



OFFICE OF  
**INSPECTOR GENERAL**  
U.S. DEPARTMENT OF THE INTERIOR

# NATIONAL PARK SERVICE LOCKUP FACILITY MANAGEMENT



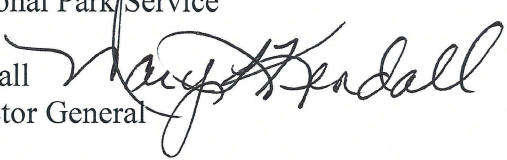


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**INSPECTOR GENERAL**  
U.S. DEPARTMENT OF THE INTERIOR

MAY 08 2014

Memorandum

To: Jonathan B. Jarvis  
Director, National Park Service

From: Mary L. Kendall   
Deputy Inspector General

Subject: Inspection Report – National Park Service Lockup Facility Management  
Report No. WR-IS-NPS-0001-2014

This memorandum transmits the findings of our inspection of the National Park Service's (NPS) lockup facilities at Yellowstone National Park and Yosemite National Park

We found that neither park complied with departmental and NPS policies pertaining to the operation of lockup facilities. Specifically, neither park complied with departmental requirements regarding inmate monitoring, inspections, emergency planning, and evacuation planning. Both parks also failed to fully comply with NPS requirements regarding the use of closed-circuit television in lockup facilities. We make seven recommendations to improve these facilities' operations and inmate safety, increase accountability, and reduce liability.

Please provide us with your written response to this report within 30 days. The response should provide information on actions taken or planned to address the recommendations, as well as target dates and title(s) of official(s) responsible for implementation. Please address your response to:

Ms. Kimberly Elmore  
Assistant Inspector General for Audits, Inspections, and Evaluations  
U.S. Department of the Interior  
Office of Inspector General  
Mail Stop 4428  
1849 C Street, NW.  
Washington, DC 20240

The legislation creating the Office of Inspector General requires that we report to Congress semiannually on all audit reports issued, actions taken to implement our recommendations, and recommendations that have not been implemented. If you have any questions regarding this memorandum or the subject report, please contact me at 202-208-5745.

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## Results in Brief

The National Park Service (NPS) operates lockup facilities at 26 different locations around the Nation. These lockup facilities are typically used to temporarily house suspected offenders (48 hours or less without a judge's order) prior to their first appearance before a judge or transfer to another law enforcement agency. Proper operation of these lockup facilities is necessary to protect the health and safety of the people in custody. We inspected lockup facilities at Yellowstone National Park and Yosemite National Park in November and December of 2013, respectively, to determine if they complied with applicable U.S. Department of the Interior (Department) and NPS policies.

We found that neither Yellowstone nor Yosemite complied with the Departmental Manual section titled "Operation of Detention Facilities" or the NPS Law Enforcement Reference Manual 9 section on the use of closed-circuit television in lockup facilities. Specifically, neither park met the departmental requirements regarding inmate monitoring, inspections, emergency planning, and evacuation planning. Both parks also failed to fully comply with NPS Reference Manual 9 requirements regarding the use of closed-circuit television in lockup facilities.

Due to health and safety concerns we identified at Yellowstone, we issued a management advisory to NPS on January 13, 2014. NPS responded on January 27, 2014 that it concurred with the recommendation in the management advisory and had begun to take action.

Independent from this inspection, the Department recently began the process of updating the Departmental Manual section on lockup facilities that had last been updated in 2000. We reviewed a draft of the revised manual and found it to include improvements in several areas.

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# Introduction

## Objective

Our objective was to determine if the National Park Service (NPS) lockup facility operations conform to applicable U.S. Department of the Interior (Department) and NPS policies. See Appendix 1 for the inspection scope and methodology.

## Background

The Department of Justice defines a lockup facility as—

a facility that contains holding cells, cell blocks, or other secure enclosures that are under the control of a law enforcement, court, or custodial officer, and are primarily used for the temporary confinement of individuals who have recently been arrested, detained, or are being transferred to or from a court, jail, prison, or other agency.

