

The Officers' Perspective

**A Rebuttal to Dean Williams'
Administrative Review of the Alaska
Department of Corrections**

April 4, 2016

Walking Alaska's Toughest Beat

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Introduction

On August 10, 2015, Governor Bill Walker appointed Special Assistant Dean Williams¹ to conduct an administrative review of the Alaska Department of Corrections (DOC). On November 13, 2015, three months later, the “*Alaska Department of Corrections: An Administrative Review*” (hereinafter Administrative Review) was released. The Administrative Review publicly ridiculed Correctional Officers for doing their jobs. These Correctional Officers were performing their duties in accordance with their training, policy, and national corrections practices. In many instances cited, the Correctional Officers not only acted appropriately, but acted heroically in their efforts to save the lives of inmates. Dean Williams stated that he would be transparent and honest, yet many parts of the Administrative Review are not transparent or honest. Instead, he made many deceptive and misleading statements about Officers’ actions. He manipulated and tampered with video evidence by removing the audio, presented several false narratives, downplayed the chronic understaffing in facilities, and incorrectly blamed Correctional Officers for many of the issues within the DOC.

On December 8, 2015, Dean Williams released institutional videos of Correctional Officers and appeared before a Joint House and Senate Judiciary Committee Hearing to brief Legislators and narrate DOC security camera videos and photos regarding the recent inmate deaths. He did so without blurring the faces of the Correctional Officers, which put them and their families at risk. He failed to inform the public and the Legislators that the Officers seen on the videos and in the photos were performing as trained and as required by DOC policies that conform to national corrections standards to maintain security and control within correctional facilities. Dean Williams made false and misleading statements that the Officers’ actions were inappropriate and contributed to inmate deaths. Without properly educating the public, or even referring to the policies that govern Officers’ actions, Dean Williams’ Administrative Review and analysis of the videos were incorrect and, at times, deliberately deceptive. His presentation, in conjunction with the Administrative Review, caused widespread negative public reaction toward Officers, putting over 1,800 Alaska correctional employees and their families at risk.² After the Administrative Review was released, the Administration removed Ron Taylor as Commissioner and replaced him with Dean Williams. Dean Williams aggrandized himself throughout the process, at the expense of Correctional Officers, in what appears to be a ploy to become Commissioner of Corrections. Unfortunately, many of the real problems within the DOC were never truly addressed.

¹ The Administrative Review referred to Dean Williams and Joe Hanlon as the ‘Review Team,’ but Correctional Officers and the Association saw little involvement by Joe Hanlon. It seemed as if Joe Hanlon’s role, as a former FBI agent, was more to provide the appearance of credibility for Dean Williams than to provide substance. Regardless, Dean Williams positioned himself as the primary spokesperson for the Administrative Review and is now the DOC Commissioner. Accordingly, the emphasis will be placed on Dean Williams as he was the one who provided a majority of the analysis after the Administrative Review was released. Dean Williams, not Joe Hanlon, made the false statements about application of DOC Policy & Procedures and implied that Officers used excessive force.

² The chapter entitled “Administrative Review Endangered Officers” further outlines many of the threats that were made against Correctional Officers since the improper release of Officer images and actions without proper explanation. Included here are just four examples: (1) “*Find out where each & every one of these officers live and pay them a visit! It’s called seek and destroy? These punks trashing on natives & killing them. Maybe these idiots are looking for a race war. GEAR UP!*”; (2) “*This is why people riot. Nothing will change without spilling blood*”; (3) “*They should get the guillotine!*”; and (4) “*THOSE GUARD GOT A WATCH THEIR BACK NOW.*”

Dean Williams made numerous accusations of alleged wrongdoing either unsupported by fact or based on limited and irrelevant evidence. He was given, both verbally and in writing, all the information necessary to write a transparent, truthful and accurate report.³ This included two extensive reports provided by the Alaska Correctional Officers Association (Association), one on staffing, and one on past and current issues within the DOC. Neither incompetence nor inexperience can account for the false allegations and misrepresentations against Correctional Officers contained in the Administrative Review. Dean Williams asked Officers if they had heard any rumors concerning DOC employees. He then used the rumors to support self-serving, false conclusions to elevate his own personal status and credibility as an investigator at the expense of facts, evidence, and Officers in DOC.

Two examples are Dean Williams' statements that "*a correctional officer assaulted an inmate*"⁴ and a "*correctional officer's report to be false.*"⁵ Both accusations were false. In these situations, he is referencing an Officer who did not assault an inmate and an Officer who did not write a false report. Dean Williams did not speak to either Officer in the above-mentioned cases and he rarely spoke with the Officers involved in any of the cases referenced in the Administrative Review. He took hearsay from individuals who were not directly involved to generate inaccurate conclusions which he used to his personal advantage. He also ignored evidence presented to the contrary, including numerous reports, memos and the concerns of those who work in Corrections. Like *McCarthyism*, he used bits and pieces of information to build his own case and spread unnecessary concern about problems that did not actually exist, thereby increasing his importance with every allegation he "discovered." Then, after being appointed Commissioner, when questioned about discrepancies in his report he stated, "*I understand if people disagree with my recommendations at the time ... I'm not going to get into a debate on a point-by-point basis.*"⁶ To the Officers involved, this is unacceptable. If Dean Williams is not even willing to stand by his own allegations, why were those allegations made public in the first place?

Correctional Officers and the Association informed Dean Williams and Governor Walker that there were numerous inaccuracies and omissions in the Administrative Review. The Association does not shy away from fair and open investigations. This investigation, however, was neither fair nor open. At first, Correctional Officers hoped the falsehoods and omissions in the Administrative Review would be quickly corrected; however, Dean Williams then released additional photos and videos, and presented even more false and misleading statements about Correctional Officers. After four months of waiting, neither Dean Williams nor the Governor, who is relying completely on Dean Williams' word that the Administrative Review is accurate, has come forward to retract the inaccuracies or exonerate the Correctional Officers. These unprecedented and misguided attacks on the character of Correctional Officers, followed by Dean Williams' appointment as DOC Commissioner, suggest that his agenda,

³ This includes two reports given to Dean Williams by the Association and conversations with Correctional Officers giving him the facts about incidents within the DOC. These facts were either ignored or covered up.

⁴ See "Administrative Investigations - Situation 1" on page 35 below for further discussion on this example.

⁵ See "Administrative Investigations - Situation 2" on page 37 below for further discussion on this example.

⁶ January 1, 2016 Alaska Dispatch News article, "Alaska prison guards union alleges bias in report on inmate deaths" <http://www.adn.com/article/20160129/alaska-prison-guards-union-alleges-bias-report-inmate-deaths>

motives, and the misrepresentations in the Administrative Review were intentional and will be an underlying theme throughout his tenure as Commissioner.

The public release of these videos and the misinformation released by Dean Williams divert attention from the role understaffing plays in compromising safety and its contribution to inmate deaths. Statewide, it has also undermined and demoralized Correctional Officers, who have one of the toughest jobs in law enforcement, and it has negatively impacted the safety and security of incarcerated Alaskans. Recruitment to fill Correctional Officer positions will become more difficult if prospective applicants have incorrect, negative perceptions of their potential co-workers in the institutions. Rather than continuing to expose Correctional Officers to unnecessary public ridicule and harm, Officers expect their new Commissioner to honor his pledge that safety is his top priority⁷ and that he will confront the many issues which have been recognized for years within the institutions, such as understaffing.

Dean Williams is now Commissioner. However, without correcting his Administrative Review, Correctional Officers are still being directed to carry out the same policies that he vilified Officers for following when he was the Governor's appointed investigator. Officers are now in a catch-22 because Dean Williams' narratives were severely misleading and inaccurate. Furthermore, the very policies he criticized Officers for following remain absolutely necessary to maintain safety and security in a corrections environment. On February 16, 2016, the Association's Board of Director sent Dean Williams a letter asking for clarification on some of the policies he publicly spoke against, yet continues to require Officers to follow.⁸ Unfortunately, as of this date (over a month and a half since the Commissioner received the letter), Correctional Officers still have not received a response. This is an inexcusable failure of communications between the Commissioner and DOC employees, and places Correctional Officers at risk.

Since Dean Williams refuses to address or retract his statements against Correctional Officers, the Association has no option but to force the issue by providing this publication to the Governor, Legislators, Correctional Officers, and the public. This Association has a responsibility to respond to these false accusations and misrepresentations because the innocent Officers mentioned cannot. Correctional Officers are barred from defending themselves against this public ridicule by their Employer.⁹ The innocent Officers involved need a retraction, it is only fair that their reputations be restored.

⁷ In a statewide DOC email sent on February 3, 2016, Dean Williams wrote "I have been asked by many what my vision is for the Department. The top three priorities for me right now are: safety, safety, safety."

⁸ <http://www.acoa.us/wp-content/uploads/2016/03/2016-02-16-Expectation-of-Officers'-Actions-in-the-DOC-Letter.pdf>

⁹ DOC Policy 202.15 (Standards of Conduct) states, "All official statements for public release concerning the affairs of the Department must be authorized by the Commissioner, a Director, or designee.", <http://www.correct.state.ak.us/pnp/pdf/202.15.pdf>

State of Corrections: Inmate Deaths

Any time an individual dies while incarcerated it is a tragedy for all involved. Throughout their careers, Correctional Officers get to know the many inmates they work around, learning their names and stories. When an inmate passes away in a facility, Officers are saddened, as well as family members and friends. Many inmates have compromised physical and/or mental health upon entering an institution. According to the DOC, 65% of Alaska inmates have a diagnosable mental health disorder and as much as 80% of the Alaska inmate population has struggled with substance abuse disorders. Compared nationally to other Americans of the same age, “prisoners are 31% more likely to have asthma, 55% more likely to have diabetes, 90% more likely to have a heart attack, and 100%-300% more likely to have a serious mental illness.”¹⁰ However, Officers are not trained medical staff. Once an individual is admitted to a facility, Officers cannot make decisions regarding an inmate’s health, treatment plans, or placement in or out of the institution’s medical facility.

Nonetheless, Officers often recognize when an inmate is medically or mentally unstable and they are regularly informing the facilities’ medical personnel. Unfortunately, in many cases, medical personnel either refuse to see the inmate and/or disagree with the Officers’ assessment. Such was the case with Devon Mosley when Officers appealed to medical staff to get Mr. Mosley the help he needed. Another case is that of Kellsie Green,¹¹ where Officers asked without success for her to receive medical assistance. Our sympathies go out to all of the families. While it is terrible that their loved ones passed away, it is wrong to blame the Officers, who followed their training and DOC policies. It is misguided and inexcusable to ignore the fact that two studies show Alaska’s Correctional institutions are dangerously understaffed.

There is a tremendous burden on Correctional Officers and medical and mental health staff caused by inadequate staffing to meet the healthcare needs of this vulnerable population, many of whom need to be in fully-staffed medical facilities to appropriately address their medical and mental health needs. It is inappropriate and disingenuous for the DOC to hold a Correctional Officer accountable when, by no fault of the Officer, an inmate dies while incarcerated, especially since Officers have no control over the inmate’s life decisions, DOC’s staffing decisions, DOC’s medical decisions, or DOC Policies &

“Throughout their careers, Correctional Officers get to know the many inmates they work around, learning their names and stories. When an inmate passes away in a facility, Officers are saddened as well as family members and friends.”

¹⁰ April 3, 2015 DOC White Paper - http://gov.alaska.gov/Walker_media/documents/medicaid-expansion/20150403_DOC-white-paper.pdf

¹¹ January 11, 2016 KTUU Newscast “Latest inmate to die in Anchorage jail was there for community work service violation”, <http://www.ktuu.com/news/news/latest-inmate-to-die-in-anchorage-jail-was-there-for-community-work-service-violation/37381990>

Procedures. DOC spokesperson Sherrie Daigle stated, “*Many inmates come to the department from exceptionally difficult lifestyles - generally not conducive to overall good health.*”¹² Correctional Officers should not be held responsible when the DOC acknowledges publicly that inmates come from difficult lifestyles, not conducive to overall health, and a certain number of deaths are unavoidable.¹³ However, Officers are still singled out to deflect attention from the DOC’s refusal to provide adequate Correctional Officer staffing as a way of cutting costs and its continuing impacts on inmate and staff safety. Continued and documented understaffing has led to more deaths and assaults and has further exacerbated a volatile and dangerous situation. In the recent death of Kellsie Green, the DOC, not Correctional Officers, determined that it was unnecessary to staff the Alpha Mod (the female intake mod where Ms. Green passed away) with a Correctional Officer position 24 hours a day. Had DOC spent the money for adequate staffing, to continue the previous policy of having an Officer assigned to this position, Ms. Green might still be alive today.

While Dean Williams reviewed 22 case files on inmate deaths, he chose to detail four deaths more thoroughly in his report.¹⁴ One cannot help but wonder why he did not comment, at least in brief, on the remaining 18 deaths he reviewed.¹⁵ Perhaps he did not because they could be a direct outcome of DOC’s decision to understaff the facilities and the resulting negative impacts on inmate safety. Commenting on all of the inmate deaths may focus too much attention on the significant and ongoing understaffing within the DOC. Alaska’s Correctional Officer understaffing was first recognized as far back as 1997,¹⁶ then again in 2010,¹⁷ and most recently, in 2016.¹⁸ The Association provided Dean Williams with a copy of the 2010 Legislative Audit and the DOC had the 2016 CGL study, which had already been completed.

Reducing inmate deaths in institutions requires systemic changes so that individuals with acute medical and mental health conditions receive the care they need. The DOC is not staffed or equipped to house medically demanding individuals, just as medical facilities are not prepared to house assaultive or combative criminals.

¹² As quoted from a June 20, 2014 Anchorage Daily News article, “*The Alaska Department of Corrections says four deaths in the span of a few months is not out of the ordinary, and even to be expected. Ten to 12 people, on average, die each year in state custody. Prisoners are more likely to have compromised health, officials say.*”, <http://www.adn.com/article/20140620/after-fourth-alaska-jail-death-french-calls-hearing-0>

¹³ In a May 1, 2014 news story by KTUU Laura Brooks, the DOC’s Health Care Administrator, said, “*The department experiences an average of 10 to 12 deaths a year....*”, <http://www.ktuu.com/news/news/autopsy-on-dead-inmate-reveals-ulcers-internal-bleeding/25766314>

¹⁴ Alaska Department of Corrections: An Administrative Review November 13, 2015, Page 2

¹⁵ One notable omission was the Israel Keyes case. Correctional Officers and the Association specifically mentioned this case to Dean Williams as a case where there was a mental health cover up and said that it needed to be investigated. Israel Keyes was suicidal and was found with a suicide note and suicide equipment in his cell, and moved to a suicide cell. Then, inexplicably, he was taken off suicide precautions, and he promptly committed suicide. Correctional Officers have asked for years how this could happen and who made the decision to remove him from suicide precautions.

¹⁶ Case No. 3AN-81-5274 Civil, Cleary Lawsuit) Court Appointed Monitor’s Report (February 1997 – August 1997)

¹⁷ Legislative Audit Control No. 20-30053B – 10, March 5, 2010, Department of Corrections Selected Health and Safety Issues, Part 2, <http://www.acoa.us/wp-content/uploads/2016/04/2010-Legislative-Audit.pdf>

¹⁸ System Staffing Analysis, Alaska Department of Corrections, February 9, 2016, prepared by CGL, <http://www.correct.state.ak.us/doc/corrections-staffing-report.pdf>

Case 1: Anchorage Correctional Complex, Devon Mosley

Dean Williams' Administrative Review details Devon Mosley's deterioration and unfortunate death while incarcerated at the Anchorage Correctional Complex (ACC).¹⁹ Although Dean Williams delves into system-wide shortcomings,²⁰ he misled many to believe that Correctional Officers were responsible for Mr. Mosley's death when, in fact, Correctional Officers were in no way responsible. Officers recognized Mr. Mosley's deteriorating condition and on multiple occasions asked for help from both Management and Medical staff to get Mr. Mosley the care he needed. Dean Williams' comment that, "*The apparent disregard for Mr. Mosley's condition was profound[.]*"²¹ is disparaging to the Officers involved. During their interactions with Mr. Mosley, Correctional Officers acted appropriately, as trained, and in compliance with standard correctional practices and written DOC Policies & Procedures. In this case, as in many others, Dean Williams failed to interview a majority of the Officers involved before publishing the Administrative Review, which indicated the Officers were at fault. He also ignored the memos and reports from these Officers when writing the Administrative Review which, in turn, led to damaging public statements against the Officers.²²

"Correctional Officers acted appropriately as trained and in compliance with standard correctional practices and written DOC policies."

