smith knew about prisons were horror stories. She desperately wanted to help her son.

The Ombudsman provided Mrs. Smith with factual information about John's situation and about the prison where he would be confined. The Ombudsman also counseled her about what she could and could not do for John. Responding to Mrs. Smith's fears, the Ombudsman promised to see John during his visit to the prison the next day.

His cell was located on the third tier at the very back of a large cellhouse. The nearest institutional staff member was several hundred feet away at the front of the cellhouse. As it turned out, this isolation contributed to a very serious medical problem.

John was scared, but for more reasons than the Ombudsman could have predicted. John was afraid that he was about to have a seizure in his locked cell. When he was moved to this prison, he had not received his medication to prevent seizures. John did not know when or if he would receive it. For that matter, he did not even know when his cell door would be opened. What John did know was that he had recently had a seizure when he did not get his medication. That time there were people around who helped him.

The Ombudsman immediately communicated the problem to the staff member in charge of the cellhouse who responded quickly. After checking with the infirmary he assured the Ombudsman the medication would be delivered to the inmate shortly. The staff member explained that the problem occurred because John's medical record had not been marked when he was transferred to show that he was receiving medication.

The Ombudsman returned to John and told him the medication was coming. The Ombudsman saw John three days later and learned that he was receiving his medication. He also had gone through orientation. John thought he was doing reasonably well. The Ombudsman informed Mrs. Smith of John's adjustment.

Disposition: Fully Rectified 2776

Example 7 - Medical Complaint

When a person is categorized as a complainer or cry baby his real complaints are sometimes met with deaf ears. By "crying wolf" when there is no "wolf", the person is in trouble when a "wolf" does appear. In the

following example, the inmate complainant had been categorized as a complainer. When he had a real complaint, staff did not respond until the Ombudsman intervened.

The inmate's wife complained to the Ombudsman that her husband was supposed to be taken from the institution to an outside hospital for surgery on his ear, but the institution had inappropriately cancelled the surgery three times. Before intervening with staff, the Ombudsman went to the inmate to clarify his complaint.

The inmate's description of his complaint was very different than his wife's. His ear drum burst in December of 1979. Before surgery could be done, the infection in his ear had to be cleared up. He had last been exmained by an outside specialist three and a half weeks earlier. The specialist told him he would be scheduled to return in two weeks. The inmate assumed his appointment had been postponed when he was not taken in two weeks and postponed again when he was not taken the following week. Finally, he asked a correctional counselor to call the institutional infirmary. He was informed that an appointment had never been scheduled.

The counselor, who had called for the inmate, reacted very negatively to the Ombudsman's inquiry. He believed the inmate was harassing staff by not accepting his situation. He also implied that the inmate was harassing him by having the Ombudsman pursue the complaint.

The medical staff member, who is responsible for scheduling appointments, told the Ombudsman the inmate was just a cry baby who really did not have a medical problem. The staff member explained that the inmate and his wife constantly complained about his treatment. An appointment was not scheduled because the specialist had not asked for one. When the staff member pulled the inmate's medical file, he was surprised to find that the specialist had requested the inmate be returned in two weeks. The staff member did not notice this because the specialist had not followed the usual procedure for scheduling. However, no one bothered to check on this when the counselor had called. It was assumed the inmate was "crying wolf" again. The appointment was scheduled and the inmate saw the specialist five days later.

Disposition: Fully Rectified 2628

Example 8 - Medical Complaint

An inmate complained to the Ombudsman that the medical staff at the institution determined he had a collasped lung when he was seen on sick call in the morning, but he was not taken to an outside hospital for treatment until the following afternoon. He maintained that he was sent back to his cellhouse after the determination had been made.

The Ombudsman learned from the medical staff that the collasped lung had actually been discovered when an x-ray of the inmate's chest was read by an outside radiologist the day after he had been to sick call. When the radiologist made the diagnosis, he telephoned the institution and the inmate was immediately taken to an outside hospital. Thus, the inmate's complaint was determined to be unfounded.

However, the Ombudsman opened a second complaint on his own initiative because the medical records did not document when the radiologist telephoned the institution and how the institution in fact responded. The medical staff, at the Ombudsman's suggestion, included this information in the inmate's medical record. Thus, the second complaint was fully rectified.

Disposition: Complaint #1 - Unfounded 2935
Complaint #2 - Fully Rectified

Example 9 - Complaint Concerning Legal Matter

An inmate complained to the Ombudsman that there are more Department of Corrections regulations governing his and staff's behavior than those in the Inmate Rule Book which inmates are provided. The inmate wanted to read all of the regulations.

The Ombudsman pulled from his brief case a copy of the complete set of Department of Corrections' regulations. He showed the inmate the regulation which requires that a complete set of regulations be available in the cellhouse and in the Inmate Library. Regulations contained in the complete set, but not in the Rule Book, govern such important procedures as those relating to telephone usage, classification for custody, rehabilitation plan and time table, inmate visitation, inmate pay and job assignments, and parole. The regulation the Ombudsman cited is not contained in the Rule Book. Thus, there is no guarantee inmates would be aware of regulations other than those in the Rule Book, or that the complete set is to be available.

With this new information, the inmate asked a correctional counselor in his cellhouse to see a complete set of regulations. The counselor could not fulfill the inmate's request because there was not a complete set of regulations in the cellhouse. Upon leaving the counselors office, the inmate went up into the cellhouse where he knew the Ombudsman was working to complain about the discrepancy.

When questioned about his statement, the counselor told the Ombudsman that he was not refusing to allow the inmate to look at the complete set of regulations, but that there was not a set in the cellhouse. The counselor was not aware of the regulation requiring the set of regulations be available. When the Ombudsman pointed out a complete set of regulations on a shelf a few feet away, the counselor expressed surprise that this was actually a complete set. These are the regulations which not only govern the conduct of inmates, but which govern the conduct of staff. Thus, it was extremely important that the counselor, who is very experienced, know what constitutes the Department of Corrections' regulations. With this new knowledge, the counselor allowed the inmate to read the regulations.

Disposition: Fully Rectified 2944

Example 10 - Record Keeping Complaint

Little did an inmate know the problems which would result when he authorized the spending of $170.40 to purchase a bicycle for his child.

After over a month had passed the bicycle had not been delivered. The inmate wrote the department store and was informed the store was temporarily out of the bicycles he had ordered. He explained this to the institutional business office and asked if the money had been credited back to his account. The business office reported that the check had never been returned so it would have to be voided. Another two weeks passed but he received no confirmation the check had been voided. Finally, the inmate asked for the Ombudsman's help.

An institutional staff member told the Ombudsman the check had been voided the previous day. The money would be credited to the inmates account the following week. Two weeks later the inmate informed the Ombudsman the money still had not been credited to his account. The Ombudsman discovered that the staff member was now on vacation and the check had never been voided. The staff member's supervisor would only promise to have the check voided the following week.

A week and a half later, the Ombudsman learned that no action had been taken. The supervisor was now temporarily off the job. However, the staff member with whom the Ombudsman had originally talked, was now back from vacation. He was extremely upset about what had happened. It had been his understanding that the check had in fact been voided. The staff member accepted the Ombudsman's suggestion that the money be credited to the inmate's account immediately even though the check had not been voided. The inmate was to receive notice when the money was officially returned to his account. The Ombudsman passed this new information on to the inmate.

A week later, the staff member informed the Ombudsman that the money had been credited to the inmate's account. A written notice had been sent. The notice, however, had not gotten to the inmate. The Ombudsman again returned to the staff member. The exasperated staff member filled out a new notification and it was personally delivered by the Ombudsman the same day. Four months had passed.