NPS reported that it operates lockup facilities at 26 different sites. Of these sites, 11 include U.S. Park Police locations in the greater Washington, DC; New York City; and San Francisco areas. The remaining sites include national parks such as Grand Canyon, Hawaii Volcanoes, Yellowstone, and Yosemite, as well as national recreation areas such as Glen Canyon and Lake Mead. The detention officers that are responsible for inmate care and responding to emergencies at NPS lockup facilities are commissioned park rangers.

We chose to focus our inspection on Yellowstone National Park and Yosemite National Park because these two parks have a long history of operating lockup facilities. In addition, both parks feature Federal courthouses presided over by resident magistrate judges. Each park reported arrests of about 150 people every year, and inmates are typically held no longer than 48 hours, unless the magistrate judge orders them held longer.

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# Findings

We inspected lockup facility operations at Yellowstone and Yosemite in November and December of 2013, respectively. As part of this inspection, we evaluated both parks' compliance with the Departmental Manual section titled "Operation of Detention Facilities" and the NPS Law Enforcement Reference Manual 9 (Reference Manual) section on the use of closed-circuit television (CCTV) in lockup facilities.<sup>1</sup> We found that Yellowstone and Yosemite lockup facilities do not fully comply with either manual.<sup>2</sup> Appendix 2 contains a detailed list of our findings.

The Departmental Manual that was in effect at the time of our inspection was last updated in 2000. Recently, the Department's Office of Law Enforcement and Security updated the section relating to lockup facilities and released a draft version for the bureaus to review on January 29, 2014. We reviewed this draft version of the revised manual and found it to be improved in several areas.

## **Noncompliance With the Departmental Manual Inmate Monitoring**

At Yosemite and Yellowstone, detention officers were not personally observing inmates at least every 15 to 30 minutes on an irregular schedule, as required by the Departmental Manual.

When we visited Yellowstone, we found that detention officers did not directly supervise inmates. Typically, detention officers only personally observe inmates when delivering meals or transporting inmates to the Yellowstone Justice Center. Primary monitoring of inmates was performed via CCTV by dispatch staff located about a quarter-mile from the lockup facility. Figure 1 shows the locations of dispatch, the Yellowstone Justice Center, and the ranger station relative to the lockup. A dispatcher would only be aware of an emergency at the lockup if he or she saw it on the CCTV or if an inmate pressed a call button to speak with a dispatcher. The dispatcher could then report the emergency to the Mammoth District rangers responsible for the lockup facility.<sup>3</sup> We were told that a dispatcher could be occupied by other work during the busy season and might not monitor the lockup CCTV for several hours at a time.

Lockup facility administrators must also provide "sufficient manpower to provide effective security at the detention facility." We determined that Yellowstone did not provide effective security because detention officers were not stationed at the lockup facility. Yellowstone officials told us that in the case of an emergency at

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<sup>1</sup> "Operation of Detention Facilities," 446 DM 6 and "CCTV use in Jail/Custodial Holding Facilities," RM-9, Chapter 26, Section 3.7.

<sup>2</sup> The Departmental Manual section applies to detention, community residential, or holding facilities. The definition of lockup facility used in this report falls under the definition of a detention or holding facility.

<sup>3</sup> NPS has commissioned park rangers who perform the role of detention officers. These commissioned rangers are sworn law enforcement officers, as opposed to dispatch staff, who are not sworn.



the lockup facility, 3 to 10 Mammoth District rangers would likely be able to respond in 5 to 15 minutes and up to 14 Mammoth District rangers within 45 minutes. In the case of a medical emergency, however, even 5 minutes could be too much time. A Yellowstone employee told us that the park has been lucky to not have had any major incidents.



Figure 1. This map of Fort Yellowstone shows the relative locations of the (1) lockup facility, (2) dispatch center, (3) Yellowstone Justice Center, and (4) Mammoth Ranger Station. Inset is a map of the Mammoth District and the approximate relative size of Fort Yellowstone. Base map courtesy of maps.google.com. Map data provided by Google. Inset map courtesy of Yellowstone.

On January 13, 2014, we issued a management advisory to NPS to express safety concerns regarding no onsite monitoring and recommend that Yellowstone close the lockup facility until it could be staffed by a detention officer. On January 27, 2014, NPS issued a response stating that when in use, it would staff the lockup facility with a detention officer who would monitor inmates by CCTV and personally observe the inmates every 30 minutes.

