Raising Arizona’s Commitment to Health and Safety: The Need for Independent Oversight of Arizona’s Prison System

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INTRODUCTION

Over the last decade or so, Arizona’s prisons have become synonymous with mismanagement, lack of safety, unconstitutional health care, and abysmal conditions for people in custody. The problems that have marred the corrections agency’s reputation have been documented in countless news stories and show the agency’s seeming inability to address even the most fundamental flaws in its operations that lead to violence and deaths in custody.¹ A litany of scandals, including broken locks on cell doors, abuses of incarcerated people, riots, escapes, horrific care of pregnant women, and water shortages have also dominated news headlines.² Moreover, a federal class-action lawsuit about Arizona’s disastrous privatized prison health care delivery system has spanned many years; it led to a detailed settlement and also to a civil contempt order against the prison agency and $1.4 million in fines for violating the terms of that settlement.³ The longtime prison chief Charles Ryan resigned in 2019 amid calls for his firing, immediately before

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2. See infra Part I.

the release of an independent report commissioned by the governor that was sharply critical of Ryan’s leadership.\(^4\)

Beyond this seemingly endless parade of institutional problems, Arizona has somehow resisted the national trend toward sentencing reform and efforts to reduce the footprint of incarceration. Across the country, most states have adopted numerous strategies that have led to closures of prisons, reduced prison populations, and significant cost savings in the corrections budget.\(^5\) The national prison population has shrunk 9% since hitting its peak in 2009, with seven states seeing a decline of over 30% during that time period.\(^6\) But in Arizona, the prison population has grown by 60% since 2000,\(^7\) and this rapid growth has put increasing pressure on every aspect of the corrections enterprise. A recent report indicated that Arizona’s prison population growth can be attributed to the state’s decision to increasingly imprison people convicted of nonviolent offenses as well as to incarcerate people for periods significantly longer than the national average.\(^8\) The budget for corrections has ballooned to $1.1 billion annually, and prison spending exceeds state spending on higher education, child safety, and family social services.\(^9\) Yet even with this increase in spending, understaffing in Arizona prisons remains a serious concern, with staff threatening walkouts for fear of their safety\(^10\) and filing lawsuits over their working conditions.\(^11\)

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8. Id. at 9–19.

9. Id. at 4.


Arizona has the nation’s eighth largest state prison system12 and the fourth highest incarceration rate in the country,13 but its deep-seated prison problems are outsized even by those standards.

It is little wonder then that policymakers, advocates, and others have been calling for independent oversight of the Arizona corrections system to increase transparency and accountability and to better protect the safety of those who live and work in the state’s prisons.14 But what exactly does “independent oversight” mean, and what might it look like in Arizona? In this article, I explore those questions, and I seek to provide guidance to policymakers interested in how an external oversight mechanism could help promote healthier and safer prison conditions and help keep legislators and the public better informed about what is happening behind the walls.

Part I of the article provides a deeper dive into the myriad issues of concern about the Arizona prison system. Beyond the scandals and lawsuits, the current COVID-19 pandemic puts the prison health care crisis in stark relief. If ever there were a time to demand greater transparency about conditions in prison, that time is now.

Part II discusses federal court involvement on issues related to prison health care in the case of Parsons v. Ryan (now renamed Parsons v. Shin).15 This ongoing lawsuit raises the potential for court-ordered oversight of the Arizona Department of Corrections, perhaps in the form of a receiver. In this Part, I explain the differences between court oversight in conjunction with a lawsuit and preventive monitoring by an independent government body and show why both are necessary for the protection of people in custody.

Part III addresses the critical need for permanent independent oversight of the Arizona prison system, above and beyond any temporary oversight structure established by the federal court. I highlight the American Bar Association’s call for independent oversight to be established in every jurisdiction, and I explain how independent monitoring benefits people in custody and their loved ones, policymakers, advocates, and correctional

13. FWD.US, supra note 7, at 3.
administrators and staff. I also discuss the state of correctional oversight in the United States and the most effective prison oversight models.