Disposition: Fully Rectified 2511

STATISTICAL PRESENTATION

The following represents a statistical overview of the Office's complaint work. Highlights of the statistical information, which is graphically presented in Figures 1 - 16 on pages 81 through 92 , are offered in the following narrative. The complaint handling terms are defined in "Definitions of Complaint Handling Terms" on pages 99 through 102.

In its six years of operation, the Ombudsman Office has experienced a tremendous growth in it's complaint work. (See Figures 1 - 3 on pages 81 - 83.) There has been a 24.7% average yearly increase of complaints received. At the same time, there has been an average yearly increase of 31.3% of contacts (telephone contacts, personal contacts, and letter contacts) invested in the resolving of these complaints. While the Office's complaint work has been increasing over the years, there has been an amazing consistency in the average number of contacts per complaint. The average number of contacts per complaint was 6.4 in FY 1977, FY 1978, and again in this fiscal year.

The Office handled 948 complaints during FY 1981 (July 1, 1980 through June 31, 1981). Not only is this figure the highest in the Office's history, but it represents a 38.2% increase over the previous high (686 complaints in FY 1980). The 948 complaints included 62 pending from FY 1980 and 886 received in FY 1981. The 886 complaints received is a 43.4% increase from the 618 received last fiscal year, and is also a new high.

Of the 948 complaints handled, 869 were closed during FY 1981. Of these closed complaints, 50.1% were initiated in the Office, 49.6% were initiated in the institutions, and .3% were initiated at some other location. A breakdown of the closed complaints by institution is offered in Figure 5 on page 84 .

Over 40% of the 869 complaints are contained in four of the twenty-three complaint categories. (See Figure 14 on page 90 .) Although the order is re-arranged, these four categories were also the top four complaint categories in FY 1980. The complaint category concerning the accuracy of records is again the largest category with 104 or 12.0% of the complaints. This is compared to 70 or 11.2% of the complaints in FY 1980. The second largest complaint category is "Medical" with 86 or 9.9% of the complaints. Complaints concerning "Lost Property/Physical Disabilities" is the third largest complaint category with 83 or 9.6% of the complaints. The fourth largest complaint category is "Custody Status and Parole Eligibility" with 77 or 8.9% of the complaints. A breakdown of the dispositions of these four complaint categories is presented in Figure 15 on page 91 .

The Ombudsman Office was able to resolve 725 or 83.5% of the complaints below middle management level within the Department of Corrections. (See Figure 13 on page 89 .) These complaints required either no intervention with Department of Corrections' staff or were resolved at the Line, Line Supervisor, or Professional Staff Levels. In 34 or 3.9% of the 869 complaints, intervention was deemed necessary with the deputy secretaries or Secretary of Corrections.

Of the 182 complaints in which the Office sought corrective action, 159 or 87.4% were fully rectified, 8 or 4.4% were partially rectified, and 15 or

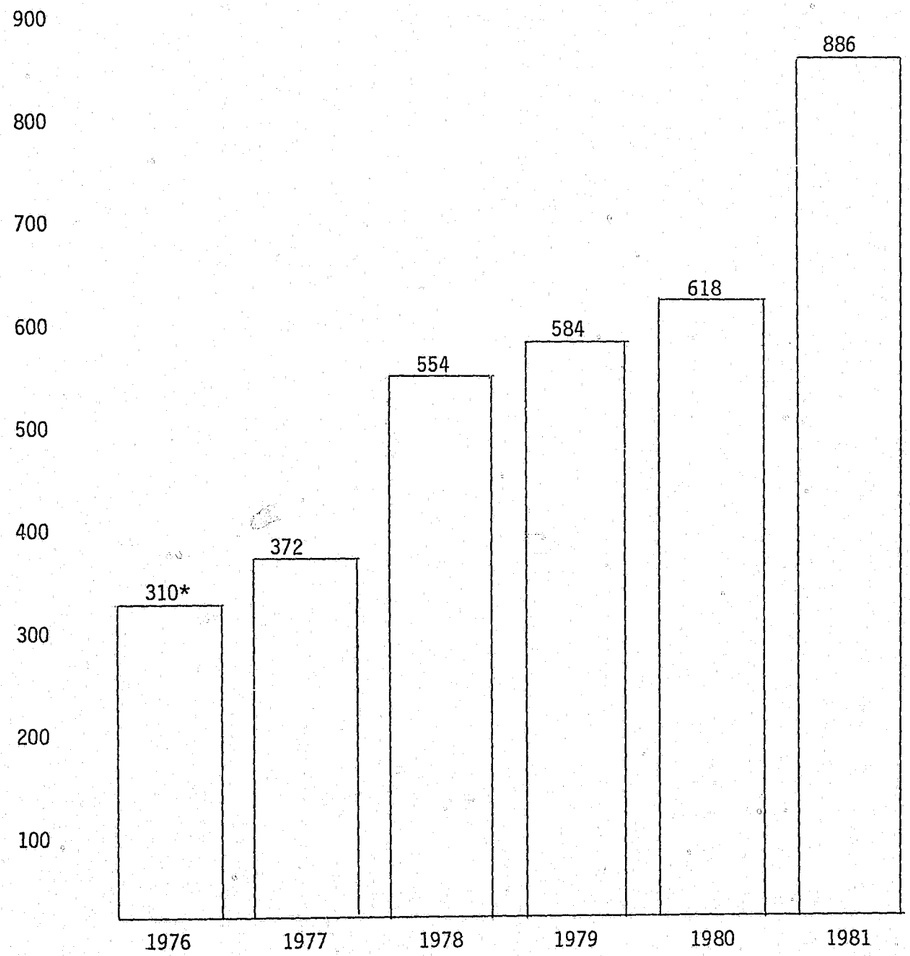
8.2% were not rectified. A complete breakdown of the dispositions is provided in Figure 16 on page 92.

In 84 or 9.7% of the complaints, the complaint was determined to be unfounded. Of these 84 unfounded complaints, 30 or 35.7% involved either "Records" complaints with 16 or "Property Loss/Physical Disability" complaints with 14. (See Figure 15 on page 91.)

As depicted in the graphic presentations, there are obvious differences in the number and types of complaints from KSP, KSIR, and KCIW. Too many variables are involved to draw conclusions based upon these differences. The variables include differences in the administration of the institutions, differences in inmate population, and differences in services provided by the Ombudsman Office at the institutions.

Figure 1

The 3,324 Complaints Received: The First Six Years



Fiscal Years (July 1 - June 30)

