

On the

# Road

Again:

# The Dangers of Transporting Ailing Inmates

By Christian Mason, Tod W. Burke and Stephen S. Owen

On Aug. 21, 2006, in Blacksburg, Va., tragedy unfolded following an inmate medical transport. Late the previous evening, William Morva, an inmate at the Montgomery County Jail, was taken to the Montgomery County Regional Hospital for a sprained leg and wrist. At approximately 2:30 a.m. on Aug. 21, Morva overpowered the deputy guarding him and, with the deputy's gun, shot and killed a hospital security guard. Morva then fled toward the Virginia Tech University campus a short distance away where, later in the morning, he ambushed and killed a Montgomery County sheriff's deputy on a bicycle trail adjacent to the campus. Morva was captured later that day on the university campus, following a massive manhunt. During the incident, the Virginia Tech campus was locked down as classes were scheduled to begin for the fall semester, and students were advised to seek shelter as law enforcement officers searched the campus and its buildings for Morva.<sup>1</sup> In 2008, Morva was found guilty of three separate counts of capital murder and four separate felony charges.<sup>2</sup>

Every day, in communities throughout America, correctional officers, sheriff's deputies and federal marshals must transport inmates from secure facilities to medical clinics and hospitals for treatment. Every transport is a risky venture for corrections officials, medical staff and the public, because the possibility that the inmate may seize an opportunity to escape is ever-present. This article will examine the problems posed and the risks inherent anytime an inmate is removed from the security of a correctional institution and taken to a medical facility where proper security is difficult to maintain.

## Inmate Medical Needs

On Nov. 9, 1973, J.W. Gamble, an inmate in the Texas Department of Corrections system, was injured while working at a Texas prison. Due to his injury, Gamble refused to continue working at the prison where he was incarcerated.

As a result, he was placed in solitary confinement. Furthermore, correctional officers refused to allow him access to the medical wing to be seen by a medical professional. Gamble argued that he was being subjected to cruel and unusual punishment in violation of the eighth amendment of the U.S. Constitution, and complained that the treatment he received from the institution was inadequate and insufficient. His complaint was eventually heard by the U.S. Supreme Court. The court held, in *Estelle v. Gamble*, that the government's obligation to give medical treatment to inmates had already been established, and that in order for inmates to argue that their Eighth Amendment rights have been violated, "[an inmate] must allege acts or omissions sufficiently harmful to evidence deliberate indifference to serious medical needs."<sup>3</sup> Subsequently, the court has made it clear that it expects inmates to be afforded reasonable health care. In 2010, the court ruled in *Brown v. Plata* that the state of California was obligated to limit the size of its inmate population following a series of findings that adequate health care could not be provided to all inmates.<sup>4</sup>

According to the U.S. Bureau of Justice Statistics, in 2012, there were approximately 2.3 million people incarcerated in state and federal prisons and local jails.<sup>5</sup> Many inmates come from deprived socioeconomic backgrounds which severely limit their access to quality health care.<sup>6</sup> Consequently, quite a few inmates are beset with physical ailments and diseases. For instance, in 2004, nearly 44 percent of state inmates, and 38.5 percent of federal inmates, reported a medical problem. Of those, 70 percent of state inmates and 76 percent of federal inmates received treatment from a medical professional.<sup>7</sup> Moreover, inmates may become victims of some type of trauma while behind bars. Data indicate that 28.2 percent of federal inmates and 32.6 percent of state inmates reported being in an accident or fight after they were admitted to their institution.<sup>8</sup>

In addition, elderly inmates are currently the fastest growing demographic within state and federal prisons. While the definition of "elderly" varies by jurisdiction, esti-

mates have shown that the population of inmates 50 years or older has increased by 750 percent since the 1990s. This significant growth can be attributed to policies that extend prison terms, such as mandatory minimum sentencing, three-strike laws and truth-in-sentencing. The stress of prison life wears on an inmate both physically and mentally — leading inmates to age prematurely. In addition to the stress, premature aging is exacerbated by a lack of sufficient health care services, poor dietary habits and even substance abuse. Research indicates that an inmate's physiological age is, on average, seven to 10 years older than their chronological age.<sup>9</sup>