Mr. Mosley's initial placement in Administrative Segregation on March 20, 2014 complied with DOC Policy & Procedure 804.01.²³ In stark contrast to Dean Williams' comment in his Administrative Review that "*Solitary confinement, also known as segregation, is used in Alaska's correctional facilities for three main purposes,*" DOC Policy & Procedure 804.01, in fact, lays out ten reasons why the DOC may assign an inmate to Administrative Segregation.²⁴ Additionally, solitary confinement and segregation are not synonymous as Dean Williams insinuates. Solitary confinement has a "Cool Hand Luke" connotation of an individual being locked in a small dark box without human interaction for hours or

¹⁹ Alaska Department of Corrections: An Administrative Review November 13, 2015, Page 10

²⁰ Alaska Department of Corrections: An Administrative Review November 13, 2015, Page 16 – "*The loss of duty posts – correctional officer positions – dominated the concerns correctional officers communicated to the Review Team. The Alaska Correctional Officers Association provided a detailed analysis of position losses from the union's perspective. Staff reductions can have significant impacts on safety and staff morale.*"

²¹ Alaska Department of Corrections: An Administrative Review November 13, 2015, page 11

²² See "Administrative Review Endangered Officers"

²³ Department of Corrections Policy and Procedure 804.01, <http://www.correct.state.ak.us/pnp/pdf/804.01.pdf>

²⁴ "(1) has not been classified since initial admission to the institution, or has not yet had a physical examination under policy #807.14, Health Examinations; (2) is incapacitated; (3) is suffering or is suspected of suffering from a communicable disease; (4) is prescribed segregation by a physician, physician's assistant, or mental health professional based upon his or her mental or physical condition; (5) requests the segregation and demonstrates a valid security-related or medical reason for the segregation; (6) is detained as a non-criminal hold under A.S. 47.30.705 or A.S. 47.37.170; (7) is being held as a material witness under a court order; (8) presents a substantial and immediate threat to the security of the facility or public safety; (9) requires protective custody; (10) requires the most restrictive housing based on the inmate's behavior which represents a severe threat to the safety and security of the facility. These inmates will be identified as Administrative Segregation Maximum and the criteria for placement are further defined below in Section B. 3."

days. Segregation is very different as inmates still have the ability to use the phone, communicate with each other, and leave their cell for multiple hours per day for various reasons. Additionally, many “segregated” inmates have one or even two cellmates. Policy 804.01 defines Administrative Segregation as “A form of separation from the general population imposed by the Superintendent or his/her designee when the continued presence of the inmate in the general population poses a serious threat to life, property, self, staff, or other inmates or to the security or orderly operation of the institution.” Section VII.B.1.a. (Procedures) of that same policy states, “A staff member may immediately place an inmate in segregation if he or she reasonably believes that the inmate presents a substantial immediate threat to him or herself, others, the security of the facility, or the public.”

Mr. Mosley’s initial placement was the proper response to his menacing statements and attempts to fight Correctional Officers.²⁵ Dean Williams testified at a Joint Judiciary Committee on December 8, 2015 that, “On 3/20 Mr. Mosley was taken to segregation for challenging a CO to fight. I don't think he actually fought anyone. It doesn't appear that he did. He voluntary handcuffed up on this day[,]” followed up with “He was escorted to segregation without incident.” This implies that because Mr. Mosley did not follow through with his threats of violence at that time and eventually allowed Officers to put handcuffs on him, his behavior was not sufficient to warrant segregation. Segregation is used as a preventative measure as opposed to reactive. How would the safety of everyone be compromised if, prior to being segregated, an inmate first had to physically strike another individual? Without the ability to segregate individuals behaving as Mr. Mosley was, assaults and injuries would significantly increase in the institutions.

The fact is that, during his incarceration, Mr. Mosley was combative and threatening, and in this situation he “voluntarily” cuffed up only after additional Officers arrived. Having additional Officers arrive is a low level show of force used to gain compliance per policy and simultaneously prepares for non-compliance. Placing Mr. Mosley on Administrative Segregation for his initial menacing statements and hostile posturing was in accordance with policy and the only wise course of action given the circumstances. Had Mr. Mosley’s behavior changed, and if he had not given Officers concern later on that he was suicidal, his stay in segregation likely would have been short.

Dean Williams further testified that Mr. Mosley “was sprayed with human pepper spray that first day.”²⁶ Mr. Mosley was admitted to the segregation unit at approximately 8:30 p.m. on March 20, 2014. Pepper spray was not administered to Mr. Mosley the rest of that day. Dean Williams also stated, “later on the same day, Mr. Mosley again got a very large blast of the spray.”²⁷ However, his chronology of events is incorrect. The incident resulting in the use of pepper spray did not occur until March 22, 2014. Not only did he have the dates wrong but, more importantly, during his testimony he also failed to inform

²⁵ “On March 20 Mr. Mosley challenged a correctional officer to a fight and made menacing statements.” Alaska Department of Corrections: An Administrative Review November 13, 2015, page 10

²⁶ From the Minutes of the Joint Meeting of the House and Senate Judiciary Committees December 8, 2015, <http://www.legis.state.ak.us/PDF/29/M/SJUD2015-12-081037.PDF>

²⁷ Ibid.

the Judiciary Committee members of the events that led to Officers needing to utilize pepper spray or that the Officers were appropriately following the DOC Policies & Procedures when it was applied.

Dean Williams wrote, “On March 22, 2014 the segregation log book noted that, Mosley was tearing clothes and trying to break the camera; was sprayed when he did not comply.”²⁸ What was not articulated by Dean Williams was that the floor of Mr. Mosley’s cell was covered with trash, food, urine, and water from the toilet. Dean Williams also fails to mention that torn institutional clothing is often used to attempt suicide or clog toilets, flooding cells and surrounding areas. Correctional Officers could not leave Mr. Mosley in this unsanitary cell or allow him to damage the security camera. Therefore, Officers gave Mr. Mosley several commands to place his hands outside the tray slot so that handcuffs could be placed on him and he could be moved safely to another cell while his cell was cleaned. Mr. Mosley refused to comply with these verbal commands.



(Figure 1 - Images from video publicly released by Dean Williams to Judiciary Committee on December 8, 2015)

Instead, he assumed a fighting stance and flipped the Officers off (as seen in these images). Policy directs Officers to use the appropriate level of force necessary to protect life, prevent physical injury, prevent state property damage, compel compliance with orders, or prevent or quell a disturbance. Mr. Mosley was pepper sprayed to gain compliance with the order to submit to being cuffed. The alternative would have been for Officers to enter his cell with the floor slippery from the urine and go “hands-on”²⁹ to place him in restraints, an alternative with a high probability that someone would slip on the wet floor and possibly expose Officers to hazardous bodily fluids or risk injury to Mr. Mosley and the Officers. No competent, trained Officer would have chosen this option, especially because it would have been contrary to DOC Policies & Procedures. Dean Williams misled Legislators and the public when he failed to explain the corresponding actions Correctional Officers are required to take to protect themselves, inmates, the State, and the public.

²⁸ Alaska Department of Corrections: An Administrative Review, November 13, 2015, page 10

²⁹ A term used in law enforcement which signifies that Officers must physically touch another individual, in this case, to gain compliance.

Later in his Administrative Review, Dean Williams states, “*In one interaction, Mr. Mosley was sprayed with pepper spray in his cell. Correctional officers reported they sprayed Mr. Mosley because he pulled away from correctional officers who were trying to un-cuff him. The video reveals Mr. Mosley had fallen down before he was sprayed, and posed no immediate threat. He is in his cell with the door closed.*”³⁰ This comment shows a lack of institutional knowledge and recklessly adds to the incorrect perception that Correctional Officers were mistreating Mr. Mosley. Mr. Mosley did not fall down; he pulled away with so much force that he broke the strap that was attached to the chain portion of the handcuffs.³¹ Bear in mind that earlier Mr. Mosley was segregated for challenging an Officer to a fight, menacing behavior, and expressing suicidal intentions. Mr. Mosley had already shown himself to be aggressive and combative, he did not comply with the Officers’ orders, and he had just pulled away from the Correctional Officers attempting to uncuff him. Mr. Mosley now had a set of handcuffs attached to his wrist, which can be, and on many occasions have been, used as a weapon to seriously harm Officers and/or the person using it. Mr. Mosley had just struggled free while being uncuffed and was still being non-compliant.

“Pepper spray is an important tool and its use has greatly reduced the frequency and severity of inmate and Officer injuries.”



(Figure 2 - Images from video publicly released by Dean Williams’ to Judiciary Committee on December 8, 2015)

Readily identifiable in the Figure 2 pictures, which were taken from the video Dean Williams had access to, are the handcuffs and suicide smock. In addition, if he had listened to any of the Officers involved in this incident they would have explained the situation and the DOC Policies & Procedures that governed their actions.

³⁰ Alaska Department of Corrections: An Administrative Review November 13, 2015, Page 10

³¹ Due to Mr. Mosley’s prior behavior of pulling away while the handcuffs were being removed, Officers decided that a cuff retainer needed to be placed on the handcuffs. A cuff retainer is a strap with a clip on the end that attaches to the chain portion of the handcuffs so the prisoner will not be able to pull away.

Mr. Mosley refused to comply with the verbal orders to back up to the cell door to safely complete the uncuffing process. With the cuff hanging from his wrist, he posed an immediate threat to himself and to anyone entering the cell to remove it. The Officers appropriately used pepper spray to gain compliance, allowing the cuff to be safely removed without anyone being hurt. The Use of Force Policy 1207.01 instructs Officers to use appropriate levels of force to compel compliance. Since Mr. Mosley was not complying with orders to allow the uncuffing process to be completed and ignored verbal commands to comply, it was reasonable for Officers to use pepper spray rather than hands-on physical force to de-escalate the situation. The Officers did as they were trained, as authorized in the Use of Force Policy, and safely ended his threatening and self-destructive behavior. Had Mr. Mosley not pulled away with the handcuffs remaining on his wrist, and if he had complied with directions to allow Officers to remove the handcuffs, Mr. Mosley would have not been pepper sprayed.

Pepper spray is an important tool and its use has greatly reduced the frequency and severity of inmate and Officer injuries.³² Pepper spray is the safest option for the prisoner and staff. Pepper spray has no lasting effects, nor does it cause permanent injury. All Correctional Officers in Alaska are sprayed when going through the Academy. It is important for Officers to understand the effects of pepper spray because many times, when it is utilized in the institution, the Officers will suffer the same effects as the inmates. If pepper spray is not effective, then the next step would be to have Correctional Officers suit up in protective gear, gain entry to the cell, and forcibly remove an inmate from a cell or an item from an inmate. This scenario risks injury to staff and the prisoner. Recklessly, and in direct contradiction to the DOC policy and its proper application, Dean Williams inappropriately and incorrectly concluded, “*I see no justification,*” in regard to the Officers’ use of pepper spray.³³ That he saw no justification reflects his lack of training and knowledge; had Dean Williams been there, directing this situation, someone could have been seriously injured. Dean Williams, with no Adult Corrections experience, either does not recognize a true safety threat or failed to fully understand and investigate the situation by asking an expert whether his conclusion was accurate. He also failed to speak to most of the Correctional Officers involved in this incident to find out why they applied the pepper spray. Dean Williams did speak directly to the Sergeant who supervised Mr. Mosley, yet ignored the Sergeant’s explanation of proper procedures. If these Officers had not acted as they did, and if they had left the handcuff on Mr. Mosley, they would have been disciplined. Dean Williams has in effect created a catch-22, in which Officers will either be vilified when a policy is adhered to or disciplined when they allow inmates to keep a weapon in their possession.

Dean Williams recognized in the Administrative Review that, “*Over the next few days Mr. Mosley exhibited unusual behavior and threatened to kill himself. Pepper spray was used to stop self-harm*”

³² U.S. Department of Justice, National Institute of Justice “The Effectiveness and Safety of Pepper Spray”, The Study “*found that the number of injuries to police officers and suspects declined after pepper spray was introduced. Complaints that the police used excessive force also declined.*”, <https://www.ncjrs.gov/pdffiles1/nij/195739.pdf>

³³ December 8, 2015 Alaska Dispatch News “Many questions, few answers at legislative hearing on prison deaths” <https://www.adn.com/article/20151208/many-questions-few-answers-legislative-hearing-prison-deaths>

behavior.”³⁴ DOC Policy and Procedure 807.20 dictates that employees shall take suicidal or self-destructive behavior seriously and take immediate actions in situations involving a suicidal individual. The initial suicide intervention required strip searching Mr. Mosley and placing him in a single bed camera cell where he was observed more frequently.³⁵ *“If it is determined that any of the following items could be used by the prisoner to continue the destructive behavior, they will be removed: clothing, bedding, housekeeping items, medications, razors, hobby craft, personal entertainment devices, and matches....”*³⁶ The only safe option given Mr. Mosley’s actions was to place him on suicide precautions.

Dean Williams’ Administrative Review led the public and Legislators to believe Mr. Mosley was left *“naked for many days in a row.”*³⁷ He faulted Officers for Mr. Mosley’s nudity and did not explain that Officers followed DOC’s Policies & Procedures when placing Mr. Mosley on suicide precautions. Because Mr. Mosley stated that he wanted to kill himself, Officers were required to remove all of his clothing and give him only a suicide smock;³⁸ however, Mr. Mosley chose not to wear it. A suicide (or safety) smock is a tear-resistant, single-piece, outer garment, which is thick and sturdily constructed. It is impossible for an individual to form a noose with the smock to attempt suicide by strangulation.³⁹ It provides modesty and warmth while not impeding the individual’s mobility. It is standard practice for a suicidal inmate to be given only a suicide smock. Dean Williams continually tried to convince the public that Mr. Mosley’s nudity was something unusual when it is not. What was unusual was publicly releasing videos of his nakedness. Anyone doing even a cursory review should have noted that giving Mr. Mosley a suicide smock was required by policy and was not simply the Officers’ decision. Mr. Mosley chose not to wear the suicide smock; this was not a choice made by the Officers trying to protect him. Additionally, it would be impractical for policy or practice to require Officers to enter the cells and physically dress individuals who choose to be naked. Forcefully dressing a combative individual who does not want to wear clothes would only lead to additional assaults and injuries.

Dean Williams’ false narrative that Mr. Mosley was left naked for multiple days⁴⁰ led to the following exchange at a Joint Judiciary Committee that was mentioned in a December 8, 2015, Alaska Dispatch News article.⁴¹

³⁴ Alaska Department of Corrections: An Administrative Review November 13, 2015, page 10

³⁵ Department of Corrections Policy and Procedure 807.20, Procedures Form 807.20A, <http://www.correct.state.ak.us/pnp/pdf/807.20a.pdf>

³⁶ Department of Corrections Policy and Procedure 807.20, Policy, <http://www.correct.state.ak.us/pnp/pdf/807.20.pdf>

³⁷ Alaska Department of Corrections: An Administrative Review November 13, 2015, Page 11

³⁸ Policy and Procedure 807.20 Suicide Prevention and Awareness (4.b.1) *“security staff thoroughly search the cell to remove items, devices, and materials that the prisoner could use to continue the destructive behavior. If it is determined that any of the following items could be used by the prisoner to continue the destructive behavior, they will be removed: clothing, bedding, housekeeping items, medications, razors, hobby craft, personal entertainment devices, and matches...”*, <http://www.correct.state.ak.us/pnp/pdf/807.20.pdf>

³⁹ The smock is similar to what movers use to protect furniture during a household move and is stiff and heavy.

