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# Probation

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*Marilyn C. Vernon*
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# Federal Probation

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## This Issue in Brief

### ***The Leadership Development Program for Federal Probation and Pretrial Services Officers.***

Authors Michael Eric Siegel and Marilyn C. Vernon describe the Federal Judicial Center's Leadership Development Program, a 3-year program designed to give participants the opportunity to develop the knowledge, skills, and attitudes of effective leaders. The authors explain why the program was developed, who is eligible to participate in the program, and what the program requires. They give examples of the in-district reports and temporary duty assignments undertaken by participants thus far.

***The Feasibility of Establishing Probation Field Offices in the District of Minnesota.***—Author Garold T. Ray reports on a comprehensive study which addressed the issue of whether to open additional probation field offices in the district. Based on data regarding numbers of supervision cases and investigations, a survey of officers' opinions, and a cost analysis, he addresses whether establishing field offices will improve the quality of investigations and supervision, provide greater service to the court, enhance officer morale, and be cost effective.

***Building Synergy in Probation.***—Can traditional management styles keep pace with the multidimensional, fast-paced fluidity of the present-day criminal justice system? Author Frederick R. Chavaria explains the limitations of the traditional top-to-bottom command authority and relates the benefits of a managerial/leadership approach which encourages synergy, a notion of partnership. He stresses the importance of continually reassessing organizational priorities, policy, and mission and of practicing a management style anchored in trust, concern for staff, and shared decisionmaking.

***Intensive Supervision: A New Way to Connect With Offenders.***—The U.S. probation office in the Southern District of Florida was looking for an immediate sanction for drug use in the occasional drug user population. It tried intensive supervision and found "a powerful method to control risk." Authors Carol Freburger and Marci B. Almon describe what intensive supervision involved for both the officers and the of-

fenders. They point out the supervision advantages and the administrative advantages of this method and what it requires as far as personnel and equipment.

***Group Reporting—A Sensible Way to Manage High Caseloads.***—With more offenders on probation and fewer officers to supervise them, what is a practical way to supervise offenders who require ongoing contact but not a high degree of intervention? Anoka County Community Corrections has had some success with group reporting. Author Jerry Soma explains how group reporting works and how it allows his agency to meet its goals to maintain face-to-face con-

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# Disaster Theory: Avoiding Crisis In a Prison Environment

BY RICHARD H. RISON AND PETER M. WITTENBERG\*

*"From a tiny spark comes a great conflagration"*

—Ben Sirach, Ecclesiasticus

SOMETIMES PLANES crash. Frequently homes burn. Buildings collapse, dams burst, and transportation accidents happen. Disasters are simply unavoidable. Why? Society probably will never be able to manufacture perfect equipment, factor in every possible contingency, or eliminate the possibility of human error. All these elements, and more, play a role in the creation of crisis and the dynamics of disasters.

Prison staffs certainly are not exempt from disasters. Correctional staff and managers work in what could be termed a "disaster environment."<sup>1</sup> The way in which prisoners adjust to incarceration has important implications for themselves, other prisoners, and the staff that is responsible for directing the safe, humane, and orderly operations of prisons. Prison unrest and disruptive behavior almost always result in life-threatening situations for staff and inmates. In addition, the property destruction which often results from prison disturbances drains the funds Congress allocates for prisons and erodes public confidence in prison management.

Prison staff must supervise the daily routines, providing meals and medical care; overseeing work, visiting, education, and vocational programs; supervising leisure time activities; and generally maintaining the inmates within small physical plants. Such responsibilities are complicated by overcrowding, close confinement, lengths and types of inmate sentences, and budget concerns. These activities must be conducted with a minimum of disruption, since the slightest incident may create chaos in the prison environment. How prisons operate in a peaceful and orderly manner is a critical question. However, both an understanding of what precipitates disorder and the ability to detect the transition between order and disorder are paramount in the operation of a safe, secure correctional facility.

