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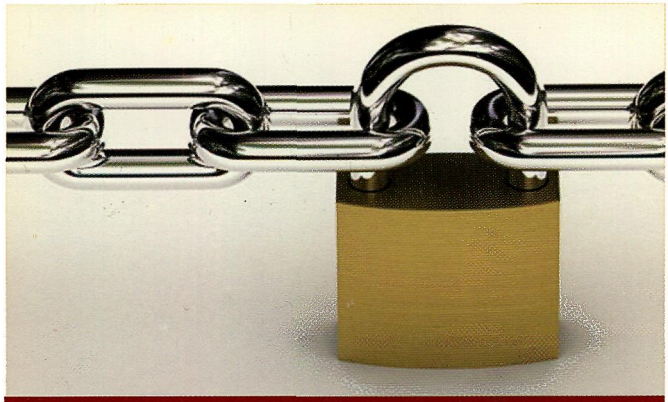

Making Headway Against Healthcare Violence And Crime

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IAHSS

The IHSSF 2011 Prisoner Escape Study

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The 2011 Prisoner Escape Study, funded by the International Healthcare Security and Safety Foundation (IHSSF), investigates 99 reported forensic prisoner escapes from hospitals which took place from April, 2010 to April, 2011. A cross-sectional, exploratory study of prisoner escapes, the study follows up findings from the 2010 IHSSF Crime Study which indicated that members were concerned about the risks to hospital campuses and healthcare facilities that are en-gaged in the medical treatment of prisoner/forensics populations.

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INTRODUCTION

Everyone takes for granted that healthcare treatment facilities provide medical care for those who need such services. What is not widely known or understood by the general public is that in recent years, healthcare facilities have also increasingly provided services to forensic/prisoner patients. In the early 1970s, a class action suit was filed on behalf of prisoners who alleged that depriving them of necessary medical treatment constituted "cruel and unusual punishment". In concurrence, the United States Supreme Court, in an interpretation of the Eight Amendment of the US constitution, ruled in 1976 (Estelle v. Gamble, 429 US 97) that correctional facilities must provide necessary medical care to all incarcerated individuals. The Supreme Court ruling was further clarified by stating that "the deliberate indifference to serious

medical need is prohibited." In effect, the Supreme Court recognized an inmate's constitutional right to obtain health care during incarceration. The Supreme Court further determined that each state was responsible for providing adequate healthcare because the inmate's inability to secure independent medical services was forfeited upon incarceration.

The decision by the Supreme Court caused dramatic changes in the delivery of health care to the prisoner population. Initially, medical treatment facilities were created to provide services in the correctional setting. However, over the decades following the Court's decision, due to state concern over duplication of services and tight state budgets, on-site medical care at corrections facilities gradually decreased or was eliminated altogether, leaving prisons and jails with little ability to care for sick or injured prisoners beyond first aid. Corrections and law enforcement began to contract with hospitals and healthcare facilities to provide medical treatment. Currently, the majority of all obligatory health care is now administered by outside medical and other healthcare facilities fully capable of delivering appropriate care.

At the same time, as numerous research studies (e.g., Carroll, et al, 2009; Glacki-Smith, et al, 2009; Kennedy, 2005; Jordan, 2011; Lavoie, et al, 2009; Leape & Berwick, 2000) have shown that healthcare facilities are becoming more violent. A Sentinel Event Alert from the Joint commission (June, 2010) noted a significant increase in crime and acts of violent aggression in healthcare settings. These conclusions were further supported by a study of crimes in hospitals and healthcare facilities (Mikow-Porto & Smith, 2010), funded by the International Healthcare Safety and Security Foundation showing that aggravated and simple assaults had increased more than five-fold over a period of four years. As a result of such violence, media coverage of violent incidents in the healthcare setting has heightened the public's sense of insecurity and made the jobs of security professionals more difficult. Media attention, in turn, draws the attention of regulatory agencies, including the Joint Commission and the Centers for Medicare and Medicaid Services when

violent events occur. After such events, these agencies often scrutinize the actions of hospital security professionals and the facilities to ensure compliance with regulations.