⁴⁰ Alaska Department of Corrections: An Administrative Review November 13, 2015, Pages 10 & 11 *“On March 27, Mr. Mosley was naked with only a blanket [suicide smock] and no mattress...On March 28, Mr. Mosley was still naked with only a blanket and no mattress.”*

⁴¹ December 8, 2015 Alaska Commons article, <http://www.alaskacommons.com/2015/12/08/lawmakers-react-damning-department-corrections-report>

“Is he totally naked?” [Legislator] asked incredulously, looking at pictures of Mosley.

“Anchorage correctional officers seemed to take the position that Mosley had lost his chance to have clothes and a mattress after tearing them,” said Williams.

“Being nude is unacceptable in prison,” he continued. Williams made allowances for nudity for short periods like searches, but said, “This was multiple days on end.”

Dean Williams knew Mr. Mosley was given a suicide smock and that he chose not to wear it. These precautions were implemented to prevent Mr. Mosley from attempting suicide.

Dean Williams also made comments suggesting inmates were not being offered showers or phone calls, implying that Officers were denying prisoners their rights and were not doing their jobs.⁴² At the Joint Judiciary Hearing, Dean Williams was asked if Mr. Mosley was allowed to rinse off after being pepper sprayed. Dean Williams responded, *“Mr. Mosley used water in the sink and toilet to rinse himself off.”* He failed to mention that Mr. Mosley was removed from his cell and taken to the shower to rinse off the pepper spray. Dean Williams’ statements deliberately led readers to conclude that these inmates were not being offered showers.

“Correctional Officers acted exactly as trained and required to comply with policy. Their actions were conducted in a manner best suited to protect the life and wellbeing of the individual in their custody.”

Dean Williams also stated in a Legislative Hearing that there appeared to be a three-hour period when Mr. Mosley was not in the video. It was at this time that Mr. Mosley was using the shower. Had Dean Williams watched all the video, he would have seen that Mr. Mosley was escorted to the shower. There is no camera in the shower room, but there is a camera that would have shown Mr. Mosley being escorted to the shower room. The shower room is across the hall from the cell Mr. Mosley occupied. DOC policy requires showers be offered to inmates in segregation at least three times a week.

Dean Williams stated that, *“On March 27, Mr. Mosley was naked with only a blanket and no mattress. The record notes Mr. Mosley had tried to destroy his mattress and flood his toilet. The Review Team had difficulty finding this documentation.”* This contradiction that *“The record notes”* and *“The Review Team had difficulty finding this documentation”* causes uninformed readers to doubt the honesty and integrity of Correctional Officers and causes informed readers to question bias and prejudice on the part of Dean Williams. Attempting to destroy clothing and mattresses is, unfortunately, a common

⁴² Alaska Department of Corrections: An Administrative Review November 13, 2015, page 11 *“Segregation logs indicate Mr. Mosley did not shower for seven days...Segregation logs do not indicate whether Mr. Mosley or other inmates requested a phone call.”*

occurrence in correctional facilities and is how prisoners in segregation cells often act out. Mr. Mosley's attempt to destroy State property on March 27, 2014 is consistent with his behavior on March 22, 2014. Dean Williams' statement is unnecessary and reinforces his intent to cast Correctional Officers in a negative light.

Officers must maintain the security and orderly administration of the facility. Allowing inmates to clog their toilets, flooding their cells, creates health risks, and diverts staff resources and attention from other important tasks. Destroyed items cost money to replace. Clearing clogged toilets and cell drains is time-consuming and expensive for maintenance personnel. Mr. Mosley's attempt to destroy his mattress was an infraction of the prisoner rules contained in the Institutional Handbook and DOC Policy & Procedure 809.02, and his attempt to flood his cell was a prohibited individual demonstration classified as a high-moderate infraction.⁴³ Staff intervened by initially taking away the items Mr. Mosley intended to use to flood his cell. Because he had stated he wanted to kill himself, he was given a suicide smock.

Dean Williams covered up the fact that, in Mr. Mosley's case, Medical refused to deal with this combative inmate. Medical will often identify inmates to have "behavioral" issues rather than "mental health" issues. In this way Medical staff can avoid dealing with inmates who are unruly. Unfortunately, many of these individuals truly need medical or mental health attention. When Dean Williams said he was investigating Mr. Mosley's death, Officers were initially excited, welcoming the idea that the investigation would uncover the deficiencies in inmate health care. Of specific concern to Officers was Medical staff not properly classifying inmates. Not only was this brought to Dean Williams' attention by Officers, but the first words spoken to Dean Williams in person by the Association were that Mr. Mosley's death was covered-up and it was good he was looking into it. Dean Williams was fully informed, yet completely excluded this information from his Administrative Review.

⁴³ Department of Corrections Policy and Procedure 809.02, VII, C.15 and E.4, <http://www.correct.state.ak.us/pnp/pdf/809.02.pdf>

Case 2: Anchorage Correctional Complex, Larry Kobuk⁴⁴

The video of inmate Larry Kobuk, released by Dean Williams on January 6, 2016, contained images of Correctional Officers performing required duties as directed by DOC Policies & Procedures and in accordance with their training. Without educating the public, or disclosing any of the DOC's Policies & Procedures that govern Officers' actions, Dean Williams' publication and analysis of this video in his Administrative Review is severely misleading and prejudicial; a lie of omission. To indicate that the Officers in the video are somehow responsible for Mr. Kobuk's death is a defamatory attack on the Officers and it puts all Officers at risk. Dean Williams did not disclose to the public that he manipulated the video to remove the audio, omitted critical evidence and hid the fact that Mr. Kobuk continually threatened to kill Officers. Dean Williams also failed to explain that Officers' actions were appropriate per DOC policy, training, and national standards, which would have provided much more appropriate context in the Administrative Review.

“Dean Williams did not disclose to the public that he manipulated the video to remove the audio, omitted critical evidence and hid the fact that Mr. Kobuk continually threatened to kill Officers.”

Dean Williams misinformed the public when he wrote, *“There was no personnel investigation in this case.”*⁴⁵ A thorough investigation was conducted by both the DOC and the Attorney General's Office. The DOC reviewed the incident and determined that the *“methods employed during the restraint process were not found to be excessive.”*⁴⁶ A DOC Media Release dated January 7, 2016 stated that, *“Acting Commissioner Walt Monegan would like to assure the public that an investigation into this inmate death did occur immediately and the criminal investigation into the incident was completed. The Department of Law reviewed the criminal investigation and the Office of Special Prosecution and Appeals (OSPA) determined there was no criminal activity on the part of the Correctional Officers.”*⁴⁷ Additionally, in response to an inquiry by the Alaska Bureau of Investigation, the Attorney General's Office, on August 17, 2015, concluded that, *“The State has determined that the criminal prosecution of the four involved correctional Officers is unwarranted.”*⁴⁸ Dean Williams knew two State Departments investigated the actions of the Officers involved. Yet, with no experience in adult correctional institutions, he determined and set out to convince the family and the media that excessive force was used, he had uncovered it, and that he was being transparent and honest by exposing it. If he was actually being transparent and honest, he only needed to state that he looked into the Kobuk incident, there were two separate investigations conducted by experienced professionals with reports issued, and the Officers acted appropriately.

⁴⁴ Alaska Department of Corrections: An Administrative Review November 13, 2015, Page 12

⁴⁵ Ibid., Page 13

⁴⁶ Ibid.

⁴⁷ <http://www.acoa.us/wp-content/uploads/2016/04/DOC-Media-Release-01-07-16.pdf>

⁴⁸ Alaska Department of Public Safety Investigation conducted by Attorney General Office 2015/08/17, <http://www.acoa.us/wp-content/uploads/2016/01/2015-8-17-Attorney-General-Report-on-Kobuk.pdf>, Page 1

On January 27, 2015, Mr. Kobuk was arrested on charges of first-degree vehicle theft, fourth-degree theft, driving with a suspended license, and reckless driving. Police Officers brought him to the Anchorage Correctional Complex (ACC) where he remained aggressive toward Officers during his initial booking process. A blood toxicology test after he died came back positive for ethanol, amphetamine, phenobarbital, nordiazepam, and chlordiazepoxide. Mr. Kobuk had a significant criminal history spanning 20 years, including 5 convictions for assaultive conduct and 2 convictions for resisting arrest. He also had a significant DOC institutional disciplinary history of being combative and violent.⁴⁹ “*Witnesses that night described Mr. Kobuk as agitated and belligerent.*”⁵⁰ In the surveillance video of the incident Dean Williams had the audio component removed from the video before it was presented to the public. When the audio is included with the video, Mr. Kobuk can be heard repeatedly threatening to kill Officers.

Dean Williams intentionally removed the audio so the public could not hear Mr. Kobuk yell “*kill the cop,*” “*f**king splatter their brains,*” “*put a bullet in their f**king head,*” “*I am going to shoot you in the f**king head,*” among multiple other threats and curses. At one point during the clothing removal an Officer can also be heard ordering Mr. Kobuk to “*stop grabbing*” and “*stop fighting.*” Mr. Kobuk was fighting with Officers and attempting to grab the Officers themselves, their keys, radio and pepper spray. Mr. Kobuk’s threats are important evidence because Dean Williams later wrote in his Administrative Review that, “*There does not appear to have been a clear and immediate safety threat such as an assault or attempted escape to warrant the level of force used.*” If Dean Williams had not deleted the audio, his statement about there being no, “*...immediate safety threat such as an assault ...*”⁵¹ would have seemed inconsistent. Officers are trained to take threats seriously as they can often lead to aggressive actions by the inmate. As an investigator, it is his job to present all the pertinent facts with the video.

Deleting essential audio on this tape contradicts his statements to “*be as honest as possible about what happened.*” By releasing the altered video without full disclosure of the facts, he presented a deceptive impression of the actual event. When Dean Williams was questioned by the media regarding why he altered the video evidence, he gave many excuses. First, “*Williams said the audio was not released because of the way the audio files were structured on the computer system[,]*”⁵² and because there was not enough capacity on the flash drive.⁵³ Dean Williams’ explanation of not disseminating the audio as a technical issue or because the flash drive was not large enough is not logical. The audio was embedded in the video file. Dean Williams had to intentionally remove the audio from the video file, or intentionally

⁴⁹ Alaska Department of Public Safety Investigation conducted by Attorney General Office 2015/08/17, <http://www.acoa.us/wp-content/uploads/2016/01/2015-8-17-Attorney-General-Report-on-Kobuk.pdf>, Page 4

⁵⁰ Ibid., Page 2

⁵¹ Dean Williams’ Administrative Review, November 13, 2015, Page 13

⁵² January 29, 2016 Alaska Dispatch News article, “Alaska prison guards union alleges bias in report on inmate deaths”, <http://www.adn.com/article/20160129/alaska-prison-guards-union-alleges-bias-report-inmate-deaths>

⁵³ January 30, 2016 KTUU Newscast, “Correctional officers union unhappy with new prison commissioner”, <http://www.ktuu.com/news/news/correctional-officers-union-unhappy-with-new-prison-commissioner/37719122>

copy the video from a screen capture program without the audio. This process is quite a bit more work and would take time and/or expertise to accomplish. Regarding the inadequate storage capacity excuse, it would have been easier to get a larger storage device rather than take the time to remove the audio content. Additionally, audio is typically a smaller file size than video so the difference in the file size before versus after removing the audio would have been small at most. It would have been less burdensome and quicker to burn the DVD received from the institution directly to another DVD or simply obtain a larger flash drive.

Then, the same day, Dean Williams must have realized his statements were not plausible, and he said, *“I would have released the audio if anyone was interested in it ... I just didn’t think it was necessary.”*⁵⁴ That is one problem with deleting vital evidence; no one would know to ask for it because no one would expect it to exist. As an investigator, it is his job to present all the pertinent information with the video. Finally, Dean Williams stated, *“The Kobuk video speaks for itself,”*⁵⁵ which after he deleted the audio was exactly the opposite; the video was now mute and it did not contain the relevant evidence necessary to fully assess the events in the video.⁵⁶ Regardless of how absurd these multiple excuses are, even if Dean Williams thought the audio was unimportant or unnecessary, why would he go out of his way to delete it? Failing to release important relevant evidence and believing it is *“not necessary”* raises a question of judgment, as well as transparency and honesty.

Dean Williams also violated DOC Policy 1207.01.F.3 (Use of Force) regarding video recordings, which states *“Video recordings of use of force shall not be altered.”* Had an Officer intentionally manipulated evidence to obscure an investigation, the Officer would have been terminated, if not prosecuted.⁵⁷ Dean Williams manipulated and hid evidence to justify an incomplete and inaccurate Administrative Review. Dean Williams actually faulted the Department of Law in the Administrative Review for not *“documenting all the facts around an inmate death [because it] might make it easier for the state to be found financially liable for the death.”*⁵⁸ Yet now, in this case, Dean Williams did not give all the facts, and actually removed evidence so the public could not see it. The deliberate omission of relevant evidence of Mr. Kobuk’s threats against law enforcement personnel allowed Dean Williams to falsely assert that he had found unnoticed problems with Correctional Officers’ actions, uncovered only during *his* investigation.

Mr. Kobuk died while his clothing was being removed during a strip search before he could be put into ACC’s general population after his arrest. Had Mr. Kobuk voluntarily removed his clothing when asked,

⁵⁴ January 29, 2016 Alaska Dispatch News article, “Alaska prison guards union alleges bias in report on inmate deaths” <http://www.adn.com/article/20160129/alaska-prison-guards-union-alleges-bias-report-inmate-deaths>

⁵⁵ Ibid.

⁵⁶ Later, Dean Williams stated that the threats did not justify what happened, insinuating that something wrong still occurred, or worse, that Officers acted inappropriately because they were threatened. This was absolutely not the case. Even when caught in his own misrepresentation, Dean Williams’ first thought was to again shift blame to the innocent Officers.

⁵⁷ Alaska Statute 11.56.815 - (Tampering with Public Records in the First Degree) (a) *“A person commits the crime of tampering with public records in the first degree if the person violates (1) AS 11.56.820(a)(3) with intent to obtain a benefit for that person or any person or to injure or deprive another person of a benefit....”*, <http://www.touchngo.com/lglcntr/akstats/Statutes/Title11/Chapter56/Section815.htm>

⁵⁸ Alaska Department of Corrections: An Administrative Review November 13, 2015, Page 7

Officers would not have been forced to remove it. DOC Policy & Procedure 811.04 requires that “A prisoner not able to secure bail or other authorized release must be strip searched before being housed in the institution.”⁵⁹ Even though Dean Williams ignored or overlooked this policy, the investigation by the Attorney General’s office did not, stating “DOC requires all inmates to be “dressed out” prior to being released into general population.”⁶⁰ This means the inmate must remove any street clothes and change into clothing provided by DOC. After a strip search is completed, an inmate is given institutional clothing to wear and his personal clothing is inventoried and held in a secure area until he is released.⁶¹ As explained by DOC training personnel, both for the safety of the employees within the facility and for the safety of other inmates, the DOC requires each inmate to be thoroughly searched before being placed into the general population. This removal of personal clothing and issuance of institutional clothing is part of that process.⁶² The inmate failed to cooperate with these institutional rules.⁶³

In stark contradiction to written policy, Dean Williams implied that Officers should not have removed Mr. Kobuk’s clothing when he wrote, “Policy 811.05 infers that a prisoner’s property should not be turned over to law enforcement without a search warrant. However, in practice there was an understanding that the department aims to help law enforcement. Subsequent to Mr. Kobuk’s death, the department issued a memo calling for staff to adhere a stricter interpretation of the policy.”⁶⁴ Regardless of law enforcement’s request for evidence, Mr. Kobuk’s clothing was required to be removed under DOC’s Policy concerning placing an inmate into the general population. DOC Policy requires that “When a prisoner is remanded to a correctional facility, a property inventory is to be completed during the booking process.”⁶⁵ The same policy directs that “weapons, combustible liquids, electronic devices, contraband items, etc., shall not be accepted and shall be turned over to the remanding authority at time of admission.”⁶⁶ Only later in this policy does it mention anything about search warrants, and the context is that a search warrant is required once the property has been received into the DOC’s custody.⁶⁷ A qualified investigator first would have reviewed policy or the investigations already completed by the DOC and the Department of Law before making such an inaccurate statement concerning contraband and personal property in correctional institutions. In an investigatory report, instead of a political piece, Dean Williams should have stated that it is common practice to search and strip inmates before they are placed in with the general prison population. He also should have stated that the procedure utilized by the Officers to remove the clothing is the standard procedure being utilized every day.