Prison administrators are charged with the duty of preventing prison disturbances. The maintenance of social control in prisons represents the single most important preoccupation of correctional officials. Identifying indicators of potential disorder and taking steps to minimize inmate disruptive behavior must be a strategic correctional management goal. Furthermore, by studying the circumstances surrounding these unwanted events, correctional staff may learn valuable information that may enhance the goal to maintain safe and orderly prisons. Even with continual alertness, prison disturbances erupt, escapes occur, staff and inmates are assaulted, and other untoward events happen. Given these facts, correctional managers need to understand theories and methods that may help identify and avoid potential institutional catastrophes. One such theory is "disaster theory." Some of the theory and practices described can help in preparing for natural disasters. However, the focus of this article will not be on catastrophes associated with "acts of God" but rather on incidents related to human error, lack of foresight, and prison dynamics. This article will not discuss the management of a crisis or disaster once it has begun but will focus on management during the pre-crisis or warning stage of disaster activity.

Control of an inmate population, when maintaining safe and secure conditions, is difficult at best and requires constant vigilance. Disaster and crisis within a correctional environment are manifested in a number of ways such as riots and disturbances, major work stoppages, staff or inmate assault or death, escapes, fire, and sabotage. In the controlled climate of a prison, there are many methods used to deter catastrophes such as monitoring by staff, electronic equipment, fences, towers, inmate informants, and intelligence information. None of these methods are foolproof, and correctional professionals must be prepared to respond to breakdowns in the system. Managers may argue that the probability is low that most events that lead to correctional disasters actually will happen. However, the grave consequences linked to disastrous events serve as a major incentive for correctional staff to learn as much as possible before a crisis actually develops.

To gain a better understanding of this issue, several terms and concepts as they relate to corrections should be identified. First, a correctional facility can be described as having *loose coupling tendencies with linear interactions*.<sup>2</sup> The concept may sound complex but really is simple. For our purposes, an organization described

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as being *loosely coupled* is one which has flexibility in handling emergencies or situations. The activities and processes are controlled in a manner that permits delay and reflection. In a *tightly coupled* organization, processes are very synchronized and delays are usually not possible. A passenger airline experiencing an emergency can be considered part of a tightly coupled operation. *Linear interactions* within an organization are those that usually have direct chain-of-commands, easily understood missions and processes, and few personnel specializations. Linear type organizations are usually focused on one mission or goal. This is opposite of *complex interactions* which have many unfamiliar processes, numerous personnel specializations, indirect command functions, and multiple missions and goals.

Pilots are trained for the norm. If events occur outside the tightly coupled operation, no standing operating procedure may exist and therefore disaster may occur. The notion is to identify, prepare, and train staff to handle "normal emergencies." If an unpredictable event or one for which training has not been offered occurs, then pilots—like correctional staff—are forced to use discretion and judgment and divert from standard operating procedures. An example of this concept is the tendency to train correctional staff repeatedly for events that are "most likely to happen." Therefore, when an unusual event takes place—for instance, when one inmate takes another inmate hostage and makes demands—staff manuals do not dictate a solution. Training usually focuses on an inmate taking a staff member hostage, a "normal emergency."

Correctional facilities operate as labor intensive operations (enough staff members are available to process the emergency and decide on a number of responses) where the mission is clear (keep the inmate behind the fence, protect the public), guidelines are direct and to the point (six inmate counts will be performed during each 24-hour period), and distinct command and control functions exist (warden, associate warden, captain, lieutenant, correctional officer). Therefore, correctional institutions are loosely coupled operations with linear interactions. Administrators should consider this concept when creating policy guidelines and staff training programs.

Second, several elements<sup>3</sup> which contribute to causing disasters can be identified:

#### *Design Failures*

The design of the facility may facilitate disaster. Examples include faulty construction and architectural mistakes that create "blind-spots" in the facility. Design failures include living units that are built in such a way that the officer cannot directly observe the activities of the inmates; officer stations placed at one

end of the unit while showers and TV rooms are on the other; prisons built with dry wall material as a cost cutting provision; segregation units that have vanity mirrors or medical style cabinets that, when removed, allow for the inmates to crawl between the most secure housing cells and open stairwells; and unsecured roofing vents, false ceilings, and even major drainage systems running from inside the institution to the outside of the institution without grids to prevent inmates from crawling out.