Medical care of prisoners is a high risk situation. Transfer of prisoners is considered the most risky procedure corrections and law enforcement engage in. When transfer of prisoners to healthcare facilities is undertaken, procedures and protocols, developed to reduce risk of violent incidents, are followed to provide safety to corrections and healthcare security officers, treatment providers, the general patient population and visitors. Indeed, transfer protocols require the use of restraints that may include handcuffs, handcuffs and belly chains, leg irons, black box security devices or flex cuffs to secure prisoners. Even so, hospital security and corrections professionals have expressed deep concern about safety and security issues associated with the medical treatment of prisoners. And their concerns are well-founded.

Over the last several years, media reports of prisoner violence and escapes from healthcare facilities appear to have increased. And while prisoner escapes that involve the use of weapons, including guns, are relatively rare, healthcare security professionals are concerned that they are increasing in frequency. A survey conducted by Campus Safety (2011) reported that the "most troubling statistic of the entire 'How Safe is Your Campus' survey involves hospitals and their inability to respond to active shooters, bombers and prisoner escapes." According to the survey, "61 percent of the campuses participating in the study reported that their departments and institutions would be unable to respond effectively to a shooting or bombing." (p. 12). Moreover, 41 percent of respondents said that they had insufficient staff to respond to serious events involving the use of weapons. In other research, Corcoran and Cawood (2005) suggested that responding to a rapidly escalating event is difficult to anticipate and prepare for; it takes time to gather and deploy security personnel and equipment.

CHARACTERISTICS OF JAIL AND PRISON POPULATIONS

Prison and jail populations, consisting of individuals who have been formally charged with the commission of a crime and are in the custody of correctional systems in the United States, have risen dramatically over the decades. In 1990, an estimated 1.1 million individuals were incarcerated in federal and state prisons or local jails. By 2009, the total population of incarcerated prisoners had risen to 2.3 million (US Department of Justice, 2009). The United States now has the largest prison population in the industrialized world.

Consistent and well-established findings (National Commission on Correctional Health Care, 2002) indicate that the incarcerated population has disproportionately high levels of acute and chronic medical and mental disorders, all of which are associated with increased risk for infectious diseases, serious illnesses, and other medical and psychological disorders that may worsen upon incarceration. For example, the National Commission (2002) reported that infectious diseases, such as tuberculosis, Hepatitis C, and AIDS/HIV as well as other sexually transmitted and communicable conditions, range from five to ten times higher in prisoners than among the general population. Wilper, et al., (2009) analyzed data from the 2002 Survey of Inmates in Local Jails and the 2004 Survey of Inmates in State and Federal Correctional Facilities and found that 49 percent of all prisoners suffered from chronic medical conditions. In addition to chronic or acute medical and psychological disorders, the health status of prisoners is frequently compromised by intentional and unintentional injuries while in custody. Perhaps of greatest concern to healthcare providers and security personnel is that prisoners are aging (Mitka, M., 2004) and, as is true of the general population, more likely to develop acute or exacerbate chronic health disorders as they age.

As can be seen from the foregoing, provision of healthcare to prisoners is likely to increase in frequency and prisoners are likely to be sicker. As noted previously, there also appears to be an

increase of reports of adverse events associated with the treatment of prisoners in public hospital and healthcare settings. Nevertheless, there is little information available in scholarly research regarding violent events associated with the treatment of prisoners or the extent to which prisoner escapes occur. Nor is there any national system for collecting information or tracking violent incidents or prisoner escapes associated with medical care of forensic prisoners. While numerous reports of prisoner incidents have appeared in the media, at present it is difficult to determine whether such reports actually capture the true prevalence and incidence of these events. Moreover, when prisoner escapes occur, it is not known how often violence is involved and to what extent injuries and deaths result beyond what is reported by the media. Prisoner escapes from healthcare facilities pose a high risk of adverse conse-quences to staff, patients and visitors as well the general public as anecdotal and media reports events indicate.