Mr. Kobuk made the choice to refuse to cooperate with this necessary part of the admissions process, which left the Officers no option but to complete a reasonable and necessary search and take his personal

⁵⁹ Department of Corrections Policy & Procedure 811.04, Procedures F.1, <http://www.correct.state.ak.us/pnp/pdf/811.04.pdf>

⁶⁰ Alaska Department of Public Safety Investigation conducted by Attorney General Office 2015/08/17, <http://www.acoa.us/wp-content/uploads/2016/01/2015-8-17-Attorney-General-Report-on-Kobuk.pdf>

⁶¹ Department of Corrections Policy and Procedure 811.05, VII, A

⁶² Alaska Department of Public Safety Investigation conducted by Attorney General Office 2015/08/17, Page 3, <http://www.acoa.us/wp-content/uploads/2016/01/2015-8-17-Attorney-General-Report-on-Kobuk.pdf>

⁶³ Mr. Kobuk also refused to provide a breath sample so his alcohol level could be determined.

⁶⁴ Dean Williams’ Administrative Review, November 13, 2015, Page 13

⁶⁵ Department of Corrections Policy & Procedure 811.05, VII, A, <http://www.correct.state.ak.us/pnp/pdf/811.05.pdf>

⁶⁶ Ibid., A.2

⁶⁷ Ibid., C

clothing. Alaska law allows Correctional Officers to use force when necessary to compel compliance with orders that directly impact the security of the institution,⁶⁸ as does the DOC's use of force policy.⁶⁹ Correctional Officers placed Mr. Kobuk face down on the cell floor in the prone position in order to secure him. Officers are trained to do it this way to minimize the risk of injury to the inmate and Officers.

Dean Williams stated that, *"Throughout this process, correctional officers have been on Mr. Kobuk's back while two Anchorage police officers and a nurse stand outside the cell observing[.]"*⁷⁰ This statement does not accurately convey the Officers' actions, which are described in detail in the Department of Law, Office of Special Prosecutions' Report, issued on August 17, 2015.⁷¹ In reality, two Officers were securing Mr. Kobuk's arms, another Officer attempted to secure his legs, and a fourth Officer had *"one knee on Mr. Kobuk's torso."*⁷² These actions complied with training and DOC Policy & Procedure, and are to be used while removing an uncooperative inmate's clothes. The Officers were not *"on Mr. Kobuk's back,"* they were restraining him on the floor with the necessary force. The purpose of having an Officer secure each of an inmate's extremities is to prevent the inmate from using an arm or leg to hit or kick an Officer or injure themselves. Dean Williams' misrepresentation led to the false perception that the Officers involved used excessive force.

"If Dean Williams had contacted any national or local corrections experts, or performed more than a superficial review, he would have known the Officers acted appropriately."

Regarding Mr. Kobuk's statements that he could not breathe, the DOC found that *"methods employed during the restraint process were not found to be excessive."* It is very common for inmates to state they cannot breathe when they can, in order to gain an upper hand over the Officers trying to do their jobs. Even if the DOC's investigation was not good enough for Dean Williams, he had the Attorney General's investigation to rely on, which also stated that *"The Officers were trained to continue to secure an uncooperative individual, even if that individual is stating that he 'can't breathe.'"* The Attorney General's investigation also said, *"As the State Medical Examiner explained, the physical restraint used on Mr. Kobuk is not usually fatal."*⁷³

The amount of force used was reasonable and necessary. It was also in accordance with training and the standard practice used throughout the United States. This was confirmed by the Attorney General's Office investigation, which stated, *"The use of several officers to remove the clothes Mr. Kobuk was wearing was an attempt to create a safe environment in accomplishing this task. The Officers are trained to restrain inmates with sufficient force to compel compliance, but not to cause injury. The use of four*

⁶⁸ Alaska Statute 11.81.410 (a), <http://touchngo.com/lglcntr/akstats/Statutes/Title11/Chapter81/Section410.htm>

⁶⁹ Alaska Department of Corrections Policy & Procedure 1207.01, Use of Force,

⁷⁰ Alaska Department of Corrections: An Administrative Review November 13, 2015, Page 12

⁷¹ Alaska Department of Public Safety Investigation conducted by Attorney General Office 2015/08/17, <http://www.acoa.us/wp-content/uploads/2016/01/2015-8-17-Attorney-General-Report-on-Kobuk.pdf>

⁷² Ibid., Page 3

⁷³ Ibid., Page 6

*correctional officers to strip an uncooperative inmate would allow for sufficient control of a disruptive inmate, and reduce the risk of injury to all involved – the officers and the inmate.”*⁷⁴ The Nurse stood by as a precaution and the Police Officers were there to assist as well. The video shows a tried and true, per policy method of taking a non-compliant inmate’s clothing prior to placing him into the institution’s general population. It is extremely unfortunate that Mr. Kobuk died in this circumstance, but the methods employed by the Officers have been used countless times. They have prevented an incalculable number of injuries and have prevented contraband, weapons, and drugs from entering the facility. Regardless, *“The report concluded that excessive force was used against Kobuk”*⁷⁵ and after Dean Williams flew up to meet with Mr. Kobuk’s mother she came out publicly with the statement *“They literally killed him... There’s absolutely no reason why it should have happened. I mean, they literally took out a 33-year-old man’s life.”* One can only imagine what Dean Williams said about the Officers when he traveled to meet Mr. Kobuk’s family.

In disregard for the trained professional positions, Dean Williams concluded that, *“An inmate with a reported heart condition might warrant decreased force or more opportunities to comply without use of force.”*⁷⁶ Again, by making statements such as these, Dean Williams proves that he did not conduct a thorough investigation. The Department of Law report acknowledged that *“the correctional officers were unaware of Mr. Kobuk’s methamphetamine toxicity – a condition that would necessarily exacerbate his pre-existing cardiomyopathy.... It is unknown the extent to which the officers’ application of restraint contributed to Mr. Kobuk’s death. However, it is clear that Mr. Kobuk’s pre-existing heart condition, combined with his methamphetamines toxicity, did contribute significantly to his death.”*⁷⁷

Two national authorities who reviewed the video stated:

“I can find no inappropriate behavior or excessive force on behalf of the staff. I see no aggression in their actions or in their response to the inmate[’]s decision to not remove his clothing. The take down was standard operating procedure, using the minimal force needed, as was the removal of the inmate[’]s clothing. The Officers performed professionally given the environment, existing policy [and] the inmate[’]s decision to not cooperate. It is always unfortunate when an incident like this occurs, however I can find no fault with the Officers[’] performance.”

Brian Dawe, American Correctional Officer Intelligence Network

⁷⁴ Alaska Department of Public Safety Investigation conducted by Attorney General Office 2015/08/17, Page 4, <http://www.acoa.us/wp-content/uploads/2016/01/2015-8-17-Attorney-General-Report-on-Kobuk.pdf>

⁷⁵ January 6, 2016 KTUU Newscast, “Governor releases 3rd video of inmate death; family calls for prison reform”, <http://www.ktuu.com/news/news/third-video-of-inmate-death-released-by-alaska-governors-office/37304746>

⁷⁶ What if Mr. Kobuk had a weapon, would his medical condition still matter? If a Police Officer responds to an active shooter emergency, but the shooter has a medical condition is the Officer supposed to respond differently? Of course not, the Officers in every scenario deal with the situation presented with the lowest level of force necessary to gain compliance.

⁷⁷ Alaska Department of Public Safety Investigation conducted by Attorney General Office 2015/08/17 Page 6, <http://www.acoa.us/wp-content/uploads/2016/01/2015-8-17-Attorney-General-Report-on-Kobuk.pdf>

“I have reviewed the video of Kobuk in the cell. The amount of force used was reasonable and necessary. Kobuk was given a choice to comply, had he complied with Officers’ demands the force would not have been necessary. I observed no excessive force by any of the Officers in this incident. The force used was in compliance with current training and policy within the DOC.”

Steven Jimerfield, Retired Corporal Alaska State Troopers
Founder\Director One-On-One-Control Tactics LLC

These two national experts’ findings are consistent with the findings in the two previous investigations conducted on the Kobuk incident. Had Dean Williams consulted any national or local correctional experts, or performed more than a superficial review to justify his incorrect conclusion regarding excessive force, he would have known the Officers acted appropriately. Although his investigation was supposed to be impartial, Dean Williams did not even speak to the Officers shown in this video. Instead, he ignored the investigations conducted by the DOC and the Attorney General’s Office, and then presented incorrect information in an official State document. This, combined with altering and tampering with video evidence that would have supported Correctional Officers’ innocence, leads one to believe his actions were deliberate. No Officers were disciplined in any way because they performed their jobs correctly and appropriately.

Case 3: Lemon Creek Correctional Center, Joseph Murphy⁷⁸

Joseph Murphy arrived at the Lemon Creek Correctional Center (LCCC) on August 13, 2015, and was admitted into protective custody because of alcohol use pursuant to Title 47.⁷⁹ He was placed on suicide precautions after informing the institution staff that he was contemplating killing himself. LCCC does not have 24/7 medical professionals in the institution. The facility is typically without medical staff for four to five hours every day. Correctional Officers receive standard Medic First Aid certificates while attending the Basic Academy⁸⁰ and receive some continual first responder training.⁸¹ In this situation, the Officers responded appropriately when Mr. Murphy was found unconscious. However, they rely on the Nurse's observations and professional opinions and are not trained to make medical decisions. It is the State that has weighed the risks and costs of not having trained medical personnel in its facilities every hour of the day, and decided that 24/7 medical staff is not warranted.

“It is the state that has weighed the risks and costs of not having trained medical personnel in its facilities every hour of the day, and decided that 24/7 medical staff is not warranted.”

On the morning of August 14, 2015, Officers responded to Mr. Murphy, who was banging on his cell door, claiming he was having chest pains. He showed no outward signs of distress. His speech, breathing, and mobility seemed normal; however, the Officer asked him if he needed emergency medical services (EMS). Mr. Murphy did not request EMS. A few minutes later, the nurse spoke to Mr. Murphy and evaluated his condition. She also offered to call an ambulance for him. Again, Mr. Murphy actively declined emergency medical services. The nurse concluded that Mr. Murphy did not need emergency services as he was able to walk, talk, and did not appear to be in distress.

It is extremely common for people admitted as a Title 47, as they begin to sober up, to have aches and pains and to be agitated and unruly. It is also common for them to ask for drugs, alcohol, or whatever might help ease their symptoms. The Officers observed the inmate pacing and talking coherently, and there was no evidence that he was in medical distress. The Officers did not have any knowledge of the inmate's past medical history. Furthermore, the Nurse, whom Officers trust to make medical decisions regarding inmates, had already reviewed the inmate's condition and told the Officers that there was not

⁷⁸ Alaska Department of Corrections: An Administrative Review November 13, 2015, Page 13

⁷⁹ An individual admitted into an Alaska correctional institution under AS 47.37.170 is commonly referred to as a Title 47. This Alaska Statute states, “A person who appears to be incapacitated by alcohol or drugs in a public place shall be taken to a state or municipal detention facility in the area if that appears necessary for the protection of the person's health or safety.” These individuals are not criminals and are only being held in protective custody for up to 12 hours until they are sober enough to safely leave the institution on their own.

⁸⁰ Per 13 AAC 87.060, <http://www.touchngo.com/lglcntr/akstats/aac/title13/chapter087/section060.htm>

⁸¹ Per DOC Policy & Procedure 401.02 “All Correctional Officers and Probation/Parole Officers shall be trained and certified in first responder methods every two years”, <http://www.correct.state.ak.us/pnp/pdf/401.02.pdf>. Realistically, this two-year requirement is frequently pushed out to three or four years because of budgetary and staffing issues.

a health problem. The Officers accepted the trained medical professional's opinion of the inmate's health. There was no evidence to suggest that this inmate's condition was anything other than that of a normal person admitted as a Title 47 who was sobering up and complaining of pain. Officers never fail to seek medical assistance for inmates when necessary. If an inmate needs emergency care or requests an ambulance, EMS is called.

Shortly after refusing emergency medical services, Mr. Murphy continued to bang on his cell door and again an Officer went to check on him. He yelled at the Officer and reiterated what he had said earlier. Having already been assured by the Nurse that Mr. Murphy did not have a medical situation, the Officer told him to be quiet and sit down, and that he would be released soon. The Officer used strong language in an attempt to de-escalate the situation, stop Mr. Murphy from banging the cell door, and gain compliance. The institution was in the process of getting someone to do a mental health evaluation for Mr. Murphy, which is required to release inmates who are on suicide protocol watch. The inmate stopped yelling and continued to pace around his cell.

Strong and forceful language is commonplace in Alaska institutions and is frequently employed by staff and Management. Officers regularly attempt to communicate effectively with inmates who are often unruly, abusive, and physically violent. An inmate cannot be allowed to continue to kick a cell door. If he hurts himself, the Officer will be held liable for not stopping the inmate's actions. By the time this third conversation occurred, Mr. Murphy had already been offered emergency medical care by two different individuals, once as recently as 15 minutes earlier. In the Administrative Review, Dean Williams misrepresented this exchange, defamed the Correctional Officer, and implied he was liable for the individual's death. This was not the case. Mr. Murphy twice rejected emergency medical care, and had been evaluated by a trained nurse. There was nothing more the Officers could do. Again, Officers are not trained medical professionals. They receive no training to spot, diagnose, or treat serious medical conditions.

“Mr. Murphy was under a Title 47, protective hold, but could not be released earlier, as Dean Williams said, because Mr. Murphy was on suicide precautions.”

Mr. Murphy had been admitted to the hospital the night before his death. He was in very poor health, prescribed several medications, and had had more than one previous heart attack. Officers on shift did not know Mr. Murphy's medical history even though he was transported to LCCC by the Juneau Police who came directly from the Juneau hospital where Mr. Murphy had been agitated and intoxicated. His life choices, including binge drinking after a medical emergency, caused such stresses on his heart that he unfortunately died a few hours later, while in custody. Nonetheless, Dean Williams insinuated guilt when he stated, *“There were no personnel actions for Staff 1 and Staff 2, one of whom had medical training.”* All available staff responded to initiate CPR and life saving measures when Mr. Murphy was found unresponsive. No Officer was responsible for Mr. Murphy's death. If anything, the staff should be commended for their attempts to save Mr. Murphy's life.

Again Dean Williams woefully proclaimed a complete lack of knowledge of DOC Policies & Procedures and misled the public when he wrote “At 0550 Mr. Murphy did not appear to be intoxicated and should have been released at that time.” First, how did Dean Williams determine that Mr. Murphy did “not appear to be intoxicated?” Simply watching a security camera video recording, devoid of anything but visual cues, could not tell someone if the individual depicted is sober or not. Presenting such an opinion as factual is egregiously misleading, especially considering Dean Williams has no medical background or expertise. Correctional Officers do not operate on appearances alone. There are individuals who do not appear to be intoxicated when brought to prison, yet their breath-alcohol reading is over 0.35, over four times the legal limit. The State is monetarily and ethically liable for the actions of persons released without being sober.⁸²

Second, Dean Williams’ comment alludes to Alaska Statute 47.37.170 (i) as a reason why Mr. Murphy should have been released prior to the time of his heart attack.

“A person taken to a detention facility under (a) or (b) of this section may be detained only (1) until a treatment facility or emergency medical service is made available, (2) until the person is no longer intoxicated or incapacitated by alcohol or drugs, or (3) for a maximum period of 12 hours, whichever occurs first. A detaining officer or a detention facility official may release a person who is detained under (a) or (b) of this section at any time to the custody of a responsible adult.”