Finally, Part IV explores what an oversight body in Arizona might look like. I examine recent legislation in Arizona that proposed potential structures for this entity, and I suggest an approach for Arizona that builds on what we are learning from other jurisdictions in the United States about the powers and duties that help make oversight bodies effective.

I. ARIZONA’S RECENT HISTORY OF PRISON CONTROVERSIES

From the time of Charles Ryan’s appointment as head of the Arizona Department of Corrections (ADC) in 2009 (first as Interim Director and later as Director),\(^\text{16}\) the agency has been mired in controversy. Soon after Ryan’s 2009 appointment, a woman named Marcia Powell died at the ADC’s Perryville Prison after being left in an outdoor holding cell for four hours in 108-degree heat.\(^\text{17}\) Not only were the circumstances that led to Ms. Powell’s heat stroke deeply disturbing, but so too was Ryan’s decision to remove the comatose woman from life support within hours, without first contacting the person who had been appointed as her guardian since Powell had been previously adjudged an incapacitated adult.\(^\text{18}\) While Powell’s death was termed an “accident” by the medical examiner,\(^\text{19}\) it raised significant concerns about the treatment of people in custody and the adequacy of their supervision.

Further troubles soon followed. In 2010, there was the suicide of a twenty-six-year-old man with mental illness who had been taken off suicide watch and erroneously provided with razors, revealing a lack of staff training about mental illness and suicide prevention.\(^\text{20}\) Then, in 2011, Amnesty International filed a report criticizing Arizona’s solitary confinement practices, and in particular the ADC’s use of Special Management Units (SMUs), finding that


\(^{18}\) \textit{Id.}

\(^{19}\) \textit{Id.}

conditions in these units fell below international human rights standards. Specifically, the report found that

more than 2,900 prisoners are held in Arizona’s highest security maximum custody facilities, the majority in the SMUs at ASPC-Eyman. Most are confined alone in windowless cells for 22 to 24 hours a day in conditions of reduced sensory stimulation, with little access to natural light and no work, educational or rehabilitation programs. Prisoners exercise alone in small, enclosed yards and, apart from a minority who have a cell-mate, have no association with other prisoners. Many prisoners spend years in such conditions; some serve out their sentences in solitary confinement before being released directly into the community.

Just as troubling, Amnesty noted that the ADC refused the organization’s request to visit the facilities or to meet with ADC officials, in striking contrast to the response that Amnesty usually receives from other corrections agencies around the world. The lack of transparency this response revealed about ADC’s operations and conditions in the facilities raises a host of concerns.

The problems did not stop there, though. The lax security of Arizona’s private prisons became the focus of national news following the escape of three incarcerated people from the private Kingman facility, the ensuing manhunt, and the murder of an elderly couple that crossed paths with the escapees. That same private prison was the site of three days of riots in 2015 due to poor living conditions, leading to the hospitalization of thirteen people. And a young man was sexually assaulted and killed at Kingman, revealing a pattern of violence, inadequate supervision, and misclassification of incarcerated people. Despite all the ongoing concerns about the safety of

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22. Id.

23. Id.


private facilities in Arizona and beyond, agency administrators continued to promote plans to expand privatization in the state. Moreover, the contracts signed with private prison operators included clauses that guaranteed the facilities would remain 90% to 100% full, which experts routinely condemned as contrary to thoughtful public policy because they would lock the state into expensive arrangements and would undermine efforts at sentencing reform.