#### *Equipment Failures*

This category includes faulty security equipment or highly complex equipment with many components susceptible to breakdown. One of the most noteworthy examples of faulty equipment is a fence alarm system that is not properly designed or calibrated and therefore generates many false alarms. False alarms after a period of time are ignored, staff members become lax, and eventually an inmate escapes. When pending investigation or the followup after-action investigation shows the alarm went off, staff did not respond, and the inmate escaped. The number of false alarms that were occurring due to the weak points of the system conditioned staff not to respond.

#### *Procedural Mistakes*

These include a lack of clear procedures; failure to follow procedures; complicated, hard-to-understand instructions; poorly written post orders; and conflicting supervisory instructions. One only needs to read some after-action reports to determine that several people reading the same instructions will have a different interpretation of the procedures.

In a recent situation inmates reported finding glass in the salad bar. The staff recommended that the warden close down the salad bar; the warden disagreed. He believed that a few inmates were placing the glass in the salad bar for attention. After consultation with senior institution staff, the warden decided not to remove the salad bar because such action might reinforce the actions of the disruptive inmates. It was decided to continue with established mealtime procedures. Unfortunately, the salad bar was removed later without consultation with the warden, and 1,100 inmates became upset because a few inmates manipulated the system. What initially was a minor problem involving a few inmates became one that could have led to inmate disruption.

To avoid procedural mistakes, correctional managers should ensure that written and verbal orders are communicated in such a way that they are easily interpreted, allow for discretion and judgment, and show recognition that the organization is "loosely coupled." With properly written post orders, staff will

make decisions based on sound correctional practice rather than according to some manual that attempts to find a solution for every problem imaginable. The truth is, in a crisis situation manuals are ignored and common sense and judgment prevail.

#### *Supply/Material Failures*

This category includes the failure to maintain appropriate materials and supplies necessary for facility operations. To illustrate, consider the example of a blackout in the institution during which the emergency lights did not work. Inmates took advantage of this situation by behaving disruptively during the power outage. Later, when the emergency lights were checked, most did not work properly. Again, staff procedures—or in this case, institution procedures—were not in place that required employees to make scheduled checks of the equipment. Such problems can occur when well-intentioned staff respond inappropriately to a lack of supplies or material or to institutional procedures which they perceive as burdensome. As an example, a hacksaw blade was discovered by staff during a routine search of an inmate living unit in a maximum security penitentiary. At first, this seemed to be a problem with routine institution tool control; however, investigation revealed that staff members were bringing in their own hacksaw blades because employees felt that the facility tool control policy was too time consuming and arduous. In this particular situation, staff members were working under the facility in a maintenance tunnel and felt it was laborious to exchange blades each time one broke. Staff members would have to secure the area, leave the tunnel, secure their inmate workers, stand in line at the tool room, exchange the broken blade for a new one, reorganize the inmate workers, reenter the tunnel, and resume work. If staff members followed the policy as written, they would have to repeat the process many times a day because blades broke frequently. Staff members decided instead to bring their own supply of hacksaw blades, one of which was stolen by an inmate on the work crew. In this case, a restrictive tool policy, coupled with the lack of an appropriate number of replacement blades on site, led to staff's violation of policy and ultimately to the loss of a dangerous tool which easily could have facilitated an escape attempt.

#### *Environment*

A "disaster environment" is one in which the mission and operation increase the possibility of major incidents occurring. Although all correctional settings can be considered a "disaster environment" the situation is enhanced where the conditions of the prison are such that inmates react negatively to procedurally unsafe conditions. Useem and Kimball<sup>4</sup> postulate that

prior to all riots they studied, there was a breakdown in administrative control in the operation of the prison. Prison riots are viewed as a product of that breakdown and should be thought of as such. Elements of the breakdown include: scandals, escapes, inconsistent and incoherent rules, fragmentation, weak administrations, outsiders to the system, and the disruption of everyday routines for eating, work, and recreation. They classify reasons for riots into three categories:

1. Bureaucratic instability of the organizational level.
2. Correctional officer unrest and dissatisfaction with work.
3. The social climate of the institution.