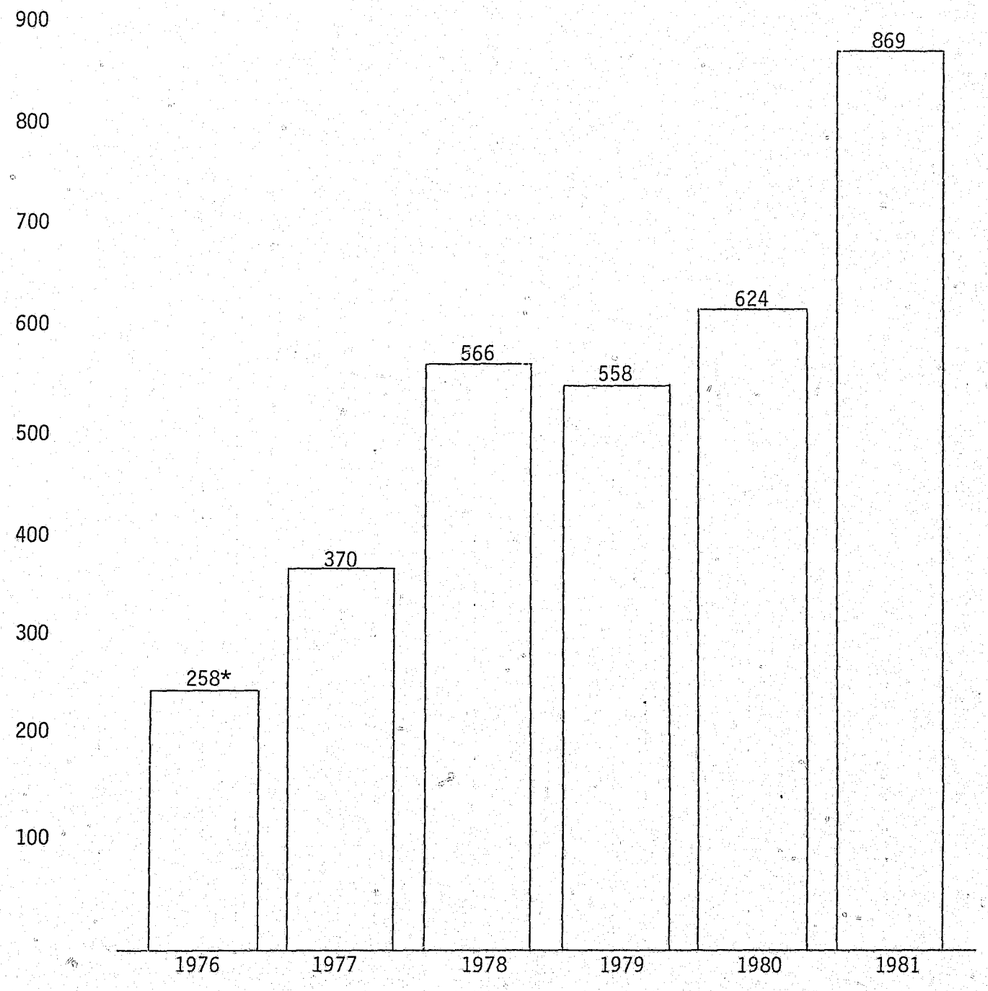
* Complaints received during first 9½ months of operation.

CONTINUED

1 OF 2

Figure 2

The 3,245 Complaints Closed: The First Six Years

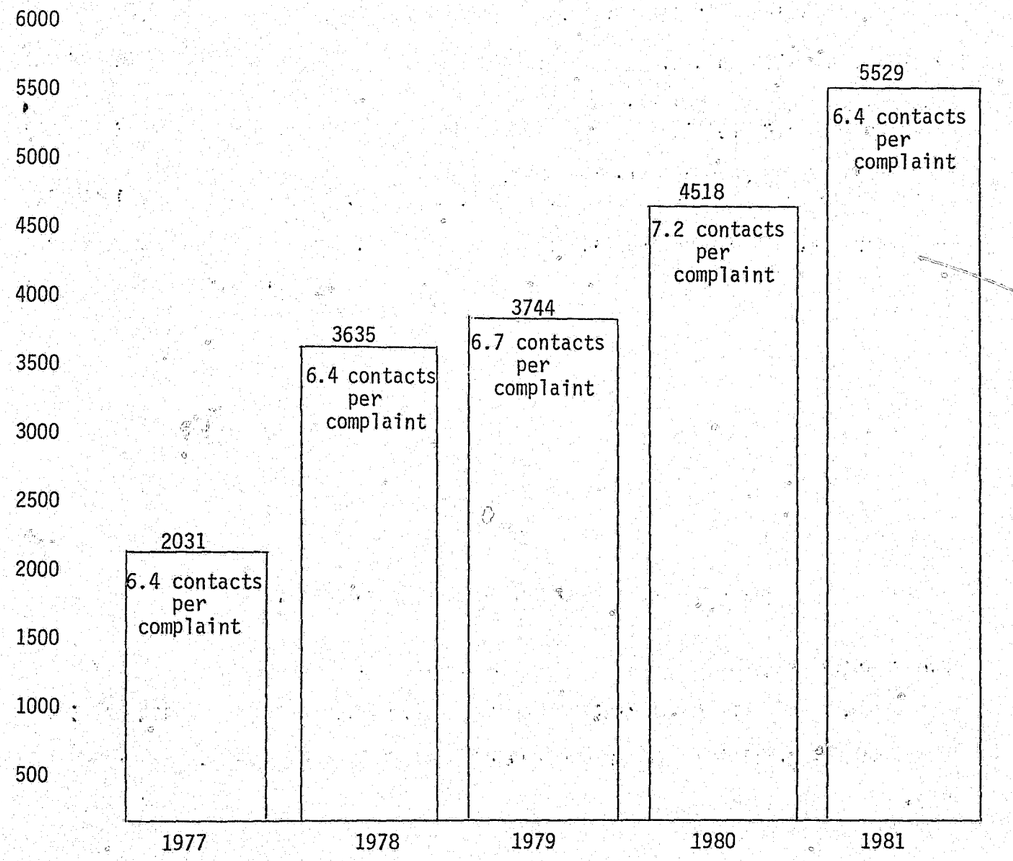


Fiscal Years (July 1 - June 30)

* Complaints closed during first 9½ months of operation.

Figure 3

The 19,457 Contacts Made in Resolving Complaints: The First Six Years*



Fiscal Years (July 1 - June 30)

* This data was not recorded on the 258 complaints closed in FY 1976, or on the 52 complaints received in FY 1976 and closed in FY 1977.

Figure 4

Referrals Received

Families and friends of complainants	69 (43.7%)
Inmates other than complainants	28 (17.7%)
Government agencies other than Department of Corrections	22 (13.9%)
Department of Corrections' staff members other than complainants	21 (13.3%)
Non-Governmental agencies and law firms	18 (11.4%)
Total	158 (100%)

Figure 5

The 869 Closed Complaints: Fiscal Year 1981

Kansas State Penitentiary (KSP)	583 (67.1%)
Kansas State Industrial Reformatory (KSIR)	131 (15.1%)
Kansas Correctional Institution for Women (KCIW)	60 (6.9%)
Other	95 (10.9%)
Total	869 (100%)

ALL OF THE FOLLOWING GRAPHS AND TABLES ARE BASED ON INFORMATION FROM THESE 869 CLOSED COMPLAINTS.

Race of Inmate Complainants*
Compared to Inmate Population on June 30, 1981**

Figure 6
Inmate Complainants*

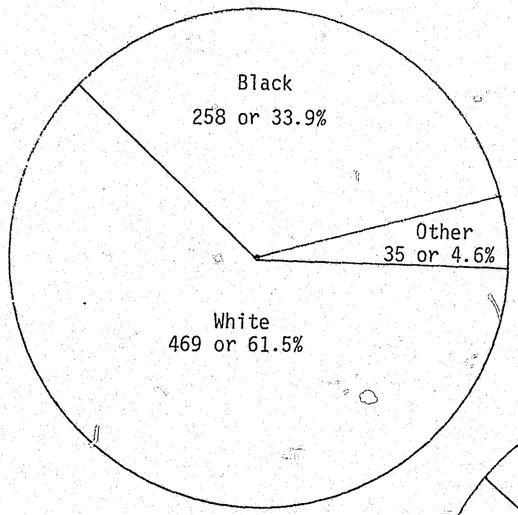
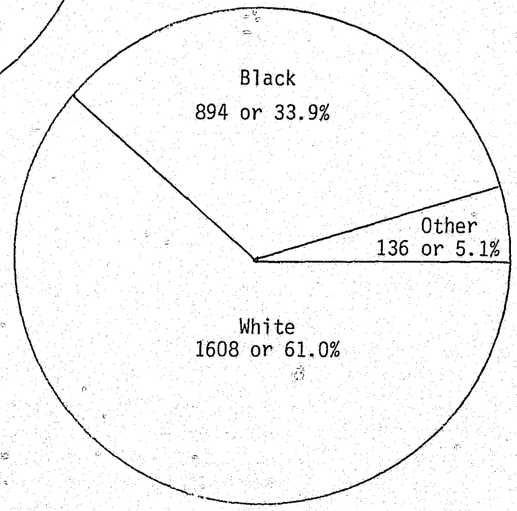


Figure 7
Inmate Population**



* This data was obtained from the 762 Department of Corrections' inmate complaints.