In 2012, lawyers from the Prison Law Office and the American Civil Liberties Union filed suit against the ADC challenging the constitutionality of health care provided to incarcerated people in Arizona as well as the prison agency’s improper and excessive use of solitary confinement, both of which the suit blamed for serious harm and unnecessary deaths. Reports filed by experts in medical care, mental health, and dental care revealed systemwide problems that had led to these harms. The class-action lawsuit resulted in a detailed settlement agreement in 2014 that required the agency to meet more than 100 health care performance measures and to overhaul its rules regarding restrictive housing for people with mental health challenges so that they receive more out of cell time and more programming. The plaintiffs’ attorneys have charged over the years since that the agency has failed to comply with the terms of this settlement agreement, resulting in increased


31. See id. at 16.

numbers of suicides and suicide attempts, as well as other harms from medical neglect.33 One report filed by the attorneys found that pregnant women faced an egregious lack of prenatal and postpartum care, resulting in some miscarriages and one woman giving birth alone in her cell.34 The lack of compliance finally led to a contempt ruling by a federal judge in 2018, along with a $1.4 million fine;35 that contempt order and the fine were recently upheld on appeal.36 Observers are watching to see if the ADC will be placed under long-term court oversight,37 as will be discussed in more detail in Part II.

A host of other problems came to light during 2018 and 2019, including a series of extraordinary security violations.38 A media investigation revealed that cell doors at a number of prison facilities did not lock properly, which resulted in serious assaults against staff and incarcerated people, including two deaths.39 At the Lewis maximum-security facility, the faulty locks led to a chaotic incident in November 2018 in which incarcerated individuals set fires outside their cells, and the entire unit needed to be evacuated.40 Footage of the incident showed that officers watched the incident unfold and did not intervene, suggesting that such behavior was normalized.41 In another incident at Lewis a few weeks later, security footage showed multiple prisoners leaving their cells after tampering with the faulty locks and overpowering and assaulting the officers on duty.42 In the wake of these events, the unit’s warden and deputy warden retired, and the governor

35. Jacques Billeaud, Arizona’s Prisons Boss Found in Contempt over Inmate Care, ASSOCIATED PRESS (June 22, 2018), https://apnews.com/3fd3a4319e544a9589ad9e3f3ea5d07 [https://perma.cc/38GU-FWX4].
37. Rothschild, supra note 3, at 969–71.
39. Id.
40. Id.
41. Id.
ordered an investigation to be conducted by two former state supreme court Chief Justices, Rebecca White Berch and Ruth McGregor. The report, issued in August 2019, was a scathing indictment of Director Ryan’s leadership as well as facility management and highlighted concerns about a culture of complacency, lack of staff morale, understaffing, and gang activity. The report also revealed that the door locking mechanisms had been faulty for many years and that officials failed to address the problem or even recognize the urgency of doing so, and did not request funding from legislators to fix the locks.

Director Ryan resigned during the course of this investigation, but the agency’s problems did not end with his departure. Custodial staff felt sufficiently unsafe that they filed a federal lawsuit against the agency, claiming that they were at serious risk of assault, and internal reports also show that the agency is critically understaffed. Moreover, a correctional sergeant who was a whistleblower regarding the dangerous conditions at the Lewis facility recently died of an apparent suicide. Additionally, assaults on staff and inmate-on-inmate assaults remain stubbornly high, according to data collected by the agency.

Also, in the summer of 2019, two Arizona prison units (Kingman and Douglas) endured critical water shortages for several days. The facility in

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44. Id. at 12–15, 36–37.
46. Hsieh, supra note 45.
47. Russett v. Arizona, 798 F. App’x 111, 112 (9th Cir. 2020) (dismissing the lawsuit on grounds of qualified immunity).
51. Elizabeth Whitman, Updated: Kingman Prison, Site of 2015 Riots, Faces Water Shortages, PHX. NEW TIMES (July 24, 2019, 4:45 PM),
Douglas lost access to running water for four days, which led to over 2,000 people using fifty portable toilets and fighting over bottled water. And the Kingman facility’s water supplier limited the amount of water diverted to the complex in order to repair a well. These water shortages provided further evidence that incarcerated people in Arizona prisons face conditions that put their health and safety at risk.