Mr. Murphy was under a Title 47 protective hold, but could not be released earlier, as Dean Williams states, because Mr. Murphy was on suicide precautions. Upon being remanded into the institution, Mr. Murphy answered affirmatively the question, “Are you thinking of killing yourself?” A “yes” response to this question requires immediate suicide precautions.⁸³ Per Policy 807.20 (Suicide Prevention and Awareness), Mr. Murphy could not have been released prior to being removed from suicide precautions. Under these circumstances, State policy requires a medical professional to conduct an examination to

⁸² Under Dean Williams’ logic, at what point should the DOC release persons who are under a Title 47 hold? Many such persons come into the DOC’s custody after being cleared by the hospital. Yet of these releases a 0.30 Breath Alcohol Content (BrAC) level (or higher) is common. That is almost four times the legal limit for Driving Under the Influence [DUI] in Alaska (AS 28.35.030(a)). [Alaska’s legal limit is 0.08] Although 12 hours is a maximum time, AS 47.37.170(i)(2) is somewhat ambiguous stating, “until the person is no longer intoxicated or incapacitated by alcohol or drugs.” Does this statutory requirement infer a 0.00 BrAC? If that is the case, most Title 47 holds would indeed stay the maximum amount of time, as their BrAC levels would still be well above 0.00 when released. At what BrAC is a person considered no longer intoxicated or incapacitated: 0.00, 0.04, or under the legal limit of 0.08? Can this requirement be met by some other means, such as sobriety testing, a medical evaluation, or medical clearance? (Historically, DOC facilities have not drawn blood to determine Blood Alcohol Content [BAC] levels.) What standard determines when a person is no longer intoxicated or incapacitated? Establishing a BrAC level acceptable for releasing persons who are under a Title 47 hold, either by statute, code, or policy, would provide Correctional Officers a definitive Breathalyzer measure to determine if a person who is under a Title 47 hold could be released from DOC custody prior to the 12-hour maximum limit. This applied standard would also protect the DOC from liability.

⁸³ DOC Policy & Procedure 807.20 dictates that employees take suicidal or self-destructive behavior seriously and take immediate actions in situations involving a suicidal individual. The initial suicide intervention requires a strip search, placement in a single camera cell where the individual is observed more frequently, and removal of all clothing except for an anti-tear suicide smock. <http://www.correct.state.ak.us/pnp/pdf/807.20.pdf>

ensure the individual can be released safely.⁸⁴ For suicidal individuals, as in Mr. Murphy's situation, it does not matter if the inmate no longer appears to be intoxicated; the inmate could not have been released without being seen by a mental health professional.

As previously mentioned, LCCC does not have 24/7 medical coverage. A mental health professional had not yet seen Mr. Murphy to evaluate him, and Mr. Murphy could not have been released until after he had been seen by a mental health professional. This is something Dean Williams knew, or should have known, had his investigation been as thorough as he led Legislators and the public to believe. If Dean Williams had done more than a cursory review, he would not have misled the public and elected officials into believing that the Correctional Officers on duty inappropriately held Mr. Murphy longer than they were supposed to per DOC Policies & Procedures.

Given the number of inmate deaths while inmates are in the DOC's custody, one could logically conclude that all correctional facilities should have 24/7 medical coverage. Again, this decision is for the DOC upper management team and is not something Officers could implement.

⁸⁴ Department of Corrections Policy & Procedure 807.20 B.1, <http://www.correct.state.ak.us/pnp/pdf/807.20.pdf>

Case 4: Fairbanks Correctional Center, Gilbert Joseph⁸⁵

Every Correctional Officer working the night Gilbert Joseph died at Fairbanks Correctional Center (FCC) performed his/her duties admirably. Prior to Dean Williams' investigation, multiple investigations exonerated every Correctional Officer and found no wrongdoing whatsoever. Dean Williams incorrectly faults Officers' actions, which conformed to policy, training, and statewide practices in every way.

A Broken System: Title 47 Non-Criminal Admissions

On August 27, 2015, Gilbert Joseph died at the Fairbanks Correctional Center. As discussed in the case concerning Joseph Murphy at Lemon Creek Correctional Center (Case 3), Gilbert Joseph was another person held as a Title 47 "non-criminal hold."⁸⁶ The Administrative Review discussed Title 47 admissions, noting the impacts on DOC. These particular individuals significantly impact Alaska's corrections system because Correctional Officers must admit, supervise, and release those detained under the statute. Individuals detained under Title 47 are often medically unstable. Placing responsibility on prisons for the safety and well-being of medically unstable individuals puts a considerable burden on corrections staff and puts the affected individuals at risk. If a hospital medically clears an intoxicated individual, the person is then taken to a correctional institution per DOC Policy and Procedure 811.01 (Authority to Admit).⁸⁷

People remanded as Title 47s often have medical conditions, high intoxication levels, and frequently display combative behavior. There is limited holding space in the institutions, and an already dangerously low amount of staff members are further burdened by working with these often medically unstable individuals. FCC Officers can see up to 70 individuals remanded pursuant to Title 47 in a week. There is only one designated cell at FCC where Officers can place such individuals. Sometimes as many as 7-10 individuals are held in this one cell until they can "sober up." Since they are non-criminal holds, DOC policy dictates that they are not to be held with criminals in the general population.

When interviewing an Officer, Dean Williams stated that keeping individuals under a Title 47 hold in prison is a "nightmare"⁸⁸ :

⁸⁵ Alaska Department of Corrections: An Administrative Review November 13, 2015, Page 14

⁸⁶ Alaska Statute 47.37.170 provides for temporary custody of an individual who is incapacitated by alcohol or drugs in a public place. The statute calls for individuals to be placed in an appropriate medical facility or their own homes; if these are unavailable, the statute allows placement of intoxicated individuals in state or municipal detention facilities. <http://www.touchngo.com/lglcntr/akstats/Statutes/Title47/Chapter37/Section235.htm>

⁸⁷ "The officer who has taken custody of a person and seeks to admit that person under AS 47.30.705 or AS 47.37.170(a) or (b), respectively, executes a remand-to-custody order in the presence of the admitting staff member and certifies in writing that he or she has exhausted all other alternatives for placement under AS 47.30.705 or AS 47.37.170(a) or (b), respectively, and; For admittance under AS 47.30.705, further certifies that he or she has probable cause to believe that the person is gravely disabled or is suffering from mental illness and is likely to cause serious harm to self or others of such immediate nature that considerations of safety do not allow initiation of involuntary commitment procedures set out in AS 47.30.700; or Under AS 47.37.170(a) or (b), further certifies that the person is intoxicated or incapacitated by alcohol;" <http://www.correct.state.ak.us/pnp/pdf/811.01.pdf>

⁸⁸ On November 9 and 10, 2015 Mr. Williams conducted over ten Investigatory Hearings and witness interviews with Correctional Officers and other FCC staff regarding this incident.

“This whole thing about why we are having Title 47[s] in jail is a nightmare, you are exactly right, I totally agree with you. So I am looking before I came here today, you know, this death occurred while I was doing the DOC review, I get there is a big problem on this Title 47 thing, and you are right... You work the remand area and I have now heard from two different people now that there are sometimes 7 or 8 people in there, or more. I totally get it, to say that is not ideal, that’s a massive understatement. The fact that I would be responsible for 7 or 8 Title 47s in one cell, I would be a wreck, totally nonfunctional sort of dynamic.”

In another conversation with an Officer, Dean Williams further acknowledged the problems with this system. *“We know that this whole set-up of what we are doing with Title 47s is about the furthest from ideal that you could get. It’s really dysfunctional, in about multiple ways, I get that, I totally get that.”* He also acknowledged how the current DOC policies put Officers in an impossible position. *“I know, I will speak for myself, that in many ways we’re asking an impossible job, an impossible job has been asked. In this particular case we have an impossible job asked but in many ways.”* Nonetheless, he faulted the Officers for Mr. Joseph’s death, by publicly making it appear that Officers were in some way responsible, and imposed discipline although the Officers had been cleared by prior investigations.

“It is not fair to hold Officers, who are not medical professionals, personally responsible for a system that the Governor and Dean Williams both admit is broken.”

The fact is that Mr. Joseph should have been in a hospital, not a jail cell. Dean Williams also addressed Mr. Joseph’s medical state in a December 8, 2015 newspaper article.⁸⁹ Mr. Joseph was *“way beyond what any one of us would be able to function at, yet he was also one of those who had been cleared by the hospital... He was not only intoxicated but he had been drinking hand sanitizer and to some degree had been poisoned before coming in the door.”* Seven days

after Mr. Joseph’s death it was revealed that Mr. Joseph had been drinking hand sanitizer, making it impossible to get an accurate breath-alcohol reading at the time he was brought in to FCC.⁹⁰

While it is readily apparent that Mr. Joseph was not healthy enough to leave the hospital, it is commonplace for medical institutions to release intoxicated individuals to detention facilities rather than taking care of them. When Mr. Joseph arrived at FCC, he could not even stand on his own. Correctional Officers literally had to carry him into the building, assist him in removing his outer clothing, and carry him to his cell where they laid him down. He was so intoxicated he could not even pull his own pants up

⁸⁹ December 8, 2015 Fairbanks News-Miner article, “Videos reveal problems with protective custody in Alaska prisons”, http://www.newsminer.com/news/local_news/videos-reveal-problems-with-protective-custody-in-alaska-prisons/article_551cfbf-9e4f-11e5-a32a-439cb05492aa.html

⁹⁰ The Community Service Patrol Officer who admitted Mr. Joseph to FCC wrote about the hand sanitizer in his Incident Report on September 2, 2015

and he fell asleep almost immediately upon being laid down in the cell. When another inmate was placed in the cell with Mr. Joseph, a Correctional Officer used a blanket to cover Mr. Joseph.

Officers cannot be held responsible every time individuals, who are not healthy enough to be placed in prison, die in prison. Officers echoed this same concern to Dean Williams, “*The Department has never stood beside the floor guy, when it comes to not accepting these guys. Mr. Joseph should not have been in that tank that night, period, end of story.*” How can Dean Williams agree with this statement, but then publicly insinuate that Officers are responsible for the death? It is not fair to hold Officers, who are not medical professionals, personally responsible for a system that the Governor and Dean Williams both admit is broken.⁹¹

*Dean Williams -
“This is not just the witch hunt, we are trying to figure out what we are going to do about this in the future, but we have to deal with the fact that a guy died.”*

Double Jeopardy Violation

The Officers were cleared by prior, separate investigations.

- The first investigation was conducted by the Superintendent at FCC. No wrongdoing was found.
- The second investigation was conducted by Dean Marshall, the Acting Director of Institutions (at the time), and Debbie Miller, a former Superintendent working as a Project Manager in DOC. This investigation also concluded that the Officers acted appropriately.
- The Alaska State Troopers conducted a separate investigation into the death, and found that Correctional Officers did nothing wrong. The Alaska State Troopers are designated by DOC Policy & Procedure 104.04 (Death of a Prisoner) to conduct investigations of unexpected prisoner deaths.

Finally, after three investigations had been completed, and nearly three months after the actual incident took place, Dean Williams initiated a fourth investigation. Despite the three previous investigations finding the Officers innocent of any wrong-doing, Dean Williams released his Administrative Review and made statements implying that multiple Officers acted inappropriately. After these public comments, Dean Williams overruled all three previous investigations and forced discipline on Officers in order to substantiate his public allegations. The fact is, these Officers were, and are, 100% innocent.

Making Officers feel that their jobs are on the line for over three months was unnecessary, inappropriate, and hurtful. In their witness interviews, multiple Officers commented on the redundancy of the fourth investigation and the negative effect it had on Officers. This fourth investigation was only initiated to place guilt and assess blame on completely innocent Officers, not to discover the truth of the matter. One exchange between an Officer and Dean Williams makes this frustration clear.

⁹¹ In a November 16, 2015 Alaska Dispatch News article, “Report: Widespread dysfunction in Alaska prisons may have led to inmate deaths” Governor Walker stated, “*It’s clear as a result of this that the system is broken... And we’re going to fix it.*”, <http://www.adn.com/article/20151116/report-widespread-dysfunction-alaska-prisons-may-have-led-inmate-deaths>

Officer – “We book 70 of those people in a week most the time, over ten a day, most of these guys are walking medical time bombs, and they are never in better shape than when they leave us. Nobody takes better care of them than us. And yet when something happens to one of them, it’s the guys who have taken the best care of them who take it in the shorts.”

Dean Williams – “Well, no one has taken anything in the shorts yet.”

Officer – “Instead of being dragged through the mud and investigated, we should be congratulated, given a hand shake and said job well done.”

Dean Williams – “We have an obligation to investigate when someone dies.”

Officer – “How many times? We have been investigated 3 times already.”

The Fifth Amendment of the United States Constitution exists to protect American citizens from being tried twice for the same offense. Four investigations, one after another, in a three-month period, is cruel to all the Officers involved. Then to be found guilty for political reasons is absolutely absurd.

Perfunctory Fourth Investigation

Not only was the fourth investigation unnecessary, it was conducted in a perfunctory manner with the sole intent to justify predetermined discipline. Although probably just a Freudian slip, in one witness interview, Dean Williams admitted this at one of these hearings. He said, *“This is not just the witch hunt, we are trying to figure out what we are going to do about this in the future, but we have to deal with the fact that a guy died.”* (Emphasis Added) He also admitted that what he was doing was equivalent to Monday Morning Quarterbacking. *“I know these questions are all Monday Morning Quarterbacking, I’ve been around a long time and I know things are so much nicer when you are not actually doing the events, so, I am fully aware about what I am going to launch into why you did or didn’t do things.”*

Dean Williams tried to convince Officers that he had not already come to a preconceived notion of the truth. *“This is not about hanging people out to dry; it’s about understanding what’s wrong. There’s a lot of things, why that guy came in as drunk as he was, why we’re even having the Department taking these guys while in a condition like that is a whole ‘nother question, why we are even doing business that way is a super huge concern of mine.”* But this, too, ended up being untruthful. Good Officers were hung out to dry in the public eye, even though they did absolutely nothing wrong, just so Dean Williams could justify his belief of guilt and comments he had made publicly to Legislators and the Governor. Nothing has changed about the institutions’ obligations to accept and care for the people remanded pursuant to Title 47. Officers are still on the short end of an admittedly broken system. The only difference is, they have now been disciplined and publicly vilified as well.

Due Process Violations

Multiple due process violations were committed in the course of Dean Williams’ fourth investigation. First, the entire investigation was not conducted fairly or objectively. Dean Williams had a preconceived notion of the event and had planned discipline prior to arriving in Fairbanks. He acknowledged this bias

on multiple occasions throughout the interview process. Dean Williams stated his personal opinion in one witness interview below:

*“In reviewing the video, I’m just giving you a chance to push back on me about **what I think** the video shows. **What I see** on the video is you doing a kinda quick walk by, glancing in, and just keep on going. And there may be reasons for that, and I’m going to ask you about that in a minute, I mean this is a very busy place, there’s lots of expectations, I get that right, I get that is part of the problem with having title 47s in jails in the first place. I get it. But to me and looking at the video it looks like you glanced by and go by and I don’t know how you could possibly see someone breathing in that short amount of time. So I need you to **tell me where I am wrong.**” (Emphasis Added)*

This is a perception based argument and Dean Williams is not a subject matter expert. How can any Officer possibly respond to this kind of statement? An impartial investigator is supposed to find the facts. Instead, Dean Williams states his bias when he says he already believes an Officer acted inappropriately prior to completing his investigation. If the Officer is honest and tells Dean Williams he is wrong, the Officer knows that Dean Williams, who has already made his determination of the situation clear, will think the Officer is lying. This is an impossible position for the Officer and is not how investigatory hearings are supposed to be conducted. Comments such as these clearly show Dean Williams’ bias. Throughout all of the interviews, it was clear that Dean Williams, a man who has no experience or training in an adult correctional facility, already knew he was going to assign guilt prior to arriving in Fairbanks.

Dean Williams knew the Troopers conducted an investigation and even cited their conclusions in the Administrative Review. *“According to the Troopers’ report, a correctional officer reported seeing Mr. Joseph’s torso rise and fall at 0227 during a routine security check.”* This, too, was ignored and Dean Williams concluded that, *“Mr. Joseph took his last breath nearly an hour earlier, and the correctional officer briefly glanced into the cell at 0227.”* Dean Williams’ conclusion was that the Officer was lying and did not observe Mr. Joseph breathing, but this is not supported by any evidence; it is only his belief.