** These statistics were computed from data provided by the Kansas Department of Corrections.

Figure 8

How Complaints Were Initiated

Direct Contact	All* Complaints	KSP Complaints	KSIR Complaints	KCIW Complaints
Letter	313 (36.0%)	198 (34.0%)	72 (55.0%)	18 (30.0%)
Personal	303 (34.9%)	254 (43.6%)	22 (16.8%)	23 (38.3%)
Phone	63 (7.2%)	19 (3.2%)	2 (1.5%)	7 (11.7%)
Sub-Total:	679 (78.1%)	471 (80.8%)	96 (73.3%)	48 (80.0%)
Third Party Contact				
Letter	34 (3.9%)	16 (2.7%)	10 (7.6%)	2 (3.3%)
Personal	42 (4.8%)	35 (6.0%)	5 (3.8%)	2 (3.3%)
Phone	82 (9.5%)	37 (6.4%)	14 (10.7%)	7 (11.7%)
Sub-Total:	158 (18.2%)	88 (15.1%)	29 (22.1%)	11 (18.3%)
Ombudsman Initiative				
Letter	1 (.1%)	1 (.2%)	0 (---)	0 (---)
Personal	26 (3.0%)	20 (3.4%)	5 (3.8%)	1 (1.7%)
Phone	5 (.6%)	3 (.5%)	1 (.8%)	0 (---)
Sub-Total:	32 (3.7%)	24 (4.1%)	6 (4.6%)	1 (1.7%)
Total:	869 (100%)	583 (100%)	131 (100%)	60 (100%)

* This column incorporates complaints from all sources, as well as KSP, KSIR, and KCIW.

Figure 9

Where Complaints Were Initiated

	All* Complaints	KSP Complaints	KSIR Complaints	KCIW Complaints
Office	435 (50.1%)	212 (36.4%)	97 (74.0%)	33 (55.0%)
Institutions	431 (49.6%)	370 (63.4%)	34 (26.0%)	26 (43.3%)
Other	3 (.3%)	1 (.2%)	0 (---)	1 (1.7%)
Total:	869 (100%)	583 (100%)	131 (100%)	60 (100%)

Figure 10

How the Ombudsman First Responded to Complaints

	All* Complaints	KSP Complaints	KSIR Complaints	KCIW Complaints
Letter	170 (19.6%)	81 (13.9%)	63 (48.1%)	3 (5.0%)
Personal	506 (58.2%)	417 (71.5%)	39 (29.8%)	41 (68.3%)
Phone	193 (22.2%)	85 (14.6%)	29 (22.1%)	16 (26.7%)
Total:	869 (100%)	583 (100%)	131 (100%)	60 (100%)

Figure 11

Ombudsman's Response Time

Calender Days To First Response:	All* Complaints	KSP Complaints	KSIR Complaints	KCIW Complaints
0 - 7 days	811 (93.3%)	535 (91.8%)	123 (93.8%)	59 (98.3%)
8 - 14 days	40 (4.6%)	34 (5.8%)	4 (3.1%)	1 (1.7%)
15+ days	18 (2.1%)	14 (2.4%)	4 (3.1%)	0 (---)
Total:	869 (100%)	583 (100%)	131 (100%)	60 (100%)

* These columns incorporate complaints from all sources, as well as KSP, KSIR, and KCIW.

Figure 12

Contacts Made in Resolving Complaints

(a)
Comparison of Number of Complaints with Contacts

Institutions	Total Contacts per Institution		Number of Complaints per Institution		Average Number of Contacts per Complaints	Percentage of Contacts per Institution
KSP	3950	÷	583	=	6.8	71.5%
KSIR	754	÷	131	=	5.8	13.6%
KCIW	265	÷	60	=	4.4	4.8%
Other	560	÷	95	=	5.9	10.1%
Total:	5529		869		6.4	100%

(b)
Individual Contacted

	Complainant		DOC Staff*		Outside DOC		Total
KSP	1852	+	1579	+	519	=	3950
KSIR	382	+	235	+	137	=	754
KCIW	151	+	68	+	46	=	265
Other	259	+	177	+	124	=	560
Total:	2644	+	2059	+	826	=	5529
Percent:	47.8%	+	37.3%	+	14.9%	=	100%

* Other than complainant.

(c)
Form of Contacts

	Letter		Personal		Phone		Total
KSP	874	+	2439	+	637	=	3950
KSIR	321	+	268	+	165	=	754
KCIW	44	+	151	+	70	=	265
Other	142	+	89	+	329	=	560
Total:	1381	+	2947	+	1201	=	5529
Percent:	25.0%	+	53.3%	+	21.7%	=	100%

Figure 13

Highest Department of Corrections' Management Level Involved in Resolution*

Management Levels	All* Complaints	KSP Complaints	KSIR Complaints	KCIW Complaints
None	456 (52.5%)	263 (45.1%)	89 (67.9%)	42 (70.0%)
Line	57 (6.6%)	44 (7.6%)	4 (3.1%)	1 (1.7%)
Line Supervisors	159 (18.3%)	132 (22.7%)	17 (13.0%)	3 (5.0%)
Professional Staff	53 (6.1%)	44 (7.5%)	2 (1.5%)	5 (8.3%)
Sub-Total:	725 (83.5%)	483 (82.9%)	112 (85.5%)	51 (85.0%)
Middle Management	41 (4.7%)	18 (3.1%)	10 (7.6%)	3 (5.0%)
Directors	69 (7.9%)	55 (9.4%)	7 (5.4%)	5 (8.3%)
Secretary of Corrections	34 (3.9%)	27 (4.6%)	2 (1.5%)	1 (1.7%)
Sub-Total:	144 (16.5%)	100 (17.1%)	19 (14.5%)	9 (15.0%)
Total:	869 (100%)	583 (100%)	131 (100%)	60 (100%)

* This column incorporates complaints from all sources as well as KSP, KSIR, and KCIW.