Any hope that 2020 would be any better was quickly dashed. The COVID-19 crisis arose in early 2020, creating extraordinary new challenges for the agency and exacerbating the deficiencies that previously existed. Prisons and jails all over the country have become hotspots for transmission of the novel coronavirus, due to the density of the population and inability to implement meaningful social distancing and effective hygiene measures. Making matters worse, incarcerated people tend to have chronic health conditions and other risk factors, making them especially vulnerable to the virus and its harms. Arizona has been hard hit by COVID-19: as of mid-October 2020, eighteen incarcerated people have died from a confirmed case of the virus, with ten other deaths presumed to be COVID-related. The number of confirmed cases among the incarcerated population is 2,621. Among staff, 733 individuals have self-reported positive tests.

The COVID data tells only part of the story, though. In April 2020, staff threatened a walkout over the fact they felt unsafe working with the limited precautions taken by the agency. Staff have continued to complain about the lack of personal protective equipment, lack of free testing, and cross-
Incarcerated people have been clamoring for basic hygiene supplies such as soap, have faced lengthy lockdowns, and have limited access to testing. Tensions are running high in the facilities, and the attorneys handling the health care class action have sought an emergency court order to protect their clients. What’s more, Hawaii’s correctional oversight body has demanded answers from the ADC regarding the safety measures being implemented for Hawaiian prisoners housed in the private Saguaro Correctional Center in Eloy, following reports that the virus is spreading rapidly due to inadequate precautions and a failure to follow even basic safety protocols.

The true impact of the COVID crisis can hardly be known at this time, but what is clear is that people who live and work in Arizona prisons do not feel safe, their health is at risk, they do not feel respected or valued, and they are facing extreme restrictions. It is also abundantly clear that the problems the agency was previously experiencing—especially with respect to access to health care, use of solitary confinement, understaffing, and a lack of morale—have been magnified and worsened by the pandemic. At a time when the agency has restricted outside visitors and service providers, the need for transparency and external scrutiny has never been greater.

In sum, the Arizona prison system is awash in serious problems that affect the safety and health of both people in custody and the people who work there. The problems revealed by this analysis are deep and systemic. While

65. Compare Berch & McGregor, supra note 43, at 7 (identifying problems such as understaffing in the Arizona Department of Corrections resulting from mismanagement), with Jenkins, supra note 10, at 2 (noting prison employees were threatening to strike due to threats from COVID-19 and “several . . . prisons are already below critical staffing levels”).
the situation clearly worsened under Director Ryan’s leadership, the cultural problems that have been allowed to fester are not ones that will be fixed overnight or by a simple transition in leadership. Changing the culture of the ADC and making it a safe environment that respects and meets the needs of both incarcerated people and staff will require the cooperation and collaboration of numerous players both inside and outside of the agency. One of those critical stakeholders should be an independent oversight body with the power to monitor and report on what is happening behind the razor wire fences of the prison facilities.

II. FEDERAL COURT INVOLVEMENT IN ARIZONA

Since the 1970s, the federal courts have served as the primary vehicle for protecting the rights of people in custody. This is a peculiarly American phenomenon, as most other countries do not have a legal tradition of relying on the courts to assess prison conditions, relying instead on preventive monitoring mechanisms. Many cases have involved the courts in long-term oversight of compliance with consent decrees that provided detailed agreements for how the correctional agency would abide by the court ruling. Such ongoing scrutiny was necessary due to the complexity of the litigation, the perceived intransigence of the corrections officials, and the challenges in obtaining funding to address the unconstitutional conditions. The remedial phase of these cases could last decades, at significant expense to the state and to the dismay of corrections officials, and often involve the appointment of a Special Master, monitors, or court experts.

The Prison Litigation Reform Act (PLRA), passed by Congress in 1996, changed this landscape by imposing enormous obstacles to court oversight in prison reform cases. Various provisions of the PLRA have led to a severe reduction in the filing of lawsuits against correctional agencies and the likelihood of successful outcomes for plaintiffs. Moreover, the PLRA

69. See Deitch, supra note 67, at 237.
70. Id.
71. Id.
limited the ability of the courts to impose extended oversight.\textsuperscript{74} While there have been some notable exceptions—most prominently, the \textit{Plata} litigation in California that resulted in the appointment of a Receiver over the correctional health care system\textsuperscript{75}—it is fair to say that long-term court oversight is quite unusual in the modern era.