An additional risk factor associated with prisoner treatment is that state and federal policies often require hospitals to use the "least restrictive" means to control hospital patients, including prisoners. Thus, standard corrections and healthcare security procedures are sometimes at odds with state and federal healthcare requirement. The US Center for Medicare and Medicaid Services, which manages the federal healthcare coverage programs, states that it is inappropriate to use any weapon to restrain a patient. However, the CMS's State Operations Manual includes exceptions in cases where a weapon is used by or on a violent patient. "We would expect the situation to be handled as a criminal activity and the perpetrator placed in the custody of local law enforcement. And while in most states, it is a felony to assault a doctor, nurse, aide, paramedic of other healthcare worker on the job, it happens frequently (see, for example, Glicki-Smith, et al, 2009). In some hospitals where violent prisoner patient incidents have taken place, the campuses have taken the position that they will only treat prisoners in cases of emergency.

The co-author of this study, Tom

Smith, wrote in the International Hospital Federation Reference Book (2007/2008) that "Among the thousands of prisoners or prisoner patients treated at health care facilities around the world each year, there are those who are clever, desperate and strong enough to defeat security measures or take advantage of complacent prison staff or uninformed clinical staff. "When prisoners escape from custody while in a HCF [Healthcare Facility], at minimum, the public confidence in the facility is affected and in the worst case, injuries and fatalities occur." (p. 059)

The Santa Cruz incident: injuries and terror

A recent example of just such an incident was reported in Santa Cruz, California in November, 2010. A female corrections officer, approximately five feet three inches tall, was overpowered by a prisoner who was six feet seven inches tall and weighs 275 pounds, while leading him through a hospital after he had received an MRI. He elbowed the guard in the face and in the ensuing struggle bit the officer's hand. She drew her Taser and the prisoner grabbed it from her and used it against her, rendering her incapable of corrective actions. He then stole her gun and fired it at a woman who attempted to intervene. Eventually the prisoner was recaptured, but not before he terrorized a preschool across the street from the hospital where he held the gun against a teacher. The preschool had forty children in attendance, ranging in age from infancy to five years. He was finally captured, but not before local officers, corrections official and the healthcare facility were lampooned in the media.

The need to understand the conditions under which prisoner escapes occur

Corrections professionals are responsible for guarding prisoners. Their presence and the safety measures they use have been created to minimize risk and inconvenience to hospital personnel, patients, hospital security staff, and the general public during emergency clinical evaluation, outpatient treatment or admission to medical facilities. In most cases, correctional officers are

required to carry firearms at all times and cannot surrender them to anyone except a properly designated authority. Since the numbers of prisoners who need medical treatment is escalating, it is critical for health care industry to understand the conditions under which prisoner escapes occur and learn more about what can be done to prevent them.

Hospital escapes by female inmates do not occur very often in comparison to the number of escapes attempted or completed by male prisoners. There are, however, a number of escapes completed each year by female prisoners. There has been considerable debate in the media and in state legislatures about the use of restraints with female prisoners, particularly with pregnant prisoners who must be seen for medical treatment on a regular basis during preg-nancy and delivery. An article that appeared in the AELE Law Enforcement monthly legal briefs (2009) reported that State Legislatures, Women's Rights groups, medical societies and major newspapers have supported the use of fewer restraints with female prisoners during medical treatment especially in cases where the female inmate is pregnant. They argue that the use of restraints qualifies as "cruel and unusual punishment." A number of state legislatures have legislation pending that would allow female prisoners to remain at least partially unshackled during medical treatment. They contend that female inmates, particularly, pregnant prisoners, pose a less serious risk of escape or danger to staff, patients and security professionals. The limited case law and lack of pertinent studies would suggest that standard procedures for reducing risk of escape in handling all prisoners seeking medical care should not be relaxed.