Figure 14

Nature of the Complaints

Categories:	Rank Order Of* All Complaints	KSP Complaints	KSIR Complaints	KCIW Complaints
Records	104 (12.0%)	81 (13.9%)	8 (6.1%)	6 (10.0%)
Medical	86 (9.9%)	69 (11.8%)	5 (3.8%)	11 (18.5%)
Property Loss/ Physical Disability	83 (9.6%)	62 (10.6%)	11 (8.4%)	0 (---)
Parole Eligibility/ Custody Status	77 (8.9%)	56 (9.6%)	13 (9.9%)	5 (8.3%)
Daily Routine	59 (6.8%)	49 (8.4%)	5 (3.8%)	3 (5.0%)
Parole	49 (5.6%)	28 (4.8%)	10 (7.6%)	2 (3.3%)
Inter-Institutional Transfer	45 (5.2%)	28 (4.8%)	10 (7.6%)	3 (5.0%)
Staff Complaints	43 (4.9%)	18 (3.1%)	5 (3.8%)	8 (13.3%)
Grievance/Property Loss Procedures	42 (4.8%)	28 (4.8%)	13 (9.9%)	0 (---)
Legal	39 (4.5%)	21 (3.6%)	9 (7.0%)	1 (1.7%)
Physical Threat/ Abuse	33 (3.8%)	14 (2.4%)	10 (7.6%)	2 (3.3%)
Complaints Against Staff	31 (3.6%)	18 (3.1%)	4 (3.1%)	5 (8.3%)
Others	27 (3.1%)	11 (1.9%)	2 (1.5%)	2 (3.3%)
Disciplinary Procedure	27 (3.1%)	14 (2.4%)	5 (3.8%)	3 (5.0%)
Education/Work/ Training	23 (2.6%)	19 (3.3%)	3 (2.3%)	1 (1.7%)
Temporary Release/ Sentence Modification	21 (2.4%)	11 (1.9%)	6 (4.6%)	3 (5.0%)
Basic Needs	19 (2.2%)	15 (2.6%)	0 (---)	3 (5.0%)
Mail	19 (2.2%)	14 (2.4%)	4 (3.1%)	0 (---)
Visiting	17 (1.9%)	12 (2.1%)	3 (2.3%)	2 (3.3%)
Unknown	11 (1.3%)	4 (.7%)	2 (1.5%)	0 (---)
Counseling/Mental Health	7 (.8%)	5 (.8%)	2 (1.5%)	0 (---)
Volunteer Complaints	4 (.5%)	4 (.7%)	0 (---)	0 (---)
Safety Procedures	3 (.3%)	2 (.3%)	1 (.8%)	0 (---)
Total:	869 (100%)	583 (100%)	131 (100%)	60 (100%)

* This column incorporates complaints from all sources, as well as KSP, KSIR, and KCIW.

Figure 15

Dispositions in Four Largest Complaint Categories

Dispositions:	Records	Medical	Property Loss/ Phys. Disability	Parole Elig./ Custody Status
Direct Intervention:				
Fully Rectified	21 (20.2%)	20 (23.3%)	15 (18.1%)	23 (29.8%)
Partially Rectified	2 (1.9%)	1 (1.2%)	2 (2.4%)	1 (1.3%)
Not Rectified	2 (1.9%)	1 (1.2%)	2 (2.4%)	1 (1.3%)
Unfounded	16 (15.4%)	7 (8.1%)	14 (16.7%)	4 (5.2%)
Sub-Total:	41 (39.4%)	29 (33.8%)	33 (39.6%)	29 (37.6%)
Indirect Intervention:				
Observed and Monitored	9 (8.7%)	17 (19.8%)	7 (8.5%)	4 (5.2%)
Information	11 (10.6%)	7 (8.1%)	12 (14.5%)	12 (15.6%)
Referral	1 (1.0%)	0 (---)	0 (---)	0 (---)
Sub-Total:	21 (20.3%)	24 (27.9%)	19 (23.0%)	16 (20.8%)
Incompleted Intervention:				
Declined	7 (6.7%)	10 (11.6%)	7 (8.5%)	13 (16.9%)
Withdrawn	18 (17.3%)	13 (15.1%)	18 (21.7%)	11 (14.3%)
Solved Prior	17 (16.3%)	10 (11.6%)	6 (7.2%)	8 (10.4%)
Sub-Total:	42 (40.3%)	33 (38.3%)	31 (37.4%)	32 (41.6%)
Totals	104 (100%)	86 (100%)	83 (100%)	77 (100%)

Figure 16

Disposition of Complaints

Dispositions:	All* Dispositions	KSP Dispositions	KSIR Dispositions	KCIW Dispositions
Direct Intervention:				
Fully Rectified	159 (18.3%)	133 (22.8%)	14 (10.7%)	6 (10.0%)
Partially Rectified	8 (.9%)	7 (1.2%)	0 (---)	0 (---)
Not Rectified	15 (1.7%)	9 (1.5%)	4 (3.0%)	1 (1.7%)
Unfounded	84 (9.7%)	67 (11.5%)	6 (4.6%)	3 (5.0%)
Sub-Total:	266 (30.6%)	216 (37.0%)	24 (18.3%)	10 (16.7%)
Indirect Intervention:				
Observed and Monitored	99 (11.4%)	68 (11.7%)	9 (6.9%)	13 (21.7%)
Information	148 (17.0%)	83 (14.2%)	24 (18.3%)	12 (20.0%)
Referral	26 (3.0%)	12 (2.1%)	4 (3.0%)	2 (3.3%)
Sub-Total:	273 (31.4%)	163 (28.0%)	37 (28.2%)	27 (45.0%)
Incompleted Intervention:				
Declined	114 (13.1%)	60 (10.3%)	36 (27.5%)	2 (3.3%)
Withdrawn	129 (14.9%)	79 (13.6%)	23 (17.6%)	12 (20.0%)
Solved Prior	87 (10.0%)	65 (11.1%)	11 (8.4%)	9 (15.0%)
Sub-Total:	330 (38.0%)	204 (35.0%)	70 (53.5%)	23 (38.3%)
Totals	869 (100%)	583 (100%)	131 (100%)	60 (100%)

* This column incorporates complaints from all sources, as well as KSP, KSIR, and KCIW.

STAFF BIOGRAPHIES

Preston N. Barton II -- Ombudsman

Preston Barton is a member of the Board of Directors of the United States Association of Ombudsmen, the Ombudsman Advisory Committee of the International Bar Association and the Academy of Certified Social Workers (ACSW). He is a Licensed Specialist Clinical Social Worker (LSCSW). He attended Wilmington College in Wilmington, Ohio and holds a Bachelor's Degree (1965) with a concentration in Social Welfare from the School of Education at Temple University in Philadelphia, Pennsylvania. He completed the two year Master's Degree program (1967) in Social Work at the University of Pennsylvania School of Social Work, in Philadelphia. During his senior year in college and two years in graduate training, he did his field training at the Pennsylvania Prison Society, also in Philadelphia. At this now 194 year old private agency dedicated to prison reform and the provision of direct services to prisoners and releasees, he provided short and long term counseling with adult inmates and parolees, and with some youthful offenders and their parents.

After graduation, he remained at the Prison Society as a staff member for nearly a year before entering the U.S. Army with a direct commission as a captain. Following two months of Medical Service Corps training, he was assigned to the U.S. Army Correctional Training Facility at Fort Riley, Kansas, in May, 1968. Two months later, this innovative facility began operation, with a capacity of accomodating 2,000 prisoners at one time and involving over 10,000 men in its program in a 12-month period. In addition to providing consultative and direct social work services, he was one of the designers and developers of a self-help counseling program. He became the military liaison officer and supervisor of the eight member staff of this program which was operated under a contract with the 7th Step Foundation of Topeka, Inc.

Upon completion of his military obligation in March, 1971, Preston and his wife, Jean, moved to Topeka where he became the Administrator and Social Work Consultant to the ex-offender staff of the Topeka 7th Step program. Additionally, he was a part-time instructor in the Sociology Department at Washburn University. In September, 1972, he received an appointment as Assistant Professor at the University of Kansas School of Social Welfare. He was responsible for a field training unit in Topeka, as well as having classroom teaching, administrative and committee assignments. As a result of this experience, he co-authored an article entitled, "Structuring Social Work Services in the Legal Setting," which was published in the April, 1975, issue of Social Casework. After teaching for two years, he left to accept a Social Work Fellowship in the 12-month Post Master's Social Work Training Program in the Menninger School of Psychiatry. While participating in this program during 1974 and 1975, he did his practicum in clinical work at the C.F. Menninger Memorial Adult Hospital.