Elderly inmates require a disproportionate amount of medical attention and treatments. On average, a 55-year-old inmate has three chronic conditions. Some of the most common conditions include cardiovascular disease, lung disease, arthritis and depression. One in five elderly inmates is estimated to have a mental illness. Elderly patients often need more care than what is available at the prison. In fact, they are five times more likely to be transported to external medical facilities for care and treatment than are younger inmates.<sup>10</sup>

## Medical Transportation

Research reveals that a large portion of the inmate population experiences physical and mental health issues.<sup>11</sup> However, treatment for these conditions is limited within correctional facilities. Most medical facilities within prisons will never be able to offer the level or quality of care available at independent hospitals due to restrictions on resources, staffing and finances. Virtually all medical units can provide medications, administer basic diagnostic tests and treat minor injuries.<sup>12</sup> However, more complicated testing and treatment must usually be executed in hospitals. As a result, inmates sometimes need to be transported to nearby hospitals for specialized care.

The transportation of inmates from institutions is costly. For instance, the California Department of Corrections and Rehabilitation reported spending \$19.3 million on inmate transportation in one year.<sup>13</sup> The actual annual cost has surpassed more than \$90 million nationwide.<sup>14</sup> It is estimated that in the U.S., more than 45,000 trips occur each month from correctional institutions to other facilities.<sup>15</sup> Reasons for transportation include anything from legal purposes to work release. However, medical treatment is a common reason for transporting inmates away from a correctional institution. For example, a 2003 study including data from 35 U.S. states and four Canadian prison systems reported 24,648 medical transports — less than the number for institutional transfers, but more than the number for legal proceedings.<sup>16</sup> Except for a courthouse, a medical facility is the only other publicly accessible place that will routinely receive visits from inmates.

## The Dangers of Transporting Inmates to Medical Facilities

Every time inmates must leave a secure facility for medical reasons, they pose a potential danger to the correctional officers, the health care professionals who will treat

them and anyone else they may encounter. Some high-security inmates may pose a greater risk than others. However, any inmate, presented with even a brief breach of security, could seize the opportunity to escape. This can result in a risk to officer safety, as inmates may use this opportunity to assault or kill transporting officers. Inmates at large may also pose a threat to public safety.

Correctional officers and others working with inmates receiving medical care must remain vigilant in preventing escape — even in seemingly routine situations. Inmates facing lengthy sentences, life terms or even the death penalty have little to lose by attempting an escape when given a chance. When determining which inmates are more likely to attempt an escape, studies suggest that gender and age make little difference. Inmates are more likely to escape on their own or in pairs rather than a small group. Data also suggests that inmates serving short terms or inmates who only have small portions of their sentences remaining can also pose an escape risk. For example, in 2001, 28 percent of escapees had one year or less remaining on their sentence. This also suggests that inmates act on impulse rather than considering the consequences of an escape.<sup>17</sup>

## General Best Practices for Transporting Inmates

Inmates are generally categorized into three broad security classifications: maximum-, medium- and minimum-security. An institution might require more officers to accompany a maximum-security inmate than they would a minimum-security inmate. However, officers should not exercise any less caution because they are transporting a minimum- or medium-security inmate. Randy Watson, director of programs and services for the Maryland Department Public Safety and Correctional Services (DPSCS), suggests that when multiple inmates with different security classifications are being transferred to or from a medical wing, they should all be treated as the highest classification present. If even one maximum-security inmate is included with a group of minimum-security inmates, every inmate should receive the same maximum-level supervision. For instance, if it is a particular institution's policy to use full restraints — such as leg irons or handcuffs — on a maximum-security inmate, then the entire mixed group of inmates should be similarly restrained. According to Watson, when it is possible to do so, segregating the inmates by security classification is a good idea. This allows transporting officers to keep closer watch on inmates known to be violent or dangerous.<sup>18</sup>

Route management plays an important role in the transporting of inmates. When possible and practical, transporting officers should have multiple routes to medical facilities so the inmate does not know the route to be taken for any given trip.<sup>19</sup> Transporting officers should be familiar with the route they will be traveling and know secondary routes should a need arise to alter their course. This issue becomes particularly important during high-risk transfers with particularly dangerous inmates who require specialized transportation. These transfers should be scheduled as "special operations" rather than departing with lower-risk inmates. Also, the times should be staggered, as the

inmates may not even know they are going to be transported. Before the inmates step inside the vehicle, officers should know the exact drop-off and pick-up points. If an inmate poses a particularly high threat, the route may need to be checked beforehand by correctional officers and deemed safe — for instance, avoiding potential areas of ambush, dead ends or known traffic delays, and ensuring that the route and possible detours are known to transporting officers. Transportation vehicles should be inconspicuous and blend in with surrounding traffic. Many transportation vehicles have striking resemblances to vans and passenger buses.<sup>20</sup> A low profile can help ensure the officers' and inmates' safety.