In addition to the debate surrounding the use of physical restraints with female inmates, it is well-known that healthcare and law enforcement/corrections policies and procedures may conflict with internal and external policies associated with Healthcare facilities and the Centers for Medicare and Medicaid Services, that call for "least restrictive" approaches to patient care. In the case of law enforcement and corrections, rules and regulations require the use of restraints with all inmates

while those who provide actual medical care, doctors, nurses and technicians, may decry the use of restraints during treatment. These procedural and philosophical disagreements sometimes increase the risk for escape of prisoners. How often this happens is unknown, though it has been reported.

THE 2011 IHSSF PRISONER ESCAPE STUDY

As noted previously, there are no data about prisoner escapes from hospitals and healthcare facilities that are systematically collected at the national level. To understand more about prisoner escapes, under the auspices of the International Healthcare Security and Safety Foundation, a study was commissioned to explore how many prisoners escape from hospitals, what locations they typically escape from, and the conditions under which escapes are attempted or succeed. The study was developed as a direct response to interest in and concern about the prisoner/forensic patient population under treatment as identified by members in the 2010 International Healthcare Security and Safety Foundation (IHSSF) Crime Study.

The purpose of the 2011 Prisoner Escape Study is study was as follows:

- Identify and assess trends in prisoner escapes reported through the media for a period of one year using prospective and retrospective data.
- Determine conditions under which prisoner escapes occur
- Provide information for use by members of the International Association for Healthcare Security and Safety
- Make recommendations for improving safety and security when prisoners are being treated.

FINDINGS

In the following sections, findings associated with the analysis of data are presented. The data are arranged by the categories associated with the interview questions. In addition, actual facts from prisoner escape cases are reported.

Location of incident

All informants were asked to identify where the escape took place. The information is reported

DATA COLLECTION PROCEDURES

The 2011 Prisoner Escape Study was a cross-sectional, exploratory study of prisoner escapes. Based on findings from the 2010 International Healthcare Safety and Security Foundation Crime Study (Mikow-Porto, V. and Smith, T., 2010), results indicated that members were concerned about the risks to hospital campuses and healthcare facilities that are engaged in the medical treatment of prisoner/forensics populations. The study, interview protocol and analytic procedures were designed by the lead researcher, Dr. Mikow-Porto, with advice and input from the leadership of the IHSS Foundation and the co-author, Tom Smith, who is responsible for hospital police and security at a large public university hospital.

The study used a purposive sampling strategy to determine how many escapes from healthcare facilities by prisoners occurred during a one year study period. Data were gathered through news alert systems available in Google, Bing and AlltheWeb as well as other search engines. All media-reported events of attempted or completed prisoner escapes from hospitals were systematically collected using a prospective and retrospective design. Also included in the study were any reports of attempted or completed escapes while prisoners were being transported to and from hospitals or other healthcare facilities for treatment. To avoid duplication of information collected, each report of an escape was systematically examined to ensure only single cases were identified since escapes were often reported by several local media providers.

Data collection began in September, 2010 and continued prospectively through April, 2011. Searches were conducted to gather all available information on prisoner escapes over the previous five months from available media articles and videos. Thus, data were collected to reflect the period of April 1, 2010 to April 30, 2011.

It should be noted that collecting data through media tracking has its limitations. Stories reported through the media do not always have a long life in the virtual world. For example, when attempting to collect data retrospectively, on numerous occasions we encountered a "pages not found" message; the stories had not been archived. Where that happened, the report was not included since it could not be investigated. As a result, we know that the number of incidents reported in this study represents an under-count of actual incidents. Nevertheless, a total of 99 non-duplicated reports that we could investigate further were obtained from online sources.

For the next phase of the research, a script was developed for use in interviewing individuals identified in the media-reported stories pertaining to prisoner escapes. A copy of the protocol is included in Appendix One. The newspaper or television

DATA COLLECTION PROCEDURES (continued)

reporter who had written/reported the story was identified and contacted. If that person was not available or no longer worked for the news agency, crime desks at the newspapers or television offices were contacted. We also followed this procedure when the reporter was not identified. Next, the corrections institutions that had custody of the prisoner at the time of the escape were contacted. Lastly, the press or security officers at the hospitals involved in the reported escapes were contacted. The purpose for identifying these individuals was to set up an appointment for an interview about the incidents.