While detention officers are stationed at the Yosemite lockup facility, they do not always monitor the cells every 30 minutes. These detention officers do monitor inmates via CCTV and personally observed inmates on an irregular schedule. Detention officers told us that they do not always observe the cells as often as required to prevent agitating inmates.

### **Annual Inspections**

Lockup operations, programs, equipment, and facilities must be inspected at least annually. While detention officers at both parks routinely inspect lockup cells as part of their normal duties, we found that neither park conducted formal inspections of their lockup operations, programs, equipment, and facilities. With the exception of a 2013 inspection of the Yellowstone lockup facility by the U.S. Marshal Service, neither park's lockup facility had been independently inspected in recent years.

### **Emergency Planning**

Lockup facilities are required to have emergency plans with procedures for situations including, but not limited to—

- riots and disturbances;
- hunger strikes;
- hostage situations;
- work stoppages;
- unattended deaths, including suicides;
- attempted suicides;
- escapes and unauthorized absences; and
- other threats to the security of the facility.

While detention officers reported that they had discussed among themselves what they would do in some of these situations, neither park had developed written emergency plans for the required situations.



## **Evacuation Planning**

Evacuation plans for lockup facilities must be prepared in case of fire or major emergencies. According to the Departmental Manual—

these plans should comply with Occupational and Safety Health Administration (OSHA) standards. Initially, the plans are reviewed and approved and, on an annual basis, the appropriate safety officer or his/her designee will update and reissue, if required. The evacuation plans should include: (a) means of immediate release of inmates from locked area and supervised escort of inmates to another secured area; (b) location of building/rooms floor plans; (c) use of exit signs and/or directional arrows for traffic flow; (d) location of publicly posted plan; (e) at least quarterly drills in all facility locations; and (f) coordination with the fire department which serves the facility.

We found that neither park had developed written evacuation plans in case of fire or major emergencies. Consequently, neither park had performed the required quarterly drills of their evacuation plans.

### **Recommendations**

We recommend that NPS:

1. Require that lockup facilities are staffed by onsite detention officers and that inmates are observed as often as is required by departmental policy;
2. Require that both parks begin to annually inspect their lockup facility operations, program, equipment, and facilities;
3. Require that both parks develop emergency plans; and
4. Require that both parks develop and exercise evacuation plans.

## **Noncompliance With the NPS Reference Manual**

We found that neither Yellowstone nor Yosemite fully complied with the NPS Reference Manual.

### **CCTV Monitoring**

Detention officers who are responsible for the facility and care of inmates must monitor CCTV live video. In addition, lockup facilities should establish secondary monitoring at park communications facilities that can dispatch backup officers in case detention officers supervising inmates need assistance. As detailed earlier in this report, we found that detention officers were not monitoring CCTV live video at Yellowstone. Instead, dispatch personnel were monitoring inmates as a collateral duty.

### **CCTV Backup**

Lockup facilities are required to archive CCTV video for 6 months. While Yellowstone met this requirement, Yosemite officials told us that Yosemite can archive CCTV video for only 80 days due to technical limitations.

## **Recommendations**

We recommend that NPS:

5. Require that detention officers responsible for the care of inmates monitor CCTV at Yellowstone; and
6. Increase Yosemite's CCTV video archive capability to 6 months.

## **Improvements in the Draft Update to the Departmental Manual**

The Departmental Manual section on operating lockup facilities in effect at the time of our inspection was last updated in October 2000. The Department's Office of Law Enforcement and Security has recently updated this section and issued an updated draft to the bureaus for comment on January 29, 2014.

We found the revised section to be improved in several areas compared to the version that was in effect at the time of our inspection. For example, the revised Departmental Manual requires annual inspections of lockup facilities, further stating that the inspections are to be conducted by independent staff not involved with jail operations. In addition, detention officers' posts must be adjacent to inmate living areas so that they can immediately respond to emergency situations. The revised section also requires bureaus annually certify compliance with the Departmental Manual and update bureau standard operating procedures as necessary. These standard operating procedures must be submitted to the Director of the Office of Law Enforcement and Security for review and concurrence prior to implementation.