Transportation vehicles need to be properly inspected before leaving both the hospital and the institution. Officers should ensure that their vehicle is fully functional and prepared to make a long trip, if necessary. For example, if an inmate is being transported across the state, officers need to be ready for any unexpected stops or delays. Gas, tire pressure, fluid levels, headlights etc., should be routinely checked before departure. Also, items within the vehicle should be frequently checked. If an emergency occurs, an officer's radio might be his or her lifeline. The officer(s) should ensure that any mobile communications devices, including cell phones, are fully charged and functional.<sup>21</sup>

Officers should regularly search the transportation vehicles for contraband or weapons — both prior to any inmate entering and after any inmate exits. Do not assume prior vehicle searches were sufficient. If an inmate tries to hide something within the vehicle that could be potentially used as a weapon, it should be quickly seized and secured by a transporting officer. Likewise, transporting officers should frequently check the inmate's restraints. Officers should not rely solely upon checking inmates' restraints prior to departure and upon arrival at their destination. An important part of being aware of surroundings involves frequently making sure that the inmates are properly and safely secured.<sup>22</sup>

## Medical Transportation Practices

Transporting officers must follow special procedures when transporting inmates to and from hospitals. There are very specific problems that come with the journey to medical facilities. For example, officers may suddenly find themselves having to figure out how to successfully restrain a person who now has a full arm cast — restricting the possibility of handcuffs. Another example is the possibility that correctional officers may have to take immediate action if an elderly inmate with a heart condition unexpectedly goes into cardiac arrest during transport. Moreover, when an inmate is relocated to a medical facility, the inmate will not be transferred to trained correctional officers as would occur if the inmate was simply being moved to another detention center. Instead, correctional officers will be supervising inmates in conjunction with medical professionals and hospital security personnel who may not be properly trained to deal with inmates.

Some correctional agencies have outsourced medical transportation. For example, the Texas Department of Criminal Justice (TDCJ) has contracted with the University

of Texas Medical Branch (UTMB) Emergency Managed Care to provide emergency medical services — including medical transports — for more than 100,000 Texas inmates. A UTMB transport bus may move roughly 100 to 200 patients daily for routine treatment. If an inmate needs emergency transportation to a proper medical facility, an ambulance will be used. Each offender is assigned a security classification by TDCJ. However, when being transported by Emergency Medical Services (EMS), each inmate is placed in full restraints and treated with extreme caution, regardless of security classification. Emergency medical technicians (EMTs) are told to never remove restraints. Handcuffs might be restricting, but they rarely prohibit an EMT from properly doing his or her job.<sup>23</sup>

**Officers should regularly search the transportation vehicles for contraband or weapons — both prior to any inmate entering and after any inmate exits. Do not assume prior vehicle searches were sufficient.**

Correctional officers and medical personnel should know in advance through which entrance inmates will be brought into a facility. It may be in the interest of both security and medical personnel to admit the inmate discretely, perhaps concealing the fact that he or she is an inmate by covering restraints or prison garb with a blanket. Prior to their arrival, correctional officers must notify the medical and security personnel at the facility to whom they are transferring the inmate — allowing hospital personnel to activate necessary security protocols.<sup>24</sup>

Additionally, institutions must ensure that they secure inmates during transport in a way that avoids public controversy. For instance, the cuffing and shackling of pregnant inmates during childbirth has resulted in lawsuits against several institutions. In 2009, the Eighth Circuit of the U.S. Court of Appeals noted in *Nelson v. Correctional Medical Services* that securing an inmate to a bed during childbirth violated the inmate's Eighth Amendment rights against cruel and unusual punishment.<sup>25</sup> As of 2013, legislation has passed restricting the practice in 18 states.<sup>26</sup> Additionally, Federal Bureau of Prisons policy restricts cuffing and shackling pregnant inmates (unless exceptional circumstances warrant restraints for security purposes).<sup>27</sup>