Whenever possible, all individuals associated with the reporting, custodial care, or treatment center where prison escapes occurred, were interviewed using the interview protocol established for the study. A total of 253 individuals were interviewed. Analysis of interview data was completed using Atlas software for qualitative data.

Data limitations

The nature of purposive sampling utilized for this study prevents the use of statistical methods associated with random sampling procedures. While every effort was made to obtain information on prisoner escapes from hospitals over a period of one year, as noted previously, it is likely that the incidents studied represent an under-count for two reasons:

1. Systematic data collection did not commence until September, 2010
2. Only retrospective data were collected for the period prior to September, 2010

Based on conversations with corrections and media officials, it is also highly likely that there were a number of prisoner incidents associated with medical treatment that were not reported or that had been expunged. Nevertheless, a total of 99 documented cases of hospital escapes by prisoners were identified for the period covering April 1, 2010 and April 30, 2011. Of those, only 6 (6%) escapes were made by female inmates. Of those 6 escapes, 4 were made by pregnant prisoners.

in Table 1. As can be seen, escapes (39.4%) took place most frequently in the clinical treatment areas. In discussions with interviewees, it was learned that treatment areas are organized differently in each hospital. Some treatment areas are separated from the general patient population and used only for prisoner patient care while other healthcare facilities did not segregate

prisoners from other patients. This is particularly true when prisoners are seen first in emergency departments. The use of restraints among prisoner patients undergoing treatment procedures is frequently handled on a case-by-case basis although most law enforcement and corrections procedures require the use of restraints at all times, regardless of type of treatment received.

The next most frequent location of prisoner escapes took place in restrooms (29.3%). The specific location of the restroom was not always identified, but included restrooms in admissions, emergency rooms and clinical treatment areas. During the interviews, law enforcement, corrections and hospital representatives were asked about the circumstances of prisoner escapes from restrooms. Interview data suggest that in most restroom escapes, custodial officers removed some or all restraints.

Moreover, findings indicate that prisoners who escaped from restrooms were more likely to have planned the escapes prior to hospital treatment or admission. An example of a planned escape involved three male inmates seeking treatment in the designated prisoner treatment ward of a major hospital who had assistance from accomplices outside prison. The accomplices sawed through a bar in a window leading to the courtyard outside the treatment areas prior to the prisoners' arrival at the hospital. The three inmates escaped through the window where the accomplices had a waiting van. The corrections officer interviewed in this case stated that, in his opinion, "the hospital was responsible for the escape since it had not prevented the destruction of the bars on the windows that allowed the prisoners to escape." He went on to conclude that "there's little we can do to prevent something like this."

It is estimated, based on the interviews, that approximately one-third to one-half of the escapes involved the development of an escape plan prior to transfer for treatment in the healthcare setting.

Custody

Securing treatment and maintaining custody of prisoners is primarily the responsibility of the corrections system or local jails. Some states have policies that

allow prisoner-patient transfer to hospital security professionals, but in those cases, rigorous safety protocols are expected to be in place. (see, for example, IAHSS guidelines on prisoner patient security, 2011). In addition, there are local agreements with police or sheriffs that allow for prisoner transfer to the healthcare system. A significant proportion of hospitals have few security professionals with sworn police powers, particularly public hospitals on university campuses. And, not all hospital security personnel carry weapons; it varies widely from state to state and hospital to hospital. Healthcare security professionals who are contracted to provide security may also have limitations on use of weapons and procedures followed in cases involving prisoners. Thus, they may be hampered in their attempts to secure a fleeing prisoner patient when an escape event occurs. Some healthcare facilities prohibit the use of weapons altogether when prisoner patients are in their custody. However, in most cases involving treatment of prisoners, outside police, sheriffs or correctional officers must accompany prisoners at all times. Table 2. reports who had custody of the prisoner(s) when an escape was attempted or completed.