The updated manual also requires that detention operations comply with the American Correctional Association Core Jail Standards. Among other things, these standards require the bureaus to maintain emergency and evacuation plans.

We believe that these changes, if implemented, will improve these facilities' operations and inmate safety, increase accountability, and reduce liability.

### **Recommendation**

We recommend that NPS:

7. Review all NPS sites that have lockup facilities and ensure they take the necessary steps to comply with the revised Departmental Manual once it is finalized.

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# Conclusion and Recommendations

## Conclusion

We found that the Yellowstone and Yosemite lockup facilities did not comply with the Departmental Manual or the NPS Reference Manual. With the number of inmates the two parks hold each year, NPS must ensure that lockup facilities operate according to Department and NPS policies and procedures to protect the health and safety of park staff, visitors, and inmates.

We briefed Yellowstone and Yosemite officials on the results of our inspections, and they concurred with the findings. Yellowstone reported that it has already taken steps to implement the recommendation from the management advisory we issued in January 2014. Specifically, Yellowstone reported that it will station a detention officer at the lockup facility who will directly supervise inmates. In addition, the park will begin the process of developing the required written plans and operating procedures.

## Recommendations Summary

We recommend that NPS:

1. Require that lockup facilities are staffed by onsite detention officers and that inmates are observed as often as is required by departmental policy;
2. Require that both parks begin to annually inspect their lockup facility operations, program, equipment, and facilities;
3. Require that both parks develop emergency plans;
4. Require that both parks develop and exercise evacuation plans;
5. Require that detention officers responsible for the care of inmates monitor CCTV at Yellowstone;
6. Increase Yosemite's CCTV video archive capability to 6 months; and
7. Review all NPS sites that have lockup facilities and ensure they take the necessary steps to comply with the revised Departmental Manual once it is finalized.

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# Appendix I: Scope and Methodology

## Scope

The scope for this inspection was U.S. Department of the Interior (Department) National Park Service (NPS) locations that currently have some form of jail, detention facility, lockup, or temporary holding cell. NPS provided us with a list of locations that met our scope. From that list, we chose to focus on Yellowstone National Park and Yosemite National Park based on their long history of operating lockup facilities. Our inspection looked at whether Yellowstone and Yosemite complied with relevant departmental and bureau guidance. We conducted our inspection in accordance with the Quality Standards for Inspection and Evaluation as put forth by the Council of the Inspectors General on Integrity and Efficiency. We believe that the work performed provides a reasonable basis for our conclusions and recommendations.

## Methodology

During our inspection, we interviewed Department and NPS officials responsible for lockup facility policies and operations and met with the Department's Office of Law Enforcement and Security as well as NPS Law Enforcement, Security and Emergency Services. We also—

- evaluated compliance with the Departmental Manual (446 DM 6) and NPS Law Enforcement Reference Manual 9 (RM-9, Chapter 26, Section 3.7) policies applicable to lockup facility operations;
- visited Yosemite and Yellowstone to visually inspect the lockup facilities and document their operating procedures through interviews and photographs;
- issued a management advisory on January 27, 2014, to notify NPS of significant health and safety concerns identified during our site visit to Yellowstone; and
- reviewed a draft revision to 446 DM 6 that was issued to the bureaus for comment on January 29, 2014.

We did not evaluate compliance with—




- Federal, State, and local detention standards and laws (446 DM 6.3 A. (1));
- Freedom of Information Act or the Privacy Act (446 DM 6.3 B. (1));
- Juvenile Justice and Delinquency Prevention Act or 28 CFR Part 31 (446 DM 6.3 B. (3)(b));
- requirements for body cavity searches (446 DM 6.3 B. (3)(g)); or
- requirements for food handlers or nutritional guides (446 DM 6.10).

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## Appendix 2: Site Visit Details

The table below displays the results of our review of Yellowstone and Yosemite national parks' compliance with the Departmental Manual section on lockup facility operations and the NPS Reference Manual 9 section on the use of CCTV in lockup facilities.

### Legend

-  The park complied with this requirement.
-  The park partially complied with this requirement.
-  The park did not comply with this requirement.