The \textit{Parsons v. Ryan} litigation over Arizona’s abysmal privatized correctional health care system, discussed earlier,\textsuperscript{76} exemplifies the need for court oversight when an agency repeatedly fails to comply with the terms of an agreed-upon settlement.\textsuperscript{77} Years of self-monitoring by the ADC proved extremely ineffective at ensuring private health care provider Corizon’s compliance with critical performance measures.\textsuperscript{78} Among other problems, the defendants relied upon a profoundly flawed information system that yielded unreliable and improper results about whether patients were receiving timely and appropriate care.\textsuperscript{79} Moreover, there was evidence presented in court that Corizon sought to “trick” the ADC monitors so as to hide noncompliance with the requirements of the Stipulation.\textsuperscript{80} As Molly Rothschild recounts in her in-depth case study of the \textit{Parsons} litigation, the federal judge ordered the ADC to show cause why the agency should not be held in contempt only “[a]fter a year and a half of remediation plans, discovery disputes, further notices of substantial noncompliance, ‘retaliation and intimidation’ during a site visit, issues with defendants’ monitoring methodologies, testimony by defendants of failure to comply, and additional motions to enforce the Stipulation.”\textsuperscript{81} Ultimately, the court held the ADC in contempt and ordered the agency to pay over $1.4 million in fines, to be put toward compliance measures.\textsuperscript{82} With that ruling now upheld on appeal to the Ninth Circuit,\textsuperscript{83} the judge will have more freedom to enforce orders using the threat of contempt.

An analysis of the \textit{Parsons} litigation and potential remedies is beyond the scope of this article. But whatever approach Federal District Judge Roslyn Silver decides to take in the \textit{Parsons} case going forward—whether it involves

\begin{enumerate}
\item \textit{Id.}; see also Deitch, \textit{supra} note 68 (manuscript at 29–32).
\item \textit{See supra} text accompanying notes 30–37.
\item \textit{See generally} Rothschild, \textit{supra} note 3 (detailed discussion of Arizona’s failure to meet its obligations under the \textit{Parsons} settlement).
\item \textit{Id.} at 966–68.
\item \textit{Id.}
\item \textit{Id.} at 967–68.
\item \textit{Id.} at 964.
\item \textit{Parsons v. Ryan}, 949 F.3d 443, 459 (9th Cir. 2020).
\end{enumerate}
putting the agency’s health care system in receivership, appointing a Special
Master, continuing to rely on an appointed court expert, or simply exercising
greater control over ADC through more frequent hearings and reporting
requirements—it is clear that federal court oversight will be an inescapable
feature of life for the corrections agency for the foreseeable future. The
question, then, is whether such court oversight satisfies the need for routine
monitoring of prison conditions by an independent government oversight
body, as discussed in more detail in Part III of this article. The answer is a
resounding “no.”

Court oversight in any form is meant to be temporary: it ends when the
defendant prison agency is in substantial compliance with the terms of
agreed-upon performance measures. Indeed, the PLRA places significant
restrictions on extended periods of judicial oversight. The downside of
temporary oversight is that there is often significant backsliding that takes
place once the external scrutiny and the threat of contempt orders is gone.
Numerous jurisdictions can attest to the conditions issues that cropped up
once the corrections agency no longer had to answer to the court. Moreover,
the judge’s orders and oversight are intended only to bring the agency up to
a constitutional level of performance, and the Constitution, as it has been
interpreted by the courts, actually sets a very low bar. But many of the
problems experienced by people in custody, while deeply troubling and
enormously important for these individuals, do not arise to the level of