He did not conduct a fact-finding investigation; it was a guilt-finding investigation. At the Alaska State Legislature Judiciary Committee Hearing Dean Williams stated, *“I have some suspicions, I have some concerns, I couldn’t prove anything conclusively on this case.”* The fact is, he already had found the Officers guilty. What he was trying to do, and the only reason he actually talked to these Officers, was to find them guilty of conspiracy as well, which is what he was referring to by the above statement. Dean Williams had a preconceived notion of guilt and saw it through to the end, publicly ridiculing good Officers for doing their jobs, then forcing discipline, regardless of the facts.

All Duties Were Conducted Appropriately and According to Policy

DOC Policy and Procedure 104.04 (Death of a Prisoner)⁹² became effective on July 29, 2014. In the Administrative Review, Dean Williams stated, *“It’s worth noting there was no formalized death investigation policy until a year ago. The existence of a policy represents progress, but significant work is required to strengthen the policy and process.”*⁹³ At no time was training ever provided to any FCC staff on this new policy. Nonetheless, the Officers still performed their duties in accordance with the policy. At one hearing the Officer stated, *“Again I have never been trained, nobody has ever walked me through this. I walked myself through this the first time.”* Despite the lack of training, the Officers performed their duties in accordance with policy.

All Evidence Secured

All videos were secured, preserved, and readily available for anyone to review. No video of this entire incident, angles or timeframes, was ever lost. Dean Williams was concerned that videos from one of the two cameras in the cell were not produced immediately, and implied that some conspiracy existed to hide one.⁹⁴ However, no conspiracy existed, and the video from both cameras was available. Most Officers at FCC are unaware that the D-unit tank, where individuals remanded under Title 47 are held and where Mr. Joseph died, has two cameras. Even Dean Williams admitted that when he was in that exact cell, he did not see the other camera. *“When I was there and I saw you, I had a copy of one video from that cell, and when I went into the cell I missed the fact that there was another camera angle video.”* (Emphasis Added) This oversight is something he again admitted later at a Legislative Judiciary Hearing *“After I actually went to the facility, went to the cell and I missed the fact that there was another second camera angle in the cell. I completely missed it.”* (Emphasis Added) The night of Mr. Joseph’s death, the Officers had many jobs to complete in a short period of time while also responding to a medical emergency, yet they were faulted for not immediately providing the second video.

The camera views the Officers selected that night capture all of Mr. Joseph’s movements at FCC, including when he entered the facility, the floor area where he was searched, the holding cell, and the hallway in front of the holding cell. The entirety of his movements and whereabouts were on the videos the Officers provided to the Alaska State Troopers. The view from inside the holding cell in question is shown synchronized with the view of the hallway and can be played side by side to see Officers conducting their checks and what was occurring in the cell at the same time. Both camera angles from inside the cell show the exact same event; nothing was omitted.

Though one camera angle was marginally grainier than the other, they both captured the entire event. If the camera angles the Officer selected were not good enough for Dean Williams, why has this camera not been repaired and why is it still being used at FCC today? Management determines what tools the

⁹² DOC Policy and Procedure 104.04 (Death of a Prisoner) <http://www.correct.state.ak.us/pnp/pdf/104.04.pdf>

⁹³ Alaska Department of Corrections: An Administrative Review November 13, 2015, Page 5

⁹⁴ In the Administrative Review, at page 16, Dean Williams states that, *“Both Troopers and Corrections investigators were apparently unaware of the second video, which did not surface until the Review Team became involved. It is unclear why this video, which provided the clearest evidence of what occurred, was not turned over earlier.”*

Officers have at their disposal. Management cannot give Officers what it believes to be sub-standard equipment and then fault Officers who use that equipment.

Dean Williams faults Officers for not “securing” the video that day, when it absolutely was secured. The fact that Dean Williams reviewed both camera angles more than ninety days after Mr. Joseph’s death obviously proves that nothing was lost or omitted. For Dean Williams to represent in the Administrative Review that evidence was missing or even intentionally withheld is disingenuous and could not be further from the truth. It is contradictory to Officers and the public to see Dean Williams, himself, altering the video in the case involving Mr. Kobuk by deleting the audio, while at the same time faulting Officers in this case for not citing a second duplicate video that was not even necessary to the investigation, yet preserved nonetheless. How can Dean Williams hold Officers to a different standard than himself, especially when the Officers did not manipulate evidence or hide it to justify false conclusions?

Statements Secured from All Staff

The initial Special Incident Report that the Officers submitted the morning of August 27, 2015 had reports from all Officers directly involved in the incident. Subsequent to the DOC death investigation, additional reports were obtained from less relevant and indirectly involved staff. Everything was included. In the Administrative Review Dean Williams said, “*We also observed significant discrepancies, omissions and inaccuracies in the initial reports filed by both the Troopers and Corrections.*”⁹⁵ This statement is completely misleading. Initial reports are just that, initial. It is unrealistic to expect that the Officers will complete the entire investigation in only three hours. The video tapes alone could not be reviewed at normal speed in three hours. Officers play a specific role in any death investigation. DOC Death Investigation Policy and Procedure 104.04 lists multiple individuals and entities, and their responsibilities, all of whom have roles in a death investigation. Policy does not dictate that the Officers finalize a death investigation in three hours before the end of their shift. The Officers initiated the investigation and compiled the initial background information for the process to proceed. It is completely unreasonable for Dean Williams to now fault the Officers for not completing an investigation in three hours, when in this case, the State has now conducted four investigations over the course of nearly half a year.

Dean Williams’ Time of Death Assumption

In the Administrative Review, Dean Williams stated that Mr. Joseph, “*appears to take his last breaths at 0135.*”⁹⁶ There is no definitive evidence to support this conclusion, only Dean Williams’ personal, non-medical opinion. Before the Judiciary Committee, Dean Williams stated, “*This is my opinion, not, saying this is everyone, but I think he passed when I noted the last agonal breath at 1:30.*”⁹⁷ Dean

⁹⁵ Alaska Department of Corrections: An Administrative Review November 13, 2015, Page 15

⁹⁶ Ibid.

⁹⁷ Dean Williams’ testimony in front of a Joint Judiciary Committee on December 8, 2015, http://www.akleg.gov/basis/Meeting/Detail?Meeting=SJUD%202015-12-08%2010:30:00#tab4_4

Williams is not a doctor and he admits publicly that others disagree with his opinion of the time of death. It is impossible to accurately determine a time of death using just the video evidence.⁹⁸

Mr. Joseph was extremely inebriated and was sleeping off his intoxication in a holding cell in FCC. Just because an inebriated individual takes a deep breath does not mean he died. To suggest this medical conclusion without any medical expertise or background is either poor judgment or a deliberate act to support a preconceived notion that Officers had failed to perform their jobs correctly.

Officers conducted all of their checks. This is readily apparent on the video. Officers confirmed that Mr. Joseph was alive during all of these checks, until he was found nonresponsive in his cell at approximately 3:00 a.m. Medical care was immediately administered by both the nurse and Correctional Officers. Emergency Medical Services were called and arrived on the scene. They also performed life-saving measures for over 15 minutes, after which they rushed Mr. Joseph to the hospital. If Mr. Joseph had been dead for over an hour and a half, as Dean Williams implies, the trained medical professionals who responded would have realized it and there would have been no reason to administer CPR to attempt to save his life. The most plausible explanation is that Mr. Joseph passed in the thirty minutes after the Officer's last check. Then, when the next check was completed, the Officer recognized something was amiss and opened the cell door to check on Mr. Joseph.

Dean Williams' Evidence Tampering Deceived the Public

The images Dean Williams cut from the video of Mr. Joseph's death to include in his PowerPoint presentation to the Judiciary Committee on



Figure 3 – Timestamp 12:45:52



Figure 4 – Timestamp 12:45:54



Figure 5 – Timestamp 12:45:56

⁹⁸ The Special Incident Report showed that Fairbanks Memorial Hospital gave an official time of death at 3:42am on August 27, 2015

December 8, 2015 had a significantly negative effect on all of the Officers depicted. For example, Figure 4 is an image that was cut out of the video and presented in Dean Williams' PowerPoint to the Judiciary Committee.⁹⁹ Regardless of the facts of the situation, Dean Williams knew that by cutting this image out of the video at just the right second, the situation as a whole would be taken out of context. The other inmate did not obstruct Mr. Joseph's airway and only hovered his hand over Mr. Joseph's face for seconds, but that is impossible to know or see in just this one image that Dean Williams released. By looking at Figures 3, 4, 5 (all within 6 seconds of each other) in succession, it becomes obvious that Figure 4 was only one brief moment and the Officers did not act inappropriately in any way.

To take the time to go through the video, then cut the video at just the right moment, so as to give Legislators and the public the impression that two Officers are standing there watching Mr. Joseph being suffocated by another inmate, is no accident. This deception is grossly inappropriate and without explanation gives the public an inaccurate perception of what actually happened. What possible reason could there be for Dean Williams to cut Figure 4 out of the video except to negatively portray the Officers in the window?

Additionally, as could have been expected, the media took the video which was released and used it to maximize their readership. For example, the image of the Officer in Figure 6 has nothing to do with Mr.



Figure 6

Joseph's death. This image was cut at this time to make it appear the Officer is throwing him to the mat. When this image appeared in the Fairbanks News-Miner, the Officer depicted was scorned by members of the public, friends, and even family. When the video is watched in its entirety it is obvious that the Officer gently lays Mr. Joseph, who could not stand on his own, down on the mat.

The effects of these pictures being released and Dean Williams' comments were devastating to the Officers involved, who were ridiculed in their communities. Though Dean Williams mentioned that the other inmate's hand was held there only seconds, by cutting the image at this point, he knew it would be misconstrued. He was looking for controversy and he got it. After Dean Williams released these images and his analysis, an article in the Fairbanks Daily News-Miner reported, "*It also suggests that a correctional officer saw the first assault but didn't take any action to prevent or intervene in further assaults.*"¹⁰⁰ Dean Williams did not clarify this, or any other, misstatements in the press.

⁹⁹ Dean Williams' PowerPoint Presentation to the Judiciary Committee

http://www.akleg.gov/basis/Meeting/Detail?Meeting=SJUD%202015-12-08%2010:30:00#tab4_4

¹⁰⁰ November 16, 2015 Fairbanks News-Miner article, "Troopers, Corrections Department criticized in death of Fairbanks man", http://www.newsminer.com/news/alaska_news/troopers-corrections-department-criticized-in-death-of-fairbanks-man/article_4edb4bc2-8cdb-11e5-8631-33fa61cd8a52.html

This led to devastating comments about Correctional Officers in the Daily News-Miner. Public Comments included (1) *"it sounds like some correctional staff were complicit [sic] in the murder of the citizen. Is the video released to the general public or just fellow state employees?"* (2) *"I agree! It's long overdue...Where's the "transparency" in the Department of Corrections. Has the District Attorney sent the prisoners name and the two jail guards along with the real video and the troopers investigation to the Grand Jury?"* (3) *"...This is an OUTRAGE! This sounds more like a "Hit" at the behest of "correctional officers." At the very least this is murder."* (4) *"The guards involved should [sic] be charged with murder and the so called community service patrol should be sued out of existence [sic]."* (5) *"It goes to show these officers got their laughs and kicks seeing a Native being abused. Prejudice is alive and well, if something was done to prevent this a man would still be alive. With their sick ignorance a man is dead, he is depicted as a drunk but they soon forget he breathed the same air and he is human who deserves Justice."* (6) *"... Personally, I think the "findings" of both DOC's internal investigation [sic], and the Trooper investigation [and I use the term very loosely] constitute "Aiding and Abetting" of murder..."* (7) *"Sure sounds like the correctional officers were covering up a murder. This is outrageous!"*¹⁰¹

The public reaction is understandable; the video was cut, and a still picture taken, to elicit just that reaction. Dean Williams' picture got exactly the response he wanted. How was Dean Williams doing his duty to reform the DOC by showing the Officers' faces? He gave these Officers no warning that he was going to be publicly vilifying them by implicating they contributed to Mr. Joseph's death. Dean Williams knew what effect these images, along with the other images presented, would have on the public.

The Officers are innocent of all accusations, as substantiated by the first three investigations. Regardless, Dean Williams publicly decried the Officers' actions and forced disciplines upon them. The facts demonstrate Dean Williams' bias in this case rather than objective decision-making. The Officers' actions conformed to policy, training, and statewide practices in every way.

¹⁰¹ December 8, 2015 Fairbanks News-Miner article, "Videos reveal problems with protective custody in Alaska prisons", http://www.newsminer.com/news/local_news/videos-reveal-problems-with-protective-custody-in-alaska-prisons/article_551cfbfe-9e4f-11e5-a32a-439cb05492aa.html, 2015 News-Miner article "Troopers, Corrections Department criticized in death of Fairbanks man", http://www.newsminer.com/news/alaska_news/troopers-corrections-department-criticized-in-death-of-fairbanks-man/article_4edb4bc2-8cdb-11e5-8631-33fa61cd8a52.html.

Administrative Investigations

Situation 1 – Assault with an Object

“Case 1 involved an incident in which a correctional officer assaulted an inmate with an object in violation of staff policy. The allegations were corroborated by video footage of the incident. Law enforcement investigated the case and referred it to prosecutors for screening. As of this writing, it is under review by the District Attorney.”¹⁰²

There is absolutely no truth to this allegation. The Correctional Officer referenced above did not assault an inmate. The video footage does not corroborate an “assault.” This is one more example of a false accusation that propagates Dean Williams’ false narrative about Correctional Officers.

The truth is the inmate was being held in the Anchorage Correctional Complex-West – Delta module (segregation unit), which holds some of the most violent, assaultive, and troublesome inmates. Multiple Officers have been threatened and assaulted in this module. After the incident described above took place, the same Officer whom Dean Williams falsely accused of assaulting an inmate was himself attacked, receiving a broken nose and deviated septum, for which the Officer has had to undergo three surgeries to repair the damage done to his face.

Dean Williams used the inmate’s account of the incident to judge the Officer’s actions. The inmate in question has had 59 booking charges against him, including two charges involving providing false information. When passing out commissary items to inmates at approximately 8 p.m. in the segregation Module, the Correctional Officer attempted to awaken the inmate in question so he could give him his commissary items, which he had paid for. It is extremely rare for inmates to ignore their weekly commissary deliveries, and inmates in fact regularly become angry and aggressive when commissary is delayed. This inmate refused to respond to verbal questions and did not move. The Officer attempted to verbally rouse the inmate and knocked on the cell door to awaken the inmate, who continued to ignore the Officer and not move. The inmate was lying on the top bunk with his head on the far side and his feet near the cell door. After several minutes without a response from the inmate, the Officer needed to make sure the inmate was okay. Officers are trained not to enter a cell without back-up. Because the Officer could not go into the cell by himself, he retrieved a long broom, cracked the cell door, and lightly tapped the inmate’s toe. After a few taps, the inmate turned over and said, “What the F**k?” The Officer responded with, “Hey man, I got your commissary.” The inmate responded by telling the Officer to “F**k off.” In addition to ensuring the inmate’s well-being, the Officer was trying to ensure that the inmate received his commissary delivery to prevent other problems in the Module. Even a casual review of the video evidence shows there can be no confusion regarding the Officer’s intent or the actions that occurred. Later, the same inmate refused to take his meds from the nurse and additional Officers had to be called to assist.

¹⁰² Alaska Department of Corrections: An Administrative Review November 13, 2015, Page 6

Falsely and then publicly accusing a Correctional Officer of a criminal activity, an assault, as the public was purposefully led to believe, is disingenuous and significantly damages the public perception of all Correctional Officers. This characterization is wholly inaccurate. The falsehood described by Dean Williams is further exacerbated because he claimed that the incident is currently being reviewed by the District Attorney. Institutional Management and the Troopers both reviewed this incident and found that absolutely no assault had occurred. It was inappropriate and defamatory for Dean Williams to publicly declare that an assault took place, when it did not, and to claim the Officer was at fault, when he was not. Dean Williams clearly had read the report. He absolutely knew what had actually taken place; in addition, it is on video. Dean Williams wanted to be a hero and be perceived as uncovering unknown information. No reasonable and unbiased person could possibly have perceived the events in the way that Dean Williams did. It was not only hurtful to the Officer involved, but continued the false perceptions that Dean Williams wanted to portray of the DOC and its Officers. Now, as Commissioner, he can come in and clean up Corrections by stopping assaults that never occurred.