#### *Human Error*

This includes failure to learn from past mistakes/situations, failure to anticipate problems/lack of intelligence information, lack of foresight, failure to adapt to changing situation/mission, and poor staff performance (poor training/failure to perform duties). Human error failures often repeat themselves. An inmate walks out the door of an institution dressed in civilian clothes and 2 months later the same thing happens again. Generally, these types of incidents result when correctional officials are unable to assess honestly the causes of unwanted events and make adjustments. Perhaps the critical point is, as Useem and Kimball point out, that almost all failures or undesirable situations can be traced to some "breakdown." Failures to assess cause because of media interest, political pressures, or concern for disciplinary adverse action have all been offered as reasons for not following up the incident with a total quality improvement evaluation to determine where modifications and procedures are needed to prevent future occurrences. Perhaps it is under the category of human error that "disaster theory" really falls. Staff fail to take the time to follow up on information and this procrastination leads to an event that could have been prevented. High staff turnover, low staff training level due to cost containment, and a lack of general direction from the administration have been cited in after-action reviews as causes of prison riots.

Disaster theory suggests that there are four levels of incidents which affect the operation of the total system<sup>5</sup> (the institution is the system):

*Level 1:* Failure of a part of the total system - In a correctional environment, this could be the failure of an alarm light on a control room monitoring board. At this level the problem normally would not lead to a major catastrophe within the system.

**Level 2:** Failure of a *unit* of the total system - In prison, a failure at this level could include the mistake of classifying an inmate at a lower security level than is warranted. Again, at this level the problem would not typically cause a disaster or create a crisis. There are enough reliable methods in place to discover and correct the error.

**Level 3:** Failure of a *subsystem* of the system - Much more serious at this level, the error, equipment failure, or situation can have major ramifications in the facility. Level 3 episodes can include total facility power failure, a pending inmate disturbance, staff corruption, poor staff/inmate management, or untrained facility staff.

**Level 4:** *Total failure* of the system - In this worst case scenario, incidents may include staff losing control of the facility, failure of the facility to meet its mission, and inmate escapes.

Finally, the theory categorizes four types of "victims"<sup>6</sup> associated with disasters. These categories are linked with the type and level of the occurrence:

**1st Party Victims:** Operators of the system - The staff of the facility could be considered in this category.

**2nd Party Victims:** Non-operating personnel or system users - Inmates within the institution could be considered in this group.

**3rd Party Victims:** Innocent bystanders - The community outside the fence or wall of the facility.

**4th Party Victims:** Future generations - For our purpose this could include legislation passed in response to an incident which would affect all future operations.

Figure 1 reflects the disaster matrix that links these terms together.

Now that we have an understanding of disaster theory concepts, it is important to examine what managers can do to avoid incidents that lead to disasters. As noted in the opening paragraph, some disasters cannot be avoided with 100 percent certainty and the best a manager can do is respond professionally in accordance with policy, procedure, and correctional common sense. Fortunately, uncontrollable catastrophes are rare and usually associated with nature's wrath such as Hurricane Andrew which in 1992 destroyed the Federal Bureau of Prisons Federal Prison Camp at Homestead, Florida, and heavily damaged