In addition to his formal work and training experience, Preston has been active in continuing education. He has studied and trained in group dynamics, including such experimental seminars as "Human Relations," "Factors in Planned Change," "Theory and Practice of Training," and "Executive Seminars," sponsored by Temple University, the National Training Laboratory Institute, and the Menninger Foundation. Other continuing educational involvement has included such areas as "Instructional Techniques," "Social Research," "Psychopharmacology," and a variety of programs relating to corrections including volunteers in corrections, hostage negotiations, inmate grievance procedures, and negotiations and collective bargaining. Preston was a delegate to the First International Ombudsman Conference in Edmonton, Alberta, Canada (1976) and the Second International Ombudsman Conference in Jerusalem, Israel (1980). He attended the first four conferences of the U.S. Association of Ombudsmen, held respectively in Seattle, Washington (1977), Dayton, Ohio (1978), Minneapolis, Minnesota (1979) and Detroit, Michigan (1980). He participated in the U.S. Conferences as a panel reactor, workshop facilitator and presenter.

He was previously active as a volunteer, consultant and Board member of various community organizations. These included the Shawnee County Community Resources Council, the Kansas Council on Crime and Delinquency, the 7th Step Foundation of Topeka, Inc., the Citizens' Jail Survey Project for Kansas, the Shawnee County Youth Center, and the Topeka Chapter of the Kansas Council on Crime and Delinquency for which he served as Chairman. Currently, he is a member of the National Association of Social Workers, the National Council on Crime and Delinquency and the American Correctional Association.

It was with this background of having functioned in correctional, educational and psychiatric settings from the perspectives of institutional staff members, offenders, ex-offenders, and community volunteers that he was appointed Corrections Ombudsman on September 15, 1975, by the Corrections Ombudsman Board. In this capacity he also functions as Executive Secretary to the Board.

David Jensen -- Ombudsman Associate

David was appointed Ombudsman Associate in August, 1978. His duties include handling complaints primarily at the Kansas State Penitentiary and compiling and presenting the Office's statistical research.

David traces his career in corrections back to a series of chance events. After graduating from high school, David had no idea where he wanted to attend college, or what field he wanted to pursue. However, when the football coach from Washburn University in Topeka offered him a scholarship to play football, it was an easy decision. Once at Washburn, he happened to overhear another student talking about a psychology practicum with the Shawnee County Adult Probation Office. His curiousity aroused, David enrolled in the course. After finding the work to be challenging and rewarding, he checked around and found that Washburn

actually offered a major in Corrections. David signed up for a Corrections internship with the same office, but his internship was shorter than expected because he was hired as an adult probation officer in March, 1973. Working full time, he hung on to complete his requirements for a Bachelor of Arts degree with a double major in Psychology and Corrections in August, 1974.

David worked for three and a half years as an adult probation officer for Shawnee County Adult Probation, which became a part of the consolidated Shawnee County Court Services. As an adult probation officer, his primary duties were to prepare pre-sentence investigations, and to counsel and supervise adults convicted in the magistrate and district courts. From May, 1976 until the end of August, 1976, David also worked weekends as a juvenile intake officer with Court Services. His responsibilities were to evaluate and make decisions as to detention and/or processing of youths through or outside the court system. While with Court Services, David also served as a volunteer probation sponsor, went on a week-long canoe trip to Minnesota with a group of court-referred youths, and worked with a drug "rap group" as a volunteer leader.

In August, 1976, David resigned from Court Services to attend the two year Social Work graduate program at the University of Kansas School of Social Welfare. As a part of his requirements for the first year, he spent two to three days a week in field training in the Ombudsman Office. His work included handling complaints at the Kansas State Penitentiary, and assisting in the prepartion of the "Report on the Adjustment and Treatment Building at the Kansas State Penitentiary." During his second year of graduate training, David gained clinical experience by spending three days a week in field work training with Shawnee County Mental Health Services in Topeka. He provided individual, marital, and family counseling; and co-led a couples group. As part of his classroom requirements, David prepared papers on prison sexuality, families of prisoners, juvenile delinquency, and chemical addiction. A shortened version of his paper "Prison Sexuality: The Non Existent Phenomenon" was included in the September, 1980 edition of KSP Lifer's Club newsletter, the "Chronicle". In order to survive while attending graduate school, David worked the following part-time jobs: graduate research assistant, Criminal Justice Department, Washburn University; summer field supervisor, Topeka Department of Labor Services; administrative assistant, University of Kansas, School of Social Welfare; and GED instructor for Court Services.

After graduating in May, 1978 with a Masters Degree in Social Work, David returned to Washburn University's Criminal Justice Department, and spent an enjoyable summer serving as correctional intern coordinator and teaching an introductory course to Corrections. He left Washburn University at the end of the summer to accept the Ombudsman Associate position.

David developed his skills by participating in numerous continuing education seminars and workshops. Those directly related to his Ombudsmanry work include: "Grievance Arbitration", "Ombudsman Investigator Training," "Investigations in Ombudsman Offices," "Conflict Management," "Dealing with Conflict," "Managerial Problem Solving and Decision Making," "Personnel Policies and Procedures," "Written Communication Skills for Managers," and "Effective Report Writing". On invitation of the Department of Corrections, he attended the "Correctional Management Training Seminar," and the "Classification Study Workshop". David also has continuing education training in group work, assertiveness, drug education, reality therapy, microcomputers, gestalt therapy, and probation and parole techniques.

Carol L. Keith -- Staff Assistant

During the latter part of January, 1981 Carol Keith joined the staff of the Ombudsman Office in the part-time position of Staff Assistant. Her primary responsibility was complaint handling at the Kansas State Penitentiary. Carol worked three days per week with two of those days normally being spent at the prison. At the time of her appointment, Carol had a bachelors degree in Sociology from Kansas State University with a specialization in correctional administration and had completed the necessary coursework for a masters degree in the Administration of Justice from Wichita State University, which has since been conferred upon her.

In addition to her educational focus, Carol had been actively involved in corrections as the Chairperson of the Riley County Community Corrections Advisory Board. In that capacity, she attended seminars on community corrections held in various parts of the state. Another activity which has occupied Carol's time has been her membership with the League of Women Voters. For the past two years, she has served on the State Board of Directors of the organization with responsibility for the program area of courts and corrections. She is currently serving the Board as Membership Chairperson.

At the end of June, 1981, Carol was promoted from Staff Assistant to the newly established Ombudsman Associate position.

Marais (Phillips) Johnson -- Administrative Secretary

Marais has served the Office of the Ombudsman since June of 1979. In January, 1981 she was promoted to Administrative Secretary. Marais' major responsibilities include secretarial support, keeping the filing and library systems up-to-date, office management, supervising the Typist and assisting the Ombudsman in various projects, such as the budget and work with the Corrections Ombudsman Board.