84. See generally Elizabeth Alexander, Getting to Yes in a PLRA World, 30 PACE L. REV. 1672 (2010) (examining the consequences of PLRA’s restrictions on federal judges’ ability to issue consent decrees).
86. For example, when Texas returned to federal court in 1999 in an effort to seek release from court oversight, which had been effectively dormant for years, the plaintiffs’ attorneys were able to show significant deterioration of conditions in several areas. See ROBERT PERKINSON, TEXAS TOUGH 325–26 (2010). More recently, the U.S. Department of Justice opened a new Civil Rights of Institutionalized Persons Act (CRIPA) investigation into four Mississippi prisons due to concerns about safety, use of isolation, access to mental health care, and suicide prevention. See Bill Hutchinson, DOJ Launches Probe of Troubled Mississippi Prisons After String of Inmate Deaths, Riots and Escapes, ABC NEWS (Feb. 6, 2020, 8:39 AM), https://abcnews.go.com/US/doj-launches-probe-troubled-mississippi-prisons-string-inmate/story?id=68798365. Mississippi’s prison system had previously been the subject of lengthy court oversight following the court ruling in Gates v. Collier. 349 F. Supp. 881, 903–05 (N.D. Miss. 1972).
87. See Deitch, supra note 67, at 238.
unconstitutionality.\textsuperscript{88} Moreover, many policies and practices are ill-advised, wasteful, or counterproductive and should be changed, but the court does not have the authority to weigh in on those matters. Agencies should be engaging in a continuous process of self-improvement and striving to implement best practices, yet that is not the objective of court oversight. The court has a powerful though limited role to ensure enforcement of rights and to make injured parties whole.\textsuperscript{89} Courts have the advantage of being able to enforce their orders by holding recalcitrant agencies in contempt and by imposing fines.\textsuperscript{90} In other words, court oversight focuses on accountability; transparency may be a byproduct of how the court fulfills its responsibility, but it is not the underlying goal. Perhaps most significantly, court oversight is reactive and after-the-fact, rather than preventive, such as the models of oversight to be discussed in Part III. It is not designed to aid in early identification of problems so that they can be remedied.\textsuperscript{91} And unlike preventive monitoring by a government oversight body, which can work in a collaborative manner, court oversight arising out of a contentious lawsuit is inherently adversarial.

Beyond these constraints, judicial oversight necessarily is limited to the issues before the court. \textit{Parsons} is about the provision of health care and the use of solitary confinement.\textsuperscript{92} But as the discussion in Part I illustrated, the problems in the ADC go far beyond these subject areas, and indeed many of these concerns reveal a troubling institutional culture that affects almost every aspect of life and work within the facilities. Meaningful preventive oversight of the ADC should include the ability to examine whatever issues have an impact on the treatment, care, safety, and success of people in custody.

In short, Arizona needs both strong judicial oversight of its compliance with the Stipulation in the \textit{Parsons} case and it needs routine monitoring of its prisons by a permanent government oversight body with the authority to access and inspect the facilities, field complaints from people in custody, and report on what is happening behind the walls. The two oversight mechanisms would fill entirely different purposes. Judicial involvement is appropriate in extreme cases where a corrections agency appears unable or unwilling to protect the health and safety of incarcerated people. The federal court provides a bulwark against the worst abuses in a correctional system; it is a

\textsuperscript{88} Id.
\textsuperscript{89} Id. at 242.
\textsuperscript{90} Id.
\textsuperscript{91} Id. at 238–39.
\textsuperscript{92} See Rothschild, supra note 3, at 954–59.
“fail-safe protector of prisoners’ rights.” At the same time, a permanent independent oversight body would provide ongoing, preventive review of prison conditions and the concerns of people in custody, regardless of whether serious problems exist. Through public reporting, it would ensure the transparency so critically necessary for legislators, the media, and the public to hold the agency accountable for ensuring the safety and health of people behind bars. Part III will explain in more depth why such independent oversight is essential.

III. THE NEED FOR A PERMANENT, INDEPENDENT PRISON OVERSIGHT ENTITY IN ARIZONA

A. Problematic Conditions as an Impetus for Oversight

Independent oversight of correctional facilities should be the standard in every jurisdiction simply because it provides an essential check on the powers of those with complete control over the lives of vulnerable people. Prisons are closed environments, and the public has little idea about what happens behind the razor wire fences and the solid brick walls. Supreme Court Justice William Brennan called prisons a “shadow world,” and as he so aptly observed, “[prisoners] are members of a ‘total institution’ that controls their daily existence in a way that few of us can imagine.”