Table 2. Custody of Prisoner

Law Enforcement/ Corrections	Hospital Security
78	21

Number of Law Enforcement/ Corrections and Healthcare Security Officers Involved in Incidents

The interview protocol was designed to ask questions about the actual number of law enforcement/corrections officers and healthcare security staff who were involved in escapes from the healthcare facility. In most cases of prisoner escape, the inmate was in the custody of law enforcement or corrections officers; rarely was the patient in the custody of a healthcare security officer. Nevertheless, it was particularly difficult to ascertain how many hospital security professionals were involved in the escape and/or recapture of an escaped prisoner because the healthcare facilities were often reluctant to provide the information. This is not the case with correc-

Table 1. Location of Prisoner Escape Incident

	Location				
	Emergency Room	Outside the Hospital (e.g., hospital entrance, parking lot, etc.)	Clinical Treatment Areas	Restrooms	Total
Number of Incidents	14 (14.1%)	17 (17.2%)	39 (39.4%)	29 (29.3%)	99 (100%)

Table 5. Injuries and Deaths

	Deaths	Injuries
Healthcare security staff		11
Law Enforcement/Corrections		26
Healthcare staff		3
Patients		1
Visitors		3
Others not on site	2	5

tions and law enforcement as such events are fully recorded in incident reports and are publically available.

As a result, we cannot say with complete confidence that the data reported below reflect the true extent of healthcare security involvement, in any way, in the actual incidents. The escapes that included law enforcement/ corrections personnel are accurate reports.

Table 3. Number of Law Enforcement/Corrections and Healthcare Security Officers

Law Enforcement/ Corrections	204
Healthcare Security	107

Restraints

In the majority of cases (62%) where prisoners have escaped, their restraints were partially or completely removed. For example, in order for a prisoner to get an MRI, metal restraints must be removed. There are plastic restraints that may be used instead of metal restraints, but in some cases they were not used. Furthermore, restraints were sometimes removed when a prisoner was asked to change into a hospital gown or requested to go to the bathroom. Yet, prisoners are usually required to be accompanied at all times by at least one armed custodial officer who is required to be near the prisoner at all times, but out of reach and one unarmed officer at the inmate's side.

In order to determine how prisoners actually escaped custody each agency involved in the incident was asked to describe the sequence of events, including when and why restraints were removed. Table 4. lists the number of times restraints were removed from prisoners who escaped.

Table 4. Restraints Removed

Restraints Removed	
Yes	68
No	31

If restraints were removed, why?

As previously noted, there were a number of explanations offered

for the reason for removing restraints. The three most common reasons given were: 1) to go to the restroom; 2) to receive a medical procedure; and, 3) when a prisoner needed to remove his/her clothing to change into a hospital gown. In addition, restraints were sometimes removed because the prisoner complained about wrist, ankle or stomach pains.

In just such an incident, a male inmate was sent to a major hospital associated with a university for medical treatment of cancer. Six other inmates were being treated at the same time. Corrections officers removed the prisoner's ankle and leg restraints so that he could change into a hospital gown. He escaped custody of the officers when he bent over to untie his shoes and ran from them. It is thought that he planned the escape since he appeared to know the layout of the hospital as he escaped through a side door in the basement. Although hospital security was immediately notified, he was still able to steal a vehicle from a visitor in the parking area in front of the hospital which he did by pushing the female visitor to the ground and taking the keys to her car that were in her hand. He then led officers on as ten mile chase on a freeway going in the wrong direction. He was killed when he crashed the car, though no one else was injured. The corrections officers were cited for failure to follow procedures. This case was surprising similar to one reported at another university hospital. In the interview with corrections officials, the spokesperson said that "We made several mistakes. We had a female corrections officer with the patient when we should have used a male officer because the prisoner was a large male. We made a mistake when the officers removed all restraints when the prisoner was changing into a hospital gown. We have learned from our experience and these kinds of mistakes will not occur again. We intend to provide more rigorous training to all of our officers."