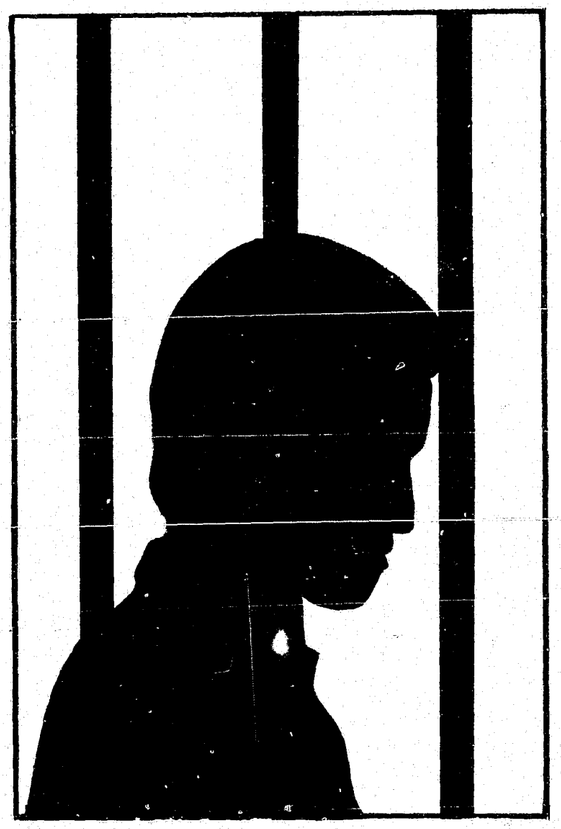
Marais has attended various workshops since being with the Ombudsman Office that she feels has helped broaden her knowledge of the job. She has attended workshops on office personnel, evaluation of employees, budget process, human relations, micro counseling, written communication skills for managers, newsletter format and the design of records and filing systems.

Because Marais enjoys working with people and trying to understand their needs she has found the challenge of working with the Ombudsman Office an enjoyable experience. In her spare time Marais in involved in sport activities. At the present time she is on bowling and vollyball teams.

Lori Frickey -- Typist

Lori Frickey has been with the Ombudsman Office as Typist since February, 1981. In addition to typing her duties include answering the phone, filing, registering complaints and opening the mail.

Lori has lived in Topeka all of her life. She attended one of Topeka's local high schools where she graduated in the winter of 1981. Lori has interests in many areas. Her favorite is repairing cars. Her other interests include, swimming, water skiing, camping, tennis, gardening and ceramics. In high school she was in forensics and competed against many of the high schools in the state. She has taken many classes pertaining to secretarial duties, including office machines, typing and word processing.



DEFINITION OF COMPLAINT HANDLING TERMS

I. Categories of Complaints

A. Care and Maintenance:

1. Basic Needs - Needs for provisions for essential body functions, such as the availability and quality of food, clothing, shelter, showers, exercise, and toilet facilities.

2. Medical - (Physical) - Availability and delivery of medical treatment and it's documentation. (Includes only somatic and not psychiatric ailments.)

3. Records - Handling of all records other than medical and mental health records.

4. Visiting - Management of inmate visiting lists, visits, and visitors.

5. Mail - Sending and receiving correspondence and packages.

B. Safety and Security:

1. Physical Threats and Abuse - Threats or incidents of bodily harm.

2. Safety Procedures - Condition and design of physical facilities and equipment, and their supervision.

3. Property Loss/Physical Disability - Loss, destruction or theft of personal property; and permanent disability injuries.

4. Temporary Releases and Sentence Modifications - Process of forming decisions, reporting decisions, and providing reasons for decisions regarding home furloughs, funeral visits, and sentence modifications initiated by the Department of Corrections.

5. Inter-Institutional Transfers - Process of forming decisions, reporting decisions, and providing reasons for decisions regarding institutional transfers.

C. Maintenance of Institutional Order:

1. Disciplinary Procedures - Management of the disciplinary process.

2. Daily Routine - Informal and formal routinized practices and procedures which govern institutional life.

3. Complaints Against Staff - Prejudicial and arbitrary behavior.

4. Internal Grievance/Property Loss Claim Procedures - Processing of inmate grievances and property loss claims within the Department of Corrections.

D. Rehabilitation:

1. Parole - Complaints relating to the Kansas Adult Authority.

2. Counseling and Mental Health - Availability of professional counseling and services, and utilization of psychopharmacological medications and psychiatric evaluations.

3. Education, Work, Training - Assignment and termination of work or educational/vocational training programs; the development and carrying out of rehabilitation programs. The availability of library and religious services, and of self help programs.

4. Custody Status and Parole Eligibility - Accountability and documentation of decision making concerning custody level (classification) and related cellhouse moves, certification to see the Kansas Adult Authority, and Departmental processing of interstate parole compact.

E. Miscellaneous:

1. Complaints From Staff - Complaints from Department of Corrections staff members.

2. Complaints From Volunteers - Training, orientation, supervision, and treatment of volunteers.

3. Legal - Access to relevant legal documents, to legal professionals and inmate advocates, and the courts.

4. Other - Complaints which do not fit within any of the above categories.

5. Unknown - Withdrawn or solved prior to the collection of sufficient information to categorize.

II. Assessments of Complaints:

A. Within Jurisdiction - Within statutory power to investigate.

B. Outside Jurisdiction - Beyond statutory power to investigate.

C. Unknown - Withdrawn or solved prior to the collection of sufficient information to assess.

III. Disposition of Complaints:

A. Fully Rectified - In response to the Ombudsman's intervention, a problematic situation, practice, or policy is resolved in the opinion of the Ombudsman.

B. Partially Rectified - In response to the Ombudsman's intervention a problematic situation, practice, or policy is in part resolved in the opinion of the Ombudsman.

C. Not Rectified - In response to the Ombudsman's intervention, a problematic situation, practice, or policy is not altered in the opinion of the Ombudsman.

D. Unfounded - Subsequent to the Ombudsman's investigation, no factual basis is found for the complaint.

E. Observed and Monitored - Ombudsman presence in a situation for the purpose of preventing deviations from policy or preventing susceptibility of false allegations of such.

F. Information - Complainant provided with information on how to go about solving a problem. Also, information provided about operation of Ombudsman Office, Department of Corrections, and other agencies.

G. Referral - Complainant directed to other resources within and outside Department of Corrections, and resources are contacted by the Ombudsman.

H. Declined - Investigation is either not started or is stopped because issue is outside jurisdiction and assistance cannot be provided, issue is beyond current capacity to handle, issue has not been appropriately pursued by complainant, or issue is frivolous.

I. Withdrawn - Complainant request's Ombudsman take no further action, or fails to follow through with requests or recommendations made by Ombudsman.

J. Solved Prior - Rectified before completion of Ombudsman's investigation and report of findings.

IV. Highest Management Level Involved in Resolution:

A. Levels Within the Department of Corrections

1. Line Staff - Clerical staff; Correctional Officers I and II; detail officers and maintenance staff.

2. Line Supervisors - Correctional Supervisors I and II (Lieutenants and Captains), all Unit Team members, and supervisors of work release facilities.

3. Professional Staff - Staff members operating in a professional or para-professional capacity in the medical, legal, mental health, religious, educational, and training fields.