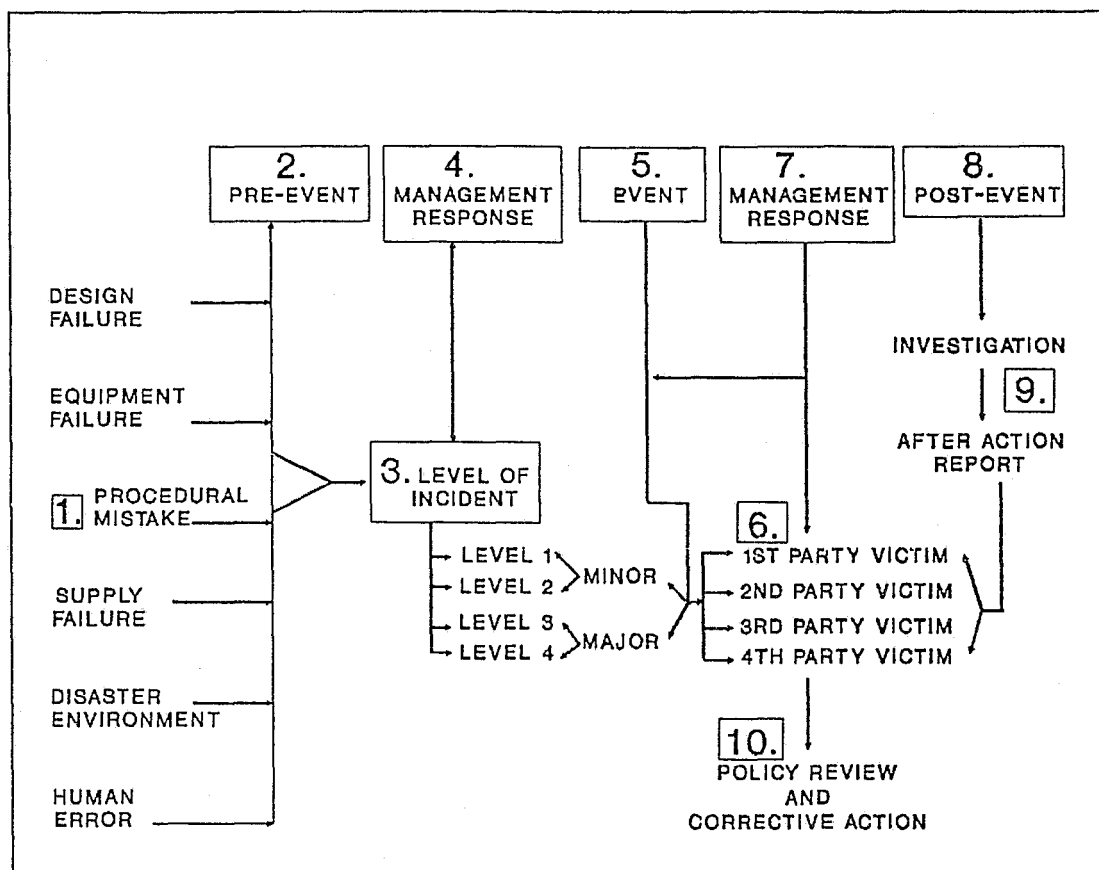


FIGURE 1. CORRECTIONAL CRISIS ANALYSIS

the Federal Metropolitan Correctional Center at Miami. Hurricane Andrew is an outstanding example of an uncontrollable situation that was managed superbly by Federal Bureau of Prisons staff and managers. While property damage was extensive, no inmates escaped, inmate and staff injuries were minor, and the public's confidence in the ability of the Federal Bureau of Prisons to perform its mission was unshaken.

But what about disasters caused either by mistake, by happenstance, or on purpose? How can correctional administrators guard against incidents that could lead to catastrophe? Most disasters do not strike without warning. How managers react during the pre-event stage<sup>7</sup> before the incident is usually the factor which determines the scope of the crisis/disaster. Information generated during this stage can be as blunt as a weather warning stating that a hurricane will reach a particular location within 72 hours or as vaporous as a rumor that inmates will engage in a work stoppage within the next 30 days. During this stage, information is critically important. Managers must gather enough data to manage the incident before it occurs. Considering the significance of this pre-event stage, it is crucial to realize that the crisis/disaster has already begun once the first bit of information has been received and staff are already in a position to control the event's outcome.

Information analysis is of momentous consequence during this juncture. Consider the following examples. A correctional supervisor on the evening shift receives a note that an inmate's life is in danger and chooses to leave the matter for the morning shift supervisor to address. The inmate is found dead from stab wounds in the early morning hours. Or an escape occurs and thousand of dollars are spent responding to the emergency and apprehending the inmate. Later in the correctional supervisor's "in" box is found a note which had been handed to her several days before and which outlined every detail of the escape including the names of the inmates involved. Priority, time, and quick analysis were not applied to the situation to allow for the information to get circulated through the organization, be investigated, and, perhaps, prevent the escape. This point is key: Information which indicates that correctional disaster may occur is almost always available, but it must be acted upon in the most timely manner possible.

How often after an escape, homicide, or prison disturbance have experienced correctional administrators heard a staff member indicate that information revealing the possibility of the crisis was available before the incident occurred? In another example, inmate information passed forward through the chain of command indicated that inmates were going to hold a food and work strike. Before the next morning a

decision was made to prepare a questionnaire and distribute it to inmates to determine their concerns. The food/work stoppage never occurred. Feedback from the inmates suggested that listening to their concerns was what they wanted, and asking for their feedback gave them a reason to stop an event that could have led to bigger problems. The smallest piece of confidential information or a seemingly insignificant event observed by an officer but not passed forward for review by correctional officials often turn out to be the piece of the puzzle which may have helped curtail or avoid an unsafe situation.