There have also been escapes made that are almost humorous were it not for the potential harm associated with an escape. In one case that occurred at a hospital in the midwest, a prisoner had his wrist cuffs removed so that he could put on a hospital gown. He had already removed his clothes for medical treatment, but re-

quested a restroom break before putting on the hospital gown. In the restroom, he removed a ceiling tile and escaped through the vent. He was entirely naked but escaped the hospital and was stopped by hospital security personnel immediately in front of the entry way. Officers were suspicious of a naked patient. When interviewed, the hospital security guard stated that when he saw the patient, "I knew the situation was suspicious because we don't often have patients outside the hospital in their birthday suits."

Injuries/Deaths

Far more serious are prisoner escapes that involve injuries or deaths. This study found that injuries associated with attempted or completed escapes happen fairly frequently, but are most likely to involve law enforcement/corrections staff. Occasionally, a healthcare security professional is also injured, but these incidents are relatively rare.

Deaths are also rare occurrences in escapes, but they but they do happen. Respondents were asked for information about injuries/deaths that were associated with attempted or completed prisoner escapes. This is probably an undercount of actual injuries, because they are not always reported or made public by either healthcare facilities or law enforcement/corrections officials. Table 5. lists the information provided.

Most injuries that prisoners cause were inflicted on law enforcement/corrections officers, followed by staff from healthcare security. In the most unfortunate circumstances murders occur. In separate events, two women were killed by escaped convicts before they were captured. In one case, a woman died after being assaulted by a prisoner attempting to steal her car. In another case, a woman was killed when she was kidnapped by an escaped prisoner. In this study, five individuals from the local community were injured when assaulted. For example, one female university student was assaulted and her car stolen during a hospital escape by an inmate. As can be seen from Table 5., prisoner escapes are often associated with injuries as well as in rare cases, deaths.

In one interview with law enforcement officers in a case that

involved a death, the officer in charge stated that "by the time we were in pursuit of the inmate, he had already kidnapped a female and forced her to accompany him in her vehicle during the escape. When she protested, he strangled her."

Weapons used during escape

The only weapons reportedly used by prisoners during their escapes were the weapons of the law enforcement/corrections officers or healthcare security staff or the restraints placed on prisoners. Most escape incidents that involved injure occurred when prisoners were able to wrest officers' guns, Tasers, pepper spray or batons from them. Also reported were incidents where prisoners used their restraints to disable officers by hitting them with metal re-straints. There were a handful of cases (4) in which accomplices brought guns into the hospital to assist in prisoner escapes.

Additional Features of Prisoner Escapes

Most prisoners were caught within minutes of their escapes, though some were able to escape for a day or two before being recaptured. In only one case was an inmate able to elude law enforcement officers for more than one month.

The methods by which prisoners escape, in the majority of cases, involved assault of inmate guards. But a number of prisoners (12) just walked out of the hospital, sometimes only in their underwear or a hospital gown. In one case a prisoner was handcuffed, but pushed a private security guard outside the healthcare facility to the ground and stole the officer's SUV to make his escape. Five incidents of prisoner escape (5%) occurred with the help of accomplices who entered the hospital or waited in cars/vans outside the entrance. One maximum security prisoner escape was facilitated by accomplices who engaged in a shoot-out with correctional officers at the hospital. The prisoner and his accomplices were able to escape in a van that had been parked near the emergency entrance.

In another case where a felon was taken to the emergency room for treatment of possible seizures, he was unshackled for a restroom visit and escaped from the rest-

room when his guard has fallen asleep in a chair outside the restroom. Surveillance equipment showed him walking away from the hospital.