Situation 2 – A False Report

“A correctional officer accused an inmate of assaulting the correctional officer... A supervisor became suspicious and reviewed relevant video footage of the alleged incident, which showed the correctional officer’s report to be false. Management reversed its finding and dropped discipline against the inmate, but did not call for any disciplinary action except “retraining” for the correctional officer who fabricated the incident.”¹⁰³

The Correctional Officer referenced above was assaulted by an inmate at Anchorage Correctional Complex (ACC). The accusation that this Officer lied is unfounded and completely false. On August 26, 2015, the Correctional Officer in question instructed all of the inmates to return to their cells, though the doors remained open, until the inmates that were transferring out were fed. Chronic understaffing causes friction between inmates and Correctional Officers because when Officer numbers are particularly low inmates are forced to stay in their cells for the majority of the time.¹⁰⁴ Shortly thereafter, the Correctional Officer noticed an inmate out of his cell and ordered him to return. Later the same inmate lured the Officer to his cell by pushing his call button. These buttons are reserved for emergencies in case an inmate needs immediate assistance. When the Officer arrived at the cell the Officer asked the inmate if he had an emergency. He said no. The Officer recognized this non-compliant behavior and noticed the inmate becoming upset, so the Officer decided to shut and secure the inmate’s door. While attempting to secure the door, the inmate waited until the door was almost closed and then he kicked the door shut, slamming the Officer’s hand between the door and the door handle. The Officer called this incident in over the phone, additional Officers responded, and the module was locked down. When the inmate was told he was being removed from his cell to go to segregation because he kicked the door shut on the Officer’s hand, he stated, “*Yea, she is playing God, locking us down like we are animals.*” The inmate never denied that he kicked the door into the Officer’s hand.

“The Correctional Officer referenced above was assaulted by an inmate at Anchorage Correctional Complex (ACC). The accusation that this Officer lied is unfounded and completely false.”

The Officer wrote a report, but was reluctant to go to the hospital and initially refused. Other Officers, seeing the Officer’s injured hand start to swell, finally convinced the Officer to go. These Officers saw that the Officer’s hand was not swollen right after the incident but began to swell as time went by. Neither of these Officers was interviewed about the situation. The Officer was diagnosed at Alaska Regional Hospital with a sprained hand.

¹⁰³ Alaska Department of Corrections: An Administrative Review November 13, 2015, Page 6

¹⁰⁴ Officers at the ACC are overworked and stressed physically and mentally due to the lack of staffing and overcrowding within the DOC. According to the DOC, ACC has been operating at a state of emergency for most of 2015 and 2016. Officers are being forced, under threat of discipline, to work overtime and without any advance notice.

The main evidence against this Officer is, that the Officer did not show any outward sign of being hurt when the door closed, and that the Officer did not show pain or grab her hand. Again, if Dean Williams had any adult corrections experience, or had asked any Officer, he would have known that an Officer is not going to react in anyway if the Officer can help it; an Officer will not show an outward reaction to any inmate if it can be possibly avoided. To show hurt, frustration, or anger at any inmate-initiated situation like this only serves to empower that inmate and others who might be watching.

Since there were at least two witnesses to the Officer's fingers swelling, what is the alternative to the Officer being assaulted by the inmate? Is it more plausible that the inmate, who was angry about being locked down, kicked the door as it was about to close, or that the Officer called for assistance so as to lie about an assault that never happened in order to get an inmate in trouble – an inmate that the Officer did not know and did not have any issues with? Then, somehow, even with other Officers around, the Officer struck her hand hard enough, and in such a way as to cause it to swell, as if it had been jammed in the door handle? Then finally, prior to anyone questioning the Officer about her honesty, are we to believe the Officer would then go back to the doctor a second time because of the pain, for no actual reason?

The video of the incident Dean Williams reviewed was from an isolated camera on the far side of the large room and is inconclusive due to its distance from the incident. The inmate was in his cell and kicking the cell door closed and therefore could not be seen by this camera. The high wall below the window of the inmate's cell obscured the inmate's lower body. Regardless, Dean Williams relied on inconclusive evidence and failed to investigate further before wrongly concluding that the Officer fabricated the incident.¹⁰⁵ Dean Williams knew that his false public accusation against the Officer in the Administrative Review could never be substantiated. Issuing an unsubstantiated public allegation that an Officer lied undermines public trust in Officers and depicts all Officers in a negative light. More importantly, by making it public, it empowers every inmate in Alaska's correctional system.

Furthermore, Dean Williams inappropriately interjected himself into the disciplinary process. He also incorrectly wrote, "*After our Review Team reviewed the video footage and related evidence, and questioned management, management dismissed the correctional officer.*"¹⁰⁶ It is deceiving to use the term "dismissed" as her separation from employment was not a dismissal. The Officer was non-retained. The Association cannot grieve the non-retention of a probationary employee. The DOC and/or Dean Williams used this action to end the Officer's employment, thus backing up his Administrative Review, knowing that it could not be challenged. The Officer was in training, on probationary status, and seeking to become certified by the Alaska Police Standards Council. The DOC retains the right to non-retain probationary Correctional Officers at any time it feels an Officer will not successfully complete the initial probationary period.

¹⁰⁵ Alaska Department of Corrections: An Administrative Review November 13, 2015, Page 6

¹⁰⁶ Ibid.

Inmate Suicides and Institutional Safety

“The public needs to know that Officers act heroically in Alaska’s institutions almost daily to ensure the safety of those being held by the DOC.”

It is alarming to read Dean Williams’ written statement for policy changes regarding inmate suicides: “...general policies require that two correctional officers be present before a correctional officer enters a cell; this policy appears to have caused the delay in aid witnessed in Case 3. The Review Team believes immediate response is warranted in cases of active suicide where there is no conflicting safety or security threat.”¹⁰⁷ Security demands that Officers obtain back-up before rushing blindly into situations that could be set-ups for inmate assaults on Officers, taking an Officer hostage, obtaining control of an Officer’s keys, radio, or pepper spray to use in an escape attempt, or other purposes that could compromise security. The policy requiring back-up is not just for the Officers’ safety, it is also for the safety of the entire institution. By implying that Officers delayed acting to stop a suicide again

makes Officers look heartless and uncaring. Inmates can and do fake suicide attempts. Correctional policies and training nationwide are quite consistent on the need for back-up. Over the years, nationally and worldwide, there have been many tragic instances of security being compromised because an Officer failed to have back-up before compassionately rushing into what turns out to be a trap.

Dean Williams’ comments show a complete disregard for national corrections’ safety precautions and standards. Though Dean Williams’ comment might help make him look good in the eyes of the casual observer, it shows a complete lack of investigative work or even a basic review of the DOC’s Policies and Procedures and the underlying reasons for their existence. Instead of simply talking to an Officer or institutional Manager who could have pointed out the problems with the potential policy revisions, he continued to come up with ill-advised solutions he felt would look good to Legislators and the public, but that would endanger Correctional Officers, institutional employees, and the public.

The public needs to know that Officers act heroically in Alaska’s institutions almost daily to ensure the safety of those being held by the DOC. Not only did these Officers act valiantly, but Officers are at risk of being exposed to blood borne pathogens and communicable diseases every day. Whether they are holding inmates’ wounds closed that are bleeding profusely, giving mouth-to-mouth resuscitation to inmates (even after the inmate vomited in an Officer’s mouth), or are holding an inmate who is attempting to hang himself until help can arrive. All three of the just mentioned examples are real and actually happened. These are the stories that the DOC should be communicating publicly; not thoughtless, ill-conceived comments about a policy that requires Officers to wait for back-up before rushing in to a situation that could be a trap. By portraying Officers negatively, the DOC not only hurts hard-working Officers’ morale and public image, but also negatively affects the DOC’s ability to attract and hire quality Officers to fill vacancies.

¹⁰⁷ Alaska Department of Corrections: An Administrative Review November 13, 2015, Page 9

In the Administrative Review, Dean Williams again attempted to aggrandize himself by stating “*The Review Team suggests a fundamental reset is needed to establish a system-wide expectation of zero suicides. There have been no suicides in the state’s juvenile justice facilities in 20 years. This is not an accident...*” Dean Williams’ statement is accurate when he says this is no accident, but it has nothing to do with him or his Management. For example, McLaughlin Youth Center has completely different staffing ratios than the adult facilities in Alaska. In the adult facilities in Alaska it is not uncommon to have one Officer for 60-100 inmates. In the juvenile facility it is typical to have one Officer with up to 10 juveniles. Additionally, if a juvenile is having a suicidal ideation, staff will sit one-on-one with that suicidal person. The intention to establish a system wide expectation of zero suicides is admirable, but unrealistic given the current staffing levels. The DOC has not designated the staff to make this possible. If Alaska’s adult system had the same inmate-to-Officer ratio as the juvenile system, it would be more realistic to have a zero suicide expectation.

Administrative Review Endangered Officers

In order to make himself look the hero, Dean Williams knew that releasing the videos, some with the audio removed, and a false narrative about excessive force, would generate strong reactions from the public he misinformed. He knew that releasing seemingly incriminating still shots, cut out of the video at just the right time, would generate strong reactions from the public he was deceiving. Dean Williams knew that showing what are daily activities in corrections to an unaware public would be misconstrued, even before his false narrative. He knew he would look the hero for bringing it to light and he was right.

The release of the images and videos has resulted in significant and misdirected public backlash against Correctional Officers. The Administrative Review characterized Correctional Officers as callous, cruel, and responsible for inmates' deaths, through either neglect, indifference, or excessive force. All these allegations are false. The damage from the misrepresentations in the Administrative Review is incalculable and will take years to repair. Publicly and falsely implicating Correctional Officers in crimes has consequences; Dean Williams put Officers' lives, and their families' lives, in jeopardy.

Some of the Threats Made Against Officers on the KTUU¹⁰⁸

“all C/O's needs to be jumped and have them make it feel how it feels to be treated that way...”

“Find out where each & everyone of these officers live and pay them a visit! It's called seek and destroy? These punks trashing on natives & killing them. Maybe these idiots are looking for a race war. GEAR UP!”

“Th[i]s is why people riot. Nothing will change without spilling blood.”

*“What I mean when I say “all cops are b*****” is – literally every single cop is complicit and participating in a system designed to uphold the capitalist oligarchy we live under and thus all cops are guilty of that systems sins.*

*F*** your brother.*

*F*** your cousin.*

*F*** your dad.*

*F*** all cops.”*

“MURDERS!!!!!!!!!!!!!!!!!!!!!!”

“They should get the guillotine!”

“THOSE GUARD GOT A WATCH THEIR BACK NOW.”

“all C/O's needs to be jumped and have them make it feel how it feels to be treated that way...”

¹⁰⁸ KTUU Facebook page, <https://www.facebook.com/Ch2KTUU> and January 6, 2016 KTUU Newscast, “Governor releases 3rd video of inmate death; family calls for prison reform”, <http://www.ktuu.com/news/news/third-video-of-inmate-death-released-by-alaska-governors-office/37304746>

Officer Statements on the Impact of Dean Williams' Actions

“All the Officers including myself are very upset [with] the news broadcast, it has impacted every one of us professionally and personally. Every day we are ridiculed by remands saying we are the ones killing people and they intend on suing us. Everyone feels their safety is always at risk. However, [now] at a more elevated rate. Family members and friends are at risk as well when we are in the community conducting everyday errands or going out for a meal. Not to mention most have been queried by people they know [to the effect of], do you know those correctional officers who kill people.”

“...this is completely devastating all of us that are involved. I'm deeply concerned for all our welfare. This is impacting everyone professionally and personally. Williams is not an expert nor well versed in the correctional environment and should be sued for defamation.... Williams has single handedly ruined our professional and some of our personal relationships just to make a political name for himself.”

Acting Commissioner Monegan E-mail to all Correctional Officers¹⁰⁹

“Folks – I understand many of you may feel uneasy with some of the community response to the news stories on the released videos.

...

Carrying weapons are more problematic; every year cops all across the country are shot with their own weapons, and they are trained to retain and use specialized equipment to keep weapons secure – but still lose them and have them used on them. OC spray is preferred as less lethal and requires less accuracy in an emergency close up situation. Ultimately, your best defense is you; be watchful and surprise is less likely...

...

You work every day with similar folks, so you understand how such talk erupts. Don't get rattled by the chatter, you are all professionals – in calmly conducting yourselves in your daily life, you will reassure your family, your love ones, and this community, that we will remain focused upon our mission...”

In the above e-mail, the Acting Commissioner lays out many safety tips for Officers. What does it say about the situation resulting from the release of the Administrative Review and subsequent media coverage if an Acting Commissioner feels the need to disseminate safety tips to his employees?

No group of Alaskan citizens should be so disrespected and humiliated. Correctional Officers perform the toughest law enforcement job in the State and nation. They should be afforded the same respect as any Alaska citizen and commended for the dangerous and difficult jobs they do. The Officers' actions

¹⁰⁹ January 8, 2016 Letter from Acting Commissioner with safety tips for Officers, <http://www.acoa.us/wp-content/uploads/2016/04/2016-1-8-Monegan-Email-to-Officers.pdf>

in the video, which Dean Williams condemned or claimed were excessive in nature, are occurring daily. Every day Officers are being directed to perform exactly as they did in the videos for which they were previously persecuted.

Currently, Officers are not sure how to proceed after seeing their colleagues vilified in the news for performing routine actions. Dean Williams' public campaign against Officers, their training, and the DOC Policies and Procedures have Officers questioning adherence to the policies that govern their actions. Officers cannot be hesitant to act when dealing with potentially violent individuals; it will only lead to more injuries and assaults. That is why it is absolutely imperative that the DOC clearly outline how it expects Officers to act. The Administrative Review, inappropriate disciplinary actions, and misleading information released publicly have significantly affected Correctional Officers' ability to do their jobs without second-guessing whether they, too, will be disciplined and condemned publicly for following their training and the DOC Policies & Procedures.

On February 16, 2016 the Association's Board of Directors sent Dean Williams a letter concerning his expectation for Officers' actions given his comments that directly contradicted DOC Policies and Procedures. It has now been a month and a half without a response. That is completely unacceptable with both Officers' and inmates' lives on the line. Dean Williams' lack of response to these questions leaves Officers still questioning how they are supposed to respond in situations.

Specifically, the Association's Board of Directors asked the following questions of the Commissioner on February 16, 2016.¹¹⁰

“Would you please clarify your statements below?”

Administrative Review: *“In one interaction, Mr. Mosley was sprayed with pepper spray in his cell. Correctional officers reported they sprayed Mr. Mosley because he pulled away from correctional officers who were trying to un-cuff him. The video reveals Mr. Mosley had fallen down before he was sprayed, and posed no immediate threat.”*

December 8, 2015 - Judiciary Committee Hearing: *“I find no justification. Plainly.” In response to the question “What justification could there be for spraying someone when they are already back in their cell?”*

Is it your expectation that Officers will never utilize pepper spray on an inmate in a cell? For example, if a suicidal inmate is being non-compliant and has possession of an object, such as a handcuff, which they could use to harm themselves, is it your expectation that Officers will not use pepper spray to gain compliance? If so, would the Officers be disciplined for leaving the inmate as is, in order to complete other duties? It is our understanding the Officers in the above situation would have been disciplined if they had not removed the handcuff in question. Are you aware that Officers, over their concerns

¹¹⁰ February 16, 2016 Association Board of Director's letter to Commissioner Dean Williams, <http://www.acoa.us/wp-content/uploads/2016/03/2016-02-16-Expectation-of-Officers'-Actions-in-the-DOC-Letter.pdf>

and objections, are being directed to act in the exact same manner as they did in the Mosley spraying? Please clarify your expectations.