### Departmental Manual (446 DM 6)

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<b>6.3 A. (3)</b>	Yellowstone 	Yosemite 
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“There are, at minimum, annual inspections of the operations, programs, equipment, and facilities. Any and all deficiencies shall be reported to the proper authorities as soon as they are discovered. Such deficiencies must be corrected in a timely manner.”

*OIG Comment: Neither park had a formal inspection program to review the operations, programs, equipment, and facilities. Detention officers routinely inspected individual cells as part of their normal duties.*


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<b>6.3 A. (4)</b>	Yellowstone 	Yosemite 
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“The policy/procedure manuals and their supporting documents are easily accessible to all employees and inmates of the facilities. There are procedures for the dissemination of approved, new or revised policies and procedures to the appropriate staff.”

*OIG Comment: Yellowstone had not developed written policy manuals. Yosemite had written standard operating procedures but did not make them accessible to inmates.*

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<b>6.3 A. (5)</b>	Yellowstone 	Yosemite 
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“There are emergency plans that specify procedures to follow in situations including, but not limited to: (a) riots and disturbances; (b) hunger strikes; (c) hostage situations; (d) work stoppages; (e) unattended deaths, including suicides; (f) attempted suicides; (g) escapes and unauthorized absences; and (h) other threats to the security of the facility.”

*OIG Comment: Neither park had established written emergency plans. Park officials told us that they verbally discussed what they would do in some of these situations.*

## Departmental Manual (446 DM 6) Continued

### 6.3 A. (6)

Yellowstone  Yosemite 

“The emergency plans are updated annually and that all personnel are trained in implementation of the emergency plans.”

*OIG Comment: Because neither park had emergency plans, neither park had conducted training in the implementation of such plans.*

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### 6.3 A. (7)

Yellowstone  Yosemite 

“There are evacuation plans prepared in case of fire or major emergencies. These plans should comply with Occupational and Safety Health Administration (OSHA) standards. Initially, the plans are reviewed and approved and, on an annual basis, the appropriate safety officer or his/her designee will update and reissue, if required. The evacuation plans should include: (a) means of immediate release of inmates from locked area and supervised escort of inmates to another secured area; (b) location of building/rooms floor plans; (c) use of exit signs and/or directional arrows for traffic flow; (d) location of publicly posted plan; (e) at least quarterly drills in all facility locations; and (f) coordination with the fire department which serves the facility.”

*OIG Comment: Neither park had developed written evacuation plans for their detention facilities. Park officials told us that they verbally discussed what they would do in some of these situations.*

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### 6.3 B. (3)(a)

Yellowstone  Yosemite 

“Sufficient manpower to provide effective security at the detention facility.”

*OIG Comment: Yellowstone did not have detention officers stationed at the lockup facility.*

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### 6.3 B. (3)(f)

Yellowstone  Yosemite 

“Male and female arrestees shall be searched by an officer of the same sex as the arrestee, except in exigent circumstances. For safety purposes, this does not preclude a ‘pat-down’ (Terry-type) frisk being conducted by an officer of the opposite sex. A female officer shall be assigned to ensure a thorough search of female prisoners.”

*OIG Comment: Although both parks had female detention officers, they reported that it was not possible to have one on duty at all times.*

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### 6.3 B. (3)(l)

Yellowstone  Yosemite 

“A detention officer shall personally observe inmates at least every 15 - 30 minutes, but on an irregular schedule. Suicidal inmates should be under continuous observation.”

*OIG Comment: At Yosemite, detention officers personally observed inmates, but not always as often as required. At Yellowstone, detention officers typically only observed inmates when serving meals or transporting inmates to the Justice Center.*



## Departmental Manual (446 DM 6) Continued

### 6.3 B. (3)(o) Yellowstone Yosemite

“Guidelines to explain the behavior expected of inmates. All detainees will be informed of these guidelines.”

*OIG Comment: At both parks, inmates were verbally instructed as to their expected behavior. Neither park had written guidelines.*

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### 6.3 C. (1) Yellowstone Yosemite

“The appropriate arrest, prisoner processing, and detention procedures are properly disseminated to officers under his/her command.”