Insular environments such as prisons put people in custody at risk of abuse, neglect, a lack of safety, inadequate health measures, and poor conditions. External scrutiny shines a light on this netherworld where human life and well-being are at risk, and it challenges any examples of ill-treatment. Such transparency—and especially the routine monitoring of conditions of confinement—is critical in any effort to ensure the safety of incarcerated people. External oversight lets staff know that observers are watching how people behind bars are treated; it offers corrections officials objective feedback about their performance and about ways they can improve their agency; it provides information to the public and policymakers about the operations of these facilities and how public monies are spent; and it provides incarcerated people with a voice and an assurance that their

93. See Deitch, supra note 67, at 242.
95. Id. (footnote omitted).
97. Id. at 294.
98. Id.
complaints and concerns will be taken seriously. The public is always skeptical when an agency is asked to police itself; independent oversight bodies provide more credible information. Moreover, the simple awareness of external scrutiny acts as a form of informal social control over the behavior of custodial officers, which in turn creates a safer environment.

Independent oversight is therefore necessary for all places of detention, regardless of whether a particular facility is known to have problems. Indeed, in most Western nations, corrections oversight bodies are the norm, and the Council of Europe requires the existence of such mechanisms for all member states. Scholar Jonathan Simon argues that the United States is exceptional among its peers in not requiring independent bodies to conduct routine monitoring of prisons.

Nevertheless, the reality in the United States is that the impetus for the establishment of oversight mechanisms is situational. As I have documented elsewhere, many if not most oversight bodies were created in the wake of scandals and highly publicized problems in a corrections agency. For example, California’s Office of the Inspector General, the state’s prison oversight body, gained expanded powers in the late 1990s after legislators became aware of widespread abuses of prisoners. In Texas, a nationally reported scandal in 2007 involving sexual abuse of youth in custody led directly to the Texas Legislature’s establishment of an Independent Ombudsman to protect the rights of incarcerated youth. And Hawaii’s Correctional System Oversight Commission was formed in 2019 after numerous allegations of problems in the correctional facilities led to the formation of a statewide Task Force that recommended the need for such an oversight body. Similar origin stories exist for countless other prison and

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99. Id. at 295.
100. Id. at 293.
101. Id. at 314.
103. See Rogan, supra note 102, at 2.
104. See Simon, supra note 68, at 162–64.
105. See Deitch, supra note 68 (manuscript at 61–63).
106. Id. (manuscript at 61).
107. Id. (manuscript at 57).
108. Id. (manuscript at 62).
jail oversight mechanisms, and we also see a similar pattern when we look at the factors that led to the creation of many police oversight entities.\textsuperscript{109}

Scandals and horror stories about what is happening behind bars appear to push oversight onto the policy agenda for lawmakers and advocates and compel a meaningful response.\textsuperscript{110} And that is where Arizona is today. There is a clear and urgent need to improve transparency and accountability in Arizona’s prison system, and establishment of an oversight entity that conducts routine inspections of correctional facilities and that responds to the complaints of incarcerated people is one of the best ways to achieve those aims. It is also consistent with the guidance provided by the American Bar Association (ABA).\textsuperscript{111}

\textbf{B. The Benefits of Independent Correctional Oversight}

In 2008, the ABA passed a resolution (ABA Resolution) calling on every jurisdiction in the country to establish an independent correctional oversight mechanism to regularly monitor and report publicly on the conditions in all prisons, jails, and other adult and juvenile correctional and detention facilities operating within that jurisdiction.\textsuperscript{112} The ABA emphasized that the operations of correctional facilities—both public and private—can and should be accountable to citizens and policymakers.\textsuperscript{113} The ABA Resolution plainly spells out the justification for this approach:

First, the public identification of significant problems in correctional conditions and operations can and should lead to the rectification of those problems, resulting in correctional and detention facilities that are safer, operated in conformance with the Constitution, other laws, and best correctional practices, and equipped to better prepare inmates for a successful reentry into society. Second, through the objective observations of an entity that is wholly independent of the facility being inspected, potential problems that have been overlooked at the facility can be detected,


\textsuperscript{110} See Deitch, supra note 68 (manuscript at 62).