In another case, when an inmate was taken to a hospital for treatment, an unnamed hospital official signed an admission form stating that the hospital had taken custody of the inmate and the deputy who had transported the inmate drove away, leaving the prisoner inside the entrance to the admissions area. The prisoner simply walked out the door and was at-large for several days before being captured. In an interview with a spokesperson for the hospital, he claimed that the hospital was not responsible for the escape because it was not a custodial facility with sworn police officers in its employ. Clearly, there were mistakes made on both sides, though following procedures and policies should have prevented the incident. Very rarely, but not unknown, an inmate escape involves criminal behavior on the part of law enforcement officers. In one case an inmate bribed two local law enforcement officers and he was allowed to walk away from the hospital. The officers were fired from their jobs and charged with criminal violations.

CONCLUSION AND RECOMMENDATIONS

In interpreting the data that were collected, it appears that prisoner escapes most frequently occurred when policies or procedures were not followed according to regulation and practice. Other cases of escape occurred when corrections/law enforcement or healthcare facility security staff misinterpreted policies because the language of the policy was not clear, or there was confusion about who was supposed to have custody or control of a prisoner patient.

In addition, delays in contacting both hospital security and local law enforcement added to conditions that allowed prisoners to escape and remain at large. In some hospitals, for example, a case-by-case decision is made about whether to provide armed guards to escort inmates while receiving treatment.

Some prisoners escaped because the equipment used to restrain them was faulty. For example, one prisoner escaped

when his handcuffs failed to completely close. He was able to free his hands and assault the custodial officers and run out of the hospital. On occasion, Tasers did not work. Another escape occurred when security guards tried to use pepper spray to subdue a 6'5" inmate. Both canisters failed and he was able to escape by using an ice pick and a hammer found in the hospital to assault staff and law enforcement officers.

In most cases identified in this study, if appropriate procedures and policies had been followed, it would have significantly reduced the incidence of prisoner escape. All too often, corrections or law enforcement officers partially or completely removed restraints. As noted previously, healthcare staff sometimes pressured security professionals to remove restraints. The conflicting approaches to medical treatment and to securing prisoners is awkward, but to safeguard the general public, law enforcement, corrections and healthcare security officers need to follow security regulations and guidelines to prevent prisoner escapes. It cannot be understated that treating prisoners poses great risks, but following standard operational procedures would do much to reduce such risks. As noted by the Joint Commission (2009), "[healthcare] leaders must recognize that all [adverse] events involve a failure in the systems and processes which led to the event."

The following recommendations are made to suggest ways to reduce or eliminate prisoner escapes from healthcare facilities.

•Develop and/or use standard procedures and policies for managing prisoner patients. If necessary, increase training and/or the frequency of training to law enforcement/corrections officers and appropriate hospital staff members.

•Encourage all HCFs to use the IAHSS Basic Guideline for Prisoner Patients to compare existing prisoner (forensic) patient policies to those recommended in the IAHSS guidelines

•Encourage use by HFCs of the IAHSS Basic Guideline for Prisoner Patients to develop and maintain internal policies and procedures

•Consider on-line training courses for law enforcement and corrections staff covering essential security elements required for

providing security of prisoner patients. An excellent example of on-line training is the State of Florida's program

•Provide adequate training for appropriate healthcare staff, particularly those who work in emergency departments and in prisoner treatment clinics

•Provide training in prisoner security for healthcare staff who contract with law enforcement and corrections to provide medical care to prisoners

•HFCs should consider review of corrections custody protocols to reasonably assure an appropriate level of custody for prisoner patients

•HFCs caring for large volumes of prisoners should evaluate the risks posed and weigh the need for additional security measures

•HFCs caring for large volumes of prisoners should consider conducting prisoner escape drills

•Utilize this study to review the risks associated with caring for prisoner patients with healthcare staff responsible for contracting for prisoner care

•Conduct further studies of prisoner escapes with prisoners to ascertain reasons for escape and utilize findings to enhance security measures

•Lobby for the creation of a "Clery Act" for reporting all criminal incidents that occur in hospitals while "holding harmless" hospitals that report prisoner incidents and other crimes

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