Administrative Review: “*Mr. Mosley was naked for many days in a row, and was moved in the hallway unclothed. This is an unacceptable standard of care.*”

December 8, 2015 - Judiciary Committee Hearing: “*...Being nude is unacceptable in prison. It’s just unacceptable...*”

It is standard practice for inmates on suicide watch to have all of their clothes removed and to be provided only a suicide smock. A suicide smock is an anti-suicide, tear-resistant, single-piece outer garment that is thick and sturdily constructed. It is impossible for an individual to use this type of clothing to harm themselves by making a noose to commit suicide or in any other way. Currently it is at the inmates’ discretion to wear or not to wear this smock. Your statements imply that Mr. Mosley’s nudity was something irregular in the institutions. It is quite the opposite. Is it your expectation that Officers are to physically dress inmates who choose to be naked? If so, when an inmate is non-compliant, should Officers use force to physically clothe them? Please clarify your expectations.

Administrative Review: “*There does not appear to have been a clear and immediate safety threat such as an assault or attempted escape to warrant the level of force used.*” [In regard to the death of Larry Kobuk]

*Please clarify what you consider a clear and immediate safety threat? When an inmate, who has a history of fighting Officers, is being non-compliant to necessary orders and is saying things to the effect of “...kill the cop..., f***ing splatter their brains..., ...put a bullet in their f***ing head..., ...I am going to shoot you in the f***ing head...”, is it your position that Officers cannot use force to gain compliance unless there is a “clearer and more immediate safety threat”? What do you consider a safety threat? Do Officers first have to be assaulted for there to be an immediate safety threat?*

Additionally, when a search needs to be conducted, is it your expectation that Officers should leave the inmate in a cell with his street clothes on and unsearched if they are non-compliant? How can the Officers know if the remand has a weapon, which he might use to harm himself or others? Are you aware that Officers, over their concerns and objections, are now being directed to act in the exact same manner as they did in the Kobuk death? Please clarify your expectations in these areas.”

Correctional Officers still have not received answers to these important questions. Officers continue to act in compliance with existing DOC Policies & Procedures, but experience additional, unnecessary stress because they do not know when they may also be disciplined or publicly condemned for following those DOC Policies & Procedures.

In other cases, Dean Williams also omitted information that would have provided a complete and accurate picture of what happened and why. One such example was the public release of video in which Officers strip-search an inmate. He offers no explanation or context. Failing to provide an explanation about DOC Policies & Procedures and the reasons the strip search was done purposefully to garner a negative public reaction. Dean Williams hurt Officers with the false narrative that was published. Even though Dean Williams has been shown that his facts are wrong, and even though he has repeatedly been asked to do so, Dean Williams has refused to rectify the situation or admit his inaccuracies.

“Dean Williams also omitted information that would have provided a complete and accurate picture of what happened and why.”

Further proof that releasing videos, which condemned Officers, was merely a political maneuver by Dean Williams, is reflected in the double-standard of the State publicly apologizing for seizing a reporter’s photos.¹¹¹ In this incident involving a Trooper, *“The state denied an ADN request for the transcript of any radio traffic between the trooper and emergency dispatchers during the stop.”* Additionally, *“The resulting 4-month investigation by the Office of Professional Standards culminated in a 680-page report that was completed this month, the newspaper reported Wednesday. The Frontiersman and Alaska Dispatch News requested copies of the final report. The state denied both requests, citing a state law that makes personnel records confidential.”* This double-standard of releasing images and videos of innocent Correctional Officers doing their jobs as directed, but not releasing the information about a Trooper who *admitted* guilt is further proof that Dean Williams defamed Correctional Officers for political gain. This discrepancy was addressed, including in a face-to-face meeting between the Association’s Business Manager, the Governor, and his Chief of Staff.

In addition, Officers were caught completely off guard by the release of the video to the public and inmates. No advance notice was given to even those Officers who were readily identifiable. No advance notice was given to Correctional Management at any level. Institutional Managers were caught completely off guard. The videos were aired on the evening news, allowing every inmate sitting in front of a television to see them, with Officers’ faces not blurred. This endangered Officers. It also shows that Dean Williams did not discuss or vet the release of the videos with any experienced Corrections personnel. He acted in his own best interests, regardless of the dangers to Correctional Officers.

¹¹¹ December 31, 2015 Alaska Dispatch News article, “Troopers apologize to newspaper for seizing reporter’s photos”, <http://www.adn.com/article/20151231/troopers-apologize-newspaper-seizing-reporters-photos>

Dean Williams Acted Improperly and Illegally

Dean Williams released videos of Correctional Officers at work without legal authority to do so and without the Officers' consents. He did not just release the videos; in one case, he knowingly altered it before releasing them. He released the video without any sound, which was a critical part of the event. In doing so, Dean Williams violated the videoed Officers' rights under DOC Policies and Procedures 808.02 (v) and (v1), F 2, and 1207.01 (Use of Force). His actions also violated State statutes (Criminal Code and the Personnel Act) and the Alaska Constitution.

Violation of DOC Policy & Procedures

DOC Policy 808.02¹¹² states that it shall be DOC policy to protect the privacy of DOC employees. This explicit policy, consistent with the State Personnel Act, Alaska Statute 39.25.080, gives Correctional Officers an expectation of privacy while on the job. The DOC privacy policy serves an especially critical public interest because of the nature of Correctional Officers' work. Correctional Officers have heightened and compelling safety and privacy interests to avoid potential intrusions into their personal lives that might be made by friends or colleagues of inmates or by former inmates. For these reasons, DOC Policy 808.02 also requires that media must obtain advance, specific, permission to film DOC staff. Dean Williams violated Policy 808.02 when he released the video to media.

He also violated DOC Policy 1207.01 (Use of Force).

F. Video Recording.

- 2. Video recordings of use of force are considered part of the Special Incident Report and are confidential and not subject to release under the Public Records Act unless specifically approved by the Public Records Coordinator.*
- 3. Video recordings of use of force shall not be altered.*

Dean Williams, apparently not content to ignore the confidential nature of the video recordings of use of force, defied the quoted proscription in section 1207.01(F)(3) by eliminating the sound. He has admitted that he did so. Because he eliminated the sound, viewers of the video have been deprived of experiencing the depicted situation from the perspective of the Correctional Officers who were endangered while they performed their professional duties.

Violation of Criminal Statutes

Alaska Statute 11.56.610(a) - Tampering with Physical Evidence

“A person commits the crime of tampering with physical evidence if the person

- (1) destroys, mutilates, alters, suppresses, conceals, or removes physical evidence with intent to impair its verity or availability in an official proceeding or a criminal investigation;*

¹¹² DOC Policy 808.02, <http://www.correct.state.ak.us/pnp/pdf/808.02.pdf>

(2) makes, presents, or uses physical evidence, knowing it to be false, with intent to mislead a juror who is engaged in an official proceeding or a public servant who is engaged in an official proceeding or a criminal investigation.

Alaska Statute 11.81.900 (Definitions) defines “official proceeding” to mean “a proceeding heard before a legislative, judicial, administrative, or other governmental body or official authorized to hear evidence under oath.”

Dean Williams intentionally altered and concealed video evidence – the audio – and so impaired the “verity” of the video and the availability of sound, to Legislators, readers of his Administrative Review, and members of the general public. By doing so, he contravened Alaska Statute 11.56.610.

Alaska Statute 11.56.820(a) - Tampering with Public Records in the Second Degree

“A person commits the crime of tampering with public records in the second degree if the person

- (1) knowingly makes a false entry in or falsely alters a public record;*
- (2) knowingly destroys, mutilates, suppresses, conceals, removes, or otherwise impairs the verity, legibility, or availability of a public record, knowing that the person lacks the authority to do so.”*

Dean Williams, in his capacity as a state official, violated Alaska Statute 11.56.820(a). By his own admission to the press, he altered the video by removing its audio and so impaired its accuracy.

Alaska Statute 11.56.815 - Tampering with Public Records in the First Degree

(a) “A person commits the crime of tampering with public records in the first degree if the person violates

- (1) AS 11.56.820(a)(3) with intent to obtain a benefit for that person or any person or to injure or deprive another person of a benefit. . .*
- (b) Tampering with public records in the first degree is a class C felony.”*

Dean Williams knowingly altered the video before its release, concealing facts material to an investigation, to gain the benefits of appointment as Commissioner and of using the distorted video to conform to his inaccurate version of the depicted events.

Alaska Statute 11.56.850(a) - Official Misconduct

“A public servant commits the crime of official misconduct if, with intent to obtain a benefit or to injure or deprive another person of a benefit, the public servant

- (1) performs an act relating to the public servant’s office but constituting an unauthorized exercise of the public servant’s official functions, knowing that that act is unauthorized;*

(2) knowingly refrains from performing a duty which is imposed upon the public servant by law or is inherent in the nature of the public servant's office."

When he modified the video, Dean Williams intended to obtain a benefit for himself and intended to harm the reputation of one sitting Commissioner and the Correctional Officers depicted in the video. He wrote a political piece to secure himself the position of Commissioner of Corrections, divert attention away from the real staffing and safety problems in the DOC's institutions, and unfairly harm the Correctional Officers' reputations to enhance his own reputation. He should have known as a special investigator that he should not have altered the video by removing the audio, without telling people he had done so when presenting the video to show what occurred.

Violation of Alaska Constitution and Other Statutes

As already noted, Correctional Officers, in common with other Alaskans, are afforded privacy rights under Article 1, Section 22, of the Constitution of Alaska. In keeping with the Constitution, the State Personnel Act at Alaska Statute 39.25.080 explains that personnel records *"are confidential and not open to public inspection,"* albeit with some carefully drawn exceptions that are not pertinent to this situation. Taking into account the critical public interest in Correctional Officers' safety, and the Officers' expectations of privacy under the Constitution, the Personnel Act, and the DOC Policies & Procedures, videos purporting to show Correctional Officers performing their duties (especially distorted videos) should not have been released to the public without the Officers' consent.

It is undeniable that the video is a "record" under Alaska Statute 40.21.150, which defines "public records." This statute defines "record" to mean:

"any document. . . photo. . . microfilm. . . electronic record, or other document of any other material, regardless of physical form or characteristic, developed or received under law or in connection with the transaction of official business and preserved or appropriate for preservation by an agency. . . as evidence of the organization's function, policies, decisions, procedures, operations, or other activities of the state . . ."

Although the Alaska Public Records Act (Alaska Statute 40.25.100 - .295), generally allows members of the public *"to inspect a public record in the state,"* AS 40.25.120 puts limits and exceptions on the right of access to certain public records. Among the exceptions to public disclosure are *"records or information compiled for law enforcement purposes. . . to the extent that the production of the law enforcement records or information could reasonably be expected to interfere with enforcement*

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proceedings”¹¹³; “*would disclose confidential techniques and procedures for law enforcement investigations or prosecutions*”¹¹⁴; “*could reasonably be expected to endanger the life or physical safety of an individual*”¹¹⁵; records or information compiled for law enforcement purposes, to the extent that the production of the law enforcement records or information, “*could reasonably be expected to constitute an unwarranted invasion of the personal privacy of a suspect, defendant, victim, or witness*”¹¹⁶; “*would deprive a person of a right to . . . an impartial adjudication*”¹¹⁷; or “*could reasonably be expected to endanger the life or physical safety of an individual or to present a real and substantial risk to the public health and welfare.*”¹¹⁸ Because Correctional Officers are duty-bound “*to enforce and preserve the public peace,*” they are “*peace officer[s]*” within the definitions at Alaska Statute 01.10.060. Their jobs include law enforcement.

In short, Dean Williams disregarded two key provisions of the Alaska Constitution - the Privacy clause and the Due Process clause (which encompasses the guarantee of fair treatment in investigations) - when he released the videos without notice to the depicted Officers. Dean Williams was either unaware of the Officers’ constitutional rights and statutory rights, or, if he was aware, he willfully disregarded those rights. He released the video recordings and commented critically about the Officers without talking to most of the Officers and hearing their side of the story, or notifying them that the video recordings would be released.

¹¹³ Alaska Statute 40.25.120(a)(6)(A), <http://www.touchngo.com/lglcntr/akstats/statutes/title40/chapter25/section120.htm>

¹¹⁴ Ibid., (6)(E)

¹¹⁵ Ibid., (6)(G)

¹¹⁶ Ibid., (6)(C)

¹¹⁷ Ibid., (6)(B)

¹¹⁸ Ibid., (10)(C)

Conclusion

Dean Williams' Administrative Review was purposely deceptive in many areas. Correctional Officers were not responsible for any of the inmates' deaths discussed in the Administrative Review. Dean Williams' commentary regarding the Administrative Review that accompanied the released videos misled Legislators and the public to wrongfully conclude that some Officers involved acted criminally and that others were simply cruel and uncaring. He withheld and manipulated information that would have helped everyone better understand these incidents and the actions of Correctional Officers. He made no attempt to explain that certain procedures and protocols are required to preserve security within correctional facilities, and that the Correctional Officers acted in compliance with their training and necessary DOC Policies & Procedures. Despite being provided solid evidence, by many individuals at many levels, that his report was filled with inaccuracies, he made no attempt to set the record straight.

Dean Williams' actions, leading up to his appointment as Commissioner, have exposed Officers to, among other things, unnecessary and increased risks inside and outside of the institutions, public condemnation, and unwarranted disciplinary action. It is now the duty of the State to correct the wrongs inflicted. Dean Williams needs to retract the false elements in his Administrative Review, reverse the unwarranted disciplines Officers suffered, and, as Officers are currently being required to conduct their actions in the same manner he publicly criticized them for, clarify the DOC's expectations.

The Governor and Dean Williams must immediately and publicly set the record straight by acknowledging the erroneous items in the Administrative Review, and defend the Officers' actions. A public acknowledgment that sections of the Administrative Review were incorrect - and failed to relay a complete picture of the various situations - would help improve Officers' morale and public image. All Officers have been injured by the inaccuracies, regardless of whether they were directly involved in the incidents mentioned in the Administrative Review. Correctional Officers throughout Alaska expect the State to attempt to correct the damage that was unnecessarily inflicted on them and the profession as a whole. This is not too much to ask.

The State can also begin to repair the damage to Officers by rescinding the unwarranted disciplinary actions against them in the cases covered in the Administrative Review. Acknowledging that Officers

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acted appropriately, and acknowledging the difficult service they perform for the State, would begin to repair the damage that has been done. Reversing the harm caused by the Administrative Review would assist in creating better labor/management relations and help the affected Officers feel validated and appreciated for the dangerous jobs they perform in institutions that remain understaffed. Neither retracting the inaccurate sections of the Administrative Review, nor rescinding unwarranted disciplinary actions will require a budgetary appropriation.

The DOC should also respond promptly to Correctional Officers' request for clarification and explanation on the DOC Policies & Procedures that the Administrative Review specifically criticized, yet remain in effect today. Correctional Officers must follow orders every day. Seeing their fellow Officers smeared in the press by the current Commissioner, seeing their fellow Officers' faces shown publicly, for actions they are ordered to implement every day, is extremely concerning to them. Dean Williams has not yet responded to Officers' concerns, including the letter sent to him on February 16, 2016 by the Association's Board of Directors. He must respond.

Finally, the most significant way the State could remedy this matter is to make good on its word and address the staffing, training, and safety issues Correctional Officers have been asking to have resolved for years. Trying to hide a problem, such as insufficient staffing, and then blaming Officers when understaffing contributes to inmate deaths, does nothing to establish Management's credibility with the Officers. The State must recognize the systemic problems plaguing the DOC, mainly acute understaffing, which endangers the lives of the public, inmates and Officers. It is far better to be forthright about problems that exist and look for common solutions which can benefit the State and the Officers. Only then will the safety of Officers, inmates and the public be improved. The Association has always been willing to work as a cooperative partner to achieve the best results for the Officers and the DOC. Dean Williams' public statement that he is about "... *safety, safety and safety*"¹¹⁹ sounded good to Legislators and the public, but without actions does Officers no good.

As has been stated many times, the Association has worked, and will continue to work with the Commissioner in a cooperative and professional manner, at all times, to resolve the many issues within the DOC. The Association will meet with the Commissioner as many times as he will allow. The Association will also work for a public retraction of the false and misleading statements in the Administrative Review. Every action necessary will be taken to undo the damage to Correctional Officers' image as a whole, to clear the innocent Officers mentioned in the Administrative Review, and to do what Dean Williams should have done - and what he promised to do - be transparent and honest.

¹¹⁹ January 28, 2016 Governor's Press Conference, <http://gov.alaska.gov/Walker/multimedia/videoscfde.html?vid=408>