Correctional leadership must recognize that line staff members need lots of room for discretion and judgment. Moreover, correctional leadership must implement training, staff mentoring and coaching, feedback, and staff empowerment that solicit and encourage open and honest communication about a procedure, both strengths and weaknesses. Empowering staff to use discretion and judgment without fear of reprisal may well be the surest way to avoid many undesirable situations. Staff members nearest to the problems are most likely to have the best answers. An endorsement of theories to include line staff in the decisionmaking process is perhaps the strongest solution offered by disaster theory.

Analysis at the pre-event stage should include the following factors:

*Threat Appraisal:*

- Is the information accurate?
- What disaster/crisis element is causing the threat?
- Can the threat be neutralized and, if not, how can it be isolated?

*Level of Incident:*

- Can the threat create a minor or major disturbance within the system?
- What will the impact be upon the institution?

*Victim Level(s):*

- Who is likely to be affected by the threat?

*Resource Identification:*

- What staff and resources are necessary to meet the challenge of the threat?

*Plan of Action:*

- Is there an established plan of action for this threat?
- Can the established plan of action respond to this particular incident?
- Is outside notification (media, other law enforcement agencies) necessary?



Each facility should have a current set of emergency plans that theoretically structures a step-by-step response to various crisis/emergencies/disasters. However, conventional wisdom dictates that responses to emergencies rarely go as planned. Therefore, written guidelines must be flexible enough to allow managers to respond to their particular set of circumstances and allow them to draft their own plan of action.

The pre-event interval is a "window of opportunity" in which the manager can take action to decrease or defuse the impact of the pending episode. Managers should be wary, however, of turning this information analysis time into "analysis paralysis." While it is understood that all salient factors should be considered, managers should not be paralyzed in discussion and fail to make a decision—especially in the face of a pending threat. It would be good for managers to remember that the Chinese ideograph depicting "crisis" is fashioned by two symbols<sup>8</sup>—one meaning "catastrophe" and the other "opportunity." When disaster looms, opportunity exists for action that can change the course of the pending catastrophe.

Finally, decisionmakers should consider an additional three points in this pre-event crisis/disaster stage<sup>9</sup>:

- Were lessons learned from a past crisis that could be applied to the pending one?
- Is it anticipated that the crisis may change form (e.g., a food strike becoming a work strike)?
- Does management have the flexibility to change or adopt its response to any changes in the situation?

Understanding the dynamics and stimuli of crisis and disasters and using this critical point in a crisis to examine the options available is the defining moment that allows managers to avoid the "FUD Factor"—Fear, Uncertainty, and Doubt—and attack the pending event before it creates more havoc than necessary.

#### NOTES

<sup>1</sup>Charles Perrow, *Normal Accidents: Living with High Risk Technologies*. New York: Basic Books, 1984.

<sup>2</sup>Ibid, p. 62.

<sup>3</sup>Charles Perrow, *Normal Accidents: Living with High Risk Technologies*. New York: Basic Books, 1984; Eliot A. Cohen and John Gooch, *Military Misfortunes: The Anatomy of Failure in War*. New York: The Free Press/Macmillan.

<sup>4</sup>B. Useem and P. Kimball, *States of Siege: U.S. Prison Riots, 1971 - 1986*. New York: Oxford University Press, 1989.

<sup>5</sup>Charles Perrow, *Normal Accidents: Living with High Risk Technologies*. New York: Basic Books, 1984; Eliot A. Cohen and John Gooch, *Military Misfortunes: The Anatomy of Failure in War*. New York: The Free Press/Macmillan.

<sup>6</sup>Ibid.

<sup>7</sup>Mayer Nudell and Norman Antokol, *The Handbook for Effective Emergency and Crisis Management*. Massachusetts: Lexington Books, p. 23.

<sup>8</sup>Eliot A. Cohen and John Gooch, *Military Misfortunes: The Anatomy of Failure in War*. New York: The Free Press/Macmillan, p. 239.

<sup>9</sup>Ibid, pp. 236-237.