*OIG Comment: At Yellowstone, prisoner processing and detention procedures were communicated verbally and through on-the-job training; they were not in written standard operating procedures.*

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### 6.4 G. Yellowstone Yosemite

“Written procedures for obtaining medical care for such prisoners, including medical emergencies, will be established and posted at all detention facilities. In addition, all detention officers will be familiar with basic first aid measures to be utilized while awaiting medical assistance.”

*OIG Comment: Detention officers are also emergency medical technicians and are familiar with basic first aid. Neither park had medical emergency procedures posted.*

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### 6.6 Visitors Yellowstone Yosemite

“Visiting hours will be scheduled by the facility administrator at least once per week. If facilities permit, a room will be set aside for visiting purposes. A detention officer will be present in the visiting room at all times during visiting hours. Officers will be courteous to all visitors and prisoners.”

*OIG Comment: Neither jail allowed visitors as they are primarily used as temporary (48 hours or less) holding cells.*

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### 6.7 Emergencies Yellowstone Yosemite

“Written plans for handling emergencies will be prepared and made known to all detention personnel and inmates. These plans will establish procedures for fire evacuation, riot control, and prevention of escape attempts. Fire plans will be posted so that all inmates are aware of evacuation routes.”

*OIG Comment: Neither park had written emergency plans. Yosemite had a fire evacuation map posted in the lockup facility offices, but not visible to inmates.*

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### 6.8 Prisoner Supervision Yellowstone Yosemite

“Adequate supervision will be provided 24 hours per day when an individual is in custody.”

*OIG Comment: At Yellowstone, dispatch staff monitored inmates using CCTV, and they reported that their attention may be diverted to other duties for extended periods of time.*

## Departmental Manual (446 DM 6) Continued

### 6.8 A.

Yellowstone

Yosemite

“A female detention officer must be on duty whenever a female is in custody.”

*OIG Comment: Both parks had female detention officers, but reported that it was not always possible to have one on duty.*

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### 6.8 B.

Yellowstone

Yosemite

“Detention officers will observe each occupied cell at least once every half hour or more often if required.”

*OIG Comment: Detention officers observed inmates at Yosemite, but not as often as once every half hour. Detention officers did not observe inmates at Yellowstone, except when entering the jail to deliver meals or transport inmates.*

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### 6.11 Training and Development

Yellowstone

Yosemite

“Each facility administrator shall establish written policies, procedures, and practices to ensure that the facility training programs for all employees are specifically planned, coordinated, and supervised by qualified employees. Staff development should be an integral part of the management and operation of the facility. The training plan should include an orientation, pre-service and in-service training curriculum. At minimum, this training curriculum should cover: A. Security procedures and regulations; B. Rights and responsibilities of inmates; C. All emergency procedures; D. Interpersonal relations; E. Communication skills; F. First aid; and G. Prisoner processing procedures.”

*OIG Comment: Yosemite had training materials, but they primarily focused on prison processing procedures. Yellowstone did not have a formal training program for detention officers.*

## NPS Law Enforcement Reference Manual 9

### Chapter 26, 3.7

Yellowstone



Yosemite



“Signs will be clearly posted in custodial holding facilities advising of audio/video monitoring.”

*OLG Comment: Yellowstone did not have any such signs posted in the detention facility. Inmates were verbally instructed that they are monitored remotely.*

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### Chapter 26, 3.7

Yellowstone



Yosemite



“In addition to archived recording, CCTV live video will be monitored by commissioned personnel responsible for the facility and care of in-custody individuals. Secondary monitoring should be established at park communications facilities that can dispatch ‘back-up’ officers in case commissioned personnel supervising in-custody individuals need assistance.”

*OLG Comment: At Yosemite, detention officers monitored the CCTV live video, but they did not use the park dispatch as a backup due to technical limitations. Yellowstone did not have detention officers reviewing the CCTV live video; park dispatchers performed this function.*

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### Chapter 26, 3.7

Yellowstone



Yosemite



“CCTV video will be archived for six months per General Records Schedule 21.”

*OLG Comment: Yosemite only had the capacity to archive video for 80 days.*