## Transporting Officer Preparedness

Although correctional officers receive basic academy training, not all officers assigned to transportation may receive extensive training particular to this duty. Many transportation officers may find themselves facing a critical situation for which they have never been thoroughly trained. For example, transporting officers must be prepared for general transportation contingencies (e.g., how to react to a motor vehicle accident) and for those specific to medical transport (e.g., management of incapacitated, wounded or physically ill inmates). Some agencies provide advanced training for officers assigned to transportation duties. For example, Maryland DPSCS mandates that its transporting officers receive extra training in techniques, such as weapon retention and disarmament, and become weapons-certified. DPSCS staff must successfully pass the standards of a 35-hour entry-level weapons training program before being issued their firearms.<sup>28</sup> Beyond any additional training that transporting officers might receive, they need to be adept at critical thinking; identification of security threats and weaknesses; and swiftly defusing situations. Transportation officers must remain focused and alert, no matter how tedious an assignment may seem.

## Collaboration Between EMS, Hospital Personnel and Correctional Officers

An additional challenge is that medical personnel are typically not accustomed to dealing with inmates. Likewise, correctional officers are often unfamiliar with medical facilities, medical procedures and treatment practices. Communication between staff must be the highest priority for medical staff and correctional officers. Inadequate communications can lead to misplacing inmates, unnecessary delays in processes and public safety risks, such as an escape. For example, these problems could occur if medical staff failed to notify the correctional officer that the inmate is being transferred to a different section of the hospital for tests or X-rays. The inmate could find himself or herself unguarded for a few moments, providing the perfect opportunity to flee.

**Security plans.** Hospitals and correctional institutions should also have clearly specified emergency plans ready to be implemented. Many hospitals collaborate with local correctional institutions to create policies and plans to either minimize problems from occurring, or to isolate a problem that has already occurred. For example, in a joint effort with correctional institutions, some hospitals have created total lockdown procedures in the event of an escape. During a total lockdown, hospital security and designees are assigned to various entrances and exits, all doors are secured and no one is permitted to exit the hos-

pital perimeter. The implementation of a lockdown will minimize the likelihood of harm to others by the inmate outside of the medical facility. However, the need for an internal security plan also presents itself, as those inside the hospital may still be at risk. There needs to be an alert notification plan for patients and medical personnel signifying areas to avoid, as well as safe zones.<sup>29</sup>

A proposed model of a security plan to deal with in-progress shootings in a hospital could also serve as a model policy for hospital lockdowns in the event of an inmate escape. The model, nicknamed “code silver,” was proposed by Scot Phelps, Robert Russell and Garrett Doering in the May/June 2007 edition of the *American Journal of Disaster Medicine*. The model proposes an internal lockdown policy designed for emergency situations. The policy begins with preparedness by ensuring that law enforcement has access to hospital floor plans and that lockable doors are marked with gray, rather than white, nameplates. When a violent situation arises, “code silver” is announced, and hospital personnel secure their units and ensure that all individuals in the building are behind locked doors. If safely possible, the “code silver” floor is evacuated. Hospital security staff minimize movement of individuals within the building and secure exterior doors, as necessary. Upon arrival, the police are briefed on the situation and plan the appropriate tactical response. The model also proposes that correctional officers and law enforcement officers exercise the plan annually with hospital personnel to better prepare for emergencies. In hospitals likely to receive inmates from correctional facilities, the plan could be modified to include correctional officers and administrators in planning, exercises and response, if necessary.<sup>30</sup>

**Weapons safety.** Weapons safety is another issue that must be considered in hospital environments. Oklahoma Department of Corrections policy states, for example, that no firearms are allowed inside an inmate’s holding area or hospital room. In many cases, the escorting officers will remove their firearms and place them in a lock box in another area. The offender will then be secured in his or her holding area. After the inmate’s treatment, the officers will check to make sure the inmate’s holding restraints are still secure, and then retrieve their firearms. If there is no secured area for the correctional officers to place their firearms, then one officer will remain outside the holding area. This officer will retain the other officer’s firearm. After the inmate’s treatment is completed, the unarmed officer will double check the inmate’s restraints before the outside officer returns his or her firearm.<sup>31</sup>