4. Middle Management - Supervises two or more line supervisors, and/or has major programmatic responsibilities.

5. Directors - Institutional Directors and Deputy Directors.

6. Secretary - The Secretary of Corrections and Deputy Secretaries.

7. None - None of the above levels were involved.

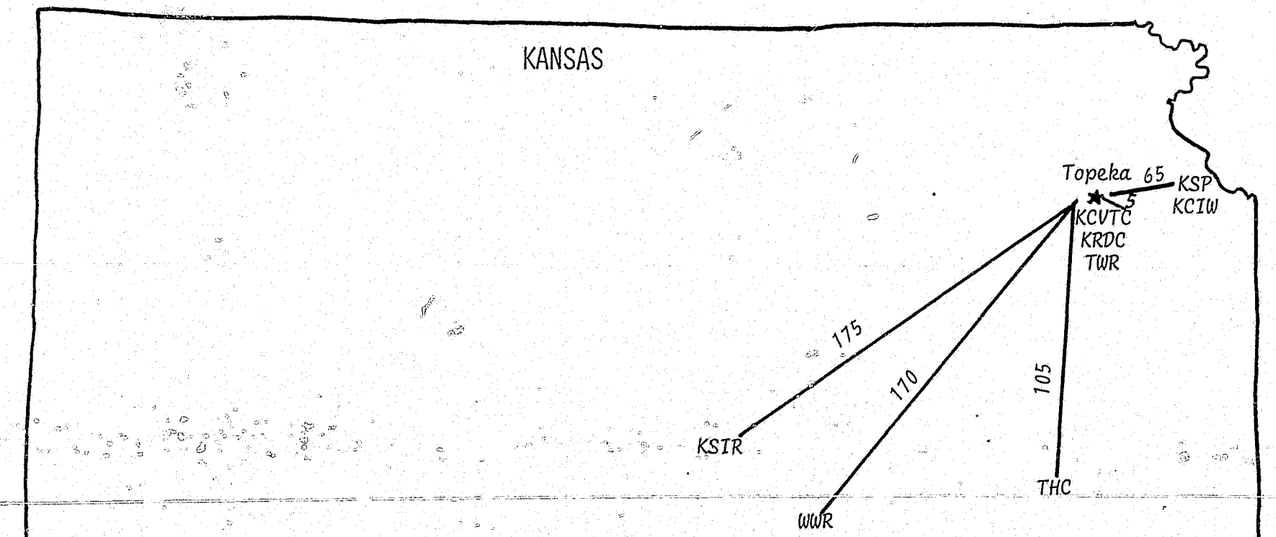
B. Levels External to the Department of Corrections

1. Governmental Agencies and Resources - Office of the Governor, the Legislature, the Kansas Adult Authority, etc.

2. Non-Governmental Agencies and Resources - Legal Services for Prisoners, Inc. 7th Step Foundation, the press, etc.

3. None - None of the above levels were involved.

Distances in Miles to Department of Corrections' Adult Correctional Facilities from the Ombudsman Office in Topeka



KCIW - Kansas Correctional Institution for Women, Lansing
KCVTC - Kansas Correctional-Vocational Training Center, Topeka
KRDC - Kansas Reception and Diagnostic Center, Topeka
KSIR - Kansas State Industrial Reformatory, Hutchinson
KSP - Kansas State Penitentiary, Lansing
THC - Toronto Honor Camp, Toronto
TWR - Topeka Work Release, Topeka
WWR - Wichita Work Release, Wichita

STATUTORY CITATIONS

SENATE BILL No. 461

AN ACT relating to the corrections ombudsman board; concerning compensation of the members thereof; amending K.S.A. 74-7401 and repealing the existing section.

Be it enacted by the Legislature of the State of Kansas:

Section 1. K.S.A. 74-7401 is hereby amended to read as follows: 74-7401. (a) There is hereby established and created as an independent agency within the executive branch of state government, the corrections ombudsman board. Prior to September 1, 1980, such board shall consist of ~~fifteen (15)~~ *15* members, three ~~(3)~~ of whom shall be appointed by the governor; three ~~(3)~~ of whom shall be appointed by the attorney general; three ~~(3)~~ of whom shall be appointed by the chief justice of the supreme court; three ~~(3)~~ of whom shall be appointed by the speaker of the house of representatives; and, three ~~(3)~~ of whom shall be appointed by the president of the senate. On and after September 1, 1980, such board shall consist of ~~ten (10)~~ *10* members, two ~~(2)~~ of whom shall be appointed by the governor; two ~~(2)~~ of whom shall be appointed by the attorney general; two ~~(2)~~ of whom shall be appointed by the chief justice of the supreme court; two ~~(2)~~ of whom shall be appointed by the speaker of the house of representatives; and, two ~~(2)~~ of whom shall be appointed by the president of the senate.

The members of said board shall hold their respective offices for a term of four ~~(4)~~ years and until their successors are appointed and qualified. On September 1, 1978, and on September 1 of each fourth year thereafter, the governor, attorney general, chief justice of the supreme court, speaker of the house of representatives and the president of the senate shall each appoint one member to such board. On September 1, 1980, and on September 1 of each fourth year thereafter, the governor, attorney general, chief justice of the supreme court, speaker of the house of representatives and the president of the senate shall each appoint one member to such board. Members serving on such board on the effective date of this act shall serve as members of the corrections ombudsman board for the remainders of the respective terms for which appointed. In case of a vacancy on such board, the person appointing the member creating the vacancy shall appoint a successor who shall serve for the remainder of the term of the member creating such vacancy. The members of such board shall be selected as far as practicable so that they will be residents of different parts of the state.

(b) The board shall select a chairperson from among its members. The board shall meet upon the call of the chairperson, or upon the call of the majority of the members of such board. A majority of the members of such board shall constitute a quorum to do business.

(c) Members of the board attending meetings of such board, or attending a subcommittee meeting thereof, *or visiting any correctional institution for the purpose of acquiring information concerning policies, procedures and administrative actions of the department of corrections, when* authorized by such board, shall be paid compensation as provided in subsection (a) of K.S.A. 75-3223, and amendments thereto, and in addition thereto the amounts provided in subsection (e) of K.S.A. 75-3223 and amendments thereto. *Payments made to board members for visiting correctional institutions prior to the effective date of this act are hereby authorized and validated.*

(d) The board shall have the following powers and duties:

(1) Appoint and supervise the activities of the ombudsman of corrections and establish the amount of compensation to be paid to such ombudsman as provided by K.S.A. 74-7403 or any amendments thereto.

(2) Adopt and file with the division of budget its budget estimates for the operation of the board and the office of ombudsman of corrections.

(3) Make recommendations to the secretary of corrections concerning policies, procedures and administrative actions of the department of corrections, which recommendations shall not be binding upon the secretary.

(e) The secretary of corrections shall provide members of the board with access to records not otherwise privileged by law and with reasonable access to facilities and persons under the jurisdiction of the secretary subject to conditions and time limitations the secretary may establish in order to insure the orderly operation of the correctional institutions.

Sec. 2. K.S.A. 74-7401 is hereby repealed.

Sec. 3. This act shall take effect and be in force from and after its publication in the official state paper.

74-7402. Same; approval of expenditures; personnel and accounting services provided by the secretary of corrections. All vouchers for expenditures from appropriations to the corrections ombudsman board shall be approved by the chairperson or by the ombudsman when the same is authorized by the board. The secretary of corrections shall provide the board and the office of the ombudsman with necessary personnel and accounting services.

History: L. 1978, ch. 370 § 2; July 1.

74-7403. Ombudsman of corrections; appointment; duties; compensation; office space; employees; complaints forwarded to secretary of corrections. The board shall appoint an ombudsman of corrections who shall serve at the pleasure of such board. Such ombudsman shall act as secretary of such board and shall perform such other duties and functions as may be required by the board. The compensation paid to such ombudsman shall be fixed by the board subject to approval by the governor. The secretary of administration shall provide the ombudsman with office space at Topeka. The ombudsman may appoint such employees as may be necessary to carry out the duties of the office of ombudsman of corrections and as are within available appropriations, and such employees shall be in the unclassified service under the Kansas civil service act. Any misfeasance or discrepancy in administration or any unreasonable treatment of inmates in the custody of the secretary of corrections which such ombudsman discovers or the inmates bring to his or her attention shall be brought to the attention of the secretary of corrections and shall be made known in periodic reports and in an annual report issued by the ombudsman to the board. The ombudsman shall forward complaints and grievances directly to the secretary of corrections for consideration by the secretary.

History: K.S.A. 75-5231; L. 1978, ch. 370, § 3; L. 1978, ch. 330, § 41; July 1.

Revisor's Note:

Section transferred from 75-5231.

END