**Telemedicine.** A major concern of corrections and health care professionals with transporting ailing inmates to medical facilities is the inmate’s exposure to the public. As an alternative, some agencies use telemedicine. Telemedicine generally involves the use of three cameras. One camera is located inside the secured prison area, another within the medical professional’s room, and a third is used to transfer important data, such as X-rays and electrocardiograms. The medical professional helps assist the medical staff at the prison by addressing and treating the problems with the inmate.<sup>32</sup>

**Learning from past experiences.** Despite careful planning, some medical transports may not go smoothly. When incidents occur, hospital and correctional staff should critically examine their procedures, policies and training to determine what might prevent future incidents. For example, in Maryland, any escape or attempted escape is internally investigated by the institution that the inmate came from, as well as by DPSCS investigation teams. The investigators attempt to discover whether the inmate received any additional assistance from visitors, medical staff or even correctional officers. The investigation teams also examine the means and methods of the escape or attempted escape.<sup>33</sup>

## Recommendations

Based on the previously mentioned concerns and issues, the following recommendations have the potential to enhance safety during inmate medical transport:

**Have a system in place to permit notification of the public in the event of an emergency.** The agency responsible for inmate medical transport needs to be able to swiftly, yet calmly, alert the public if an escape has occurred. Many departments already have a communications office that receives and distributes critical information across agencies. A representative of the office communicates with local law enforcement and local news media. To better alert the public, some agencies, such as the Montana Department of Corrections, have implemented city watch systems, which function similarly to reverse 911 operations. Citizens may register for the watch system via the correctional department's website, and may choose specific geographical regions and the type of device on which they would like to be notified (e.g. cell phone).<sup>34</sup> Systems such as these provide a rapid means of alerting the public when there is immediate danger. These are similar to alert systems implemented among colleges and universities throughout the nation in the event of a campuswide emergency.

**Train medical personnel in security precautions to use when working with inmates.** Medical facility designs often do not take into account the security concerns inherent in the treatment of potentially dangerous inmates. Most medical practitioners are not specifically trained to handle inmates. The nurses or medical personnel who will most likely be treating the inmates should receive special training on the security precautions and risks associated with treating inmates. All medical staff should be familiar with special policies regarding inmates and emergency situations, such as lockdowns. If the same group of medical professionals regularly works with correctional officers, communication between the two groups will be much more efficient and effective.

**Take advantage of evolving technologies to reduce the number of transports required.** Implementing telemedicine in a prison setting is a relatively new idea. However, in almost every situation in which it has been used, telemedicine has proven to be cost-effective, efficient and safer.<sup>35</sup> The Ohio Department of Rehabilitation and Correction and the Louisiana State Penitentiary (LSP) in Angola, La., have both incorporated telemedicine programs into their inmate treatment practices. Telemedicine does

not completely eliminate the need for inmates to be transported to more suitable medical facilities; however, it has drastically reduced the number. The telemedicine program in Ohio accommodates up to 300 patients per month.<sup>36</sup> The LSP program, at its onset, was able to process nearly 273 inmates during a two-year period.<sup>37</sup>

**Train correctional officers in security procedures unique to medical facility settings.** Correctional officers should receive basic training on hospital protocols, layouts and clinical processes to better help them understand the course of inmate treatment, security implications and how to plan accordingly. Officers should also understand their roles should lockdowns or other emergency procedures be implemented at the medical facility.

**Regularly review and exercise security procedures.** Security procedures should regularly be reviewed for currency and for any necessary changes due to factors such as facility redesign, revised legislation or court rulings; and changes in hospital or correctional agency standard operating procedure. Policies should also be reviewed following any incident, no matter how minor. Model policy guidance can be found through organizations such as the International Association of Healthcare Security and Safety.<sup>38</sup>

Exercises should be scheduled and conducted annually, and should include participation from relevant constituent groups (e.g., hospital security, medical staff, correctional agency representatives and local law enforcement). In addition to considering possible scenarios and their implications, exercises may help to build a positive working relationship between groups. Guidance in exercise development may be sought from the Federal Emergency Management Agency.<sup>39</sup>

## Conclusion

Transporting inmates to medical facilities is risky. However, there are steps that can be taken to mitigate those risks. Security can be enhanced through training and well-developed policies. In addition, effective strategies and cooperation between correctional and medical personnel can go a long way toward enhancing the safety of correctional officers, medical staff, inmates and most importantly — the public.

## ENDNOTES

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