\textsuperscript{111} Id. (manuscript at 34–36).


\textsuperscript{113} Id. at 4.
preventing them from becoming major problems for correctional officials. Third, external oversight of correctional operations and the problem solving that it catalyzes can be a cost-effective and proactive means to potentially avert lawsuits challenging the legality of conditions of confinement or the treatment of prisoners. Fourth, the factual findings of the monitoring entity can substantiate the need for funds requested by correctional administrators. And finally, the revelation by a monitoring entity of what is and is not happening behind prison walls can lead to better-informed decisions about a jurisdiction’s sentencing and correctional policies.\(^{114}\)

As the ABA’s justification makes clear, independent oversight benefits not only people in custody but also correctional administrators and policymakers. External scrutiny leads to safer institutions for both incarcerated people and for staff members and can provide credible and objective support when a prison director seeks funding for programming or for repairs to the physical plant, for example.\(^{115}\) As former prison administrator Andrew Coyle has written, independent oversight “can be of assistance to those who manage these institutions.”\(^{116}\) Coyle goes on to argue that independent oversight helps make correctional managers more professional by showing them ways they can improve prison operations and helps draw public attention to “the pressures which [make] it difficult to manage [a] prison properly.”\(^{117}\) Professor Stan Stojkovic concurs and highlights numerous examples of ways in which correctional administrators have used oversight to improve outcomes within their facilities.\(^{118}\)

To the extent that oversight can prevent expensive lawsuits through early identification and remediation of problematic conditions, those savings accrue to taxpayers. Monitoring reports provide unbiased information to lawmakers, who can use these findings to aid their own legislative responsibilities to probe agency operations and budgets and to ensure the quality of agency leadership. Moreover, having this source of independent information enables policymakers to assess the success and failures of various initiatives, especially when it comes to the effectiveness of programs and services, including those helping to prepare incarcerated people for re-

\(^{114}\) Id.

\(^{115}\) See Deitch, supra note 68 (manuscript at 16).


\(^{117}\) Id. at 1508.

\(^{118}\) Stan Stojkovic, Prison Oversight and Prison Leadership, 30 PACE L. REV. 1476, 1480 (2010).
entry to the community. Given the high recidivism rates in Arizona,\textsuperscript{119} it would seem that lawmakers would want reliable information about whether the funds they have invested in correctional programming are having desirable outcomes, or whether there are other approaches that would be more effective.

\textbf{C. Models of Independent Oversight}

While the need for independent correctional oversight and its benefits are extremely clear, defining and operationalizing what oversight looks like is a little more difficult. “Independent oversight” is not a term of art, and we may each be thinking of a different concept when we use that term.\textsuperscript{120} As I have written elsewhere, “oversight” should be thought of as an umbrella concept that incorporates various functions, including inspection, investigation, regulation, reporting, auditing, legislative, legal, and data collection and reporting.\textsuperscript{121} These functions are not in competition with each other; each of them is necessary because they each serve the goals of transparency and accountability in different ways, and they each have different primary constituencies.\textsuperscript{122} For example, accreditation, typically performed by a professional association, allows correctional administrators to show that they have a “stamp of approval” by an organization in the field.\textsuperscript{123} However, the accreditation reports are not usually public so they do not enhance the goal of transparency, nor is the objective to assess the treatment of incarcerated people or to investigate their complaints.\textsuperscript{124} Similarly, an office that investigates staff misconduct helps provide accountability for wrongdoing, but because it is essentially reactive, it does little to prevent harm from occurring or to shine a light on routine conditions of confinement.\textsuperscript{125} Because the goals and constituencies are so varied, I have previously argued that there should be a number of oversight mechanisms in place to serve each of the critical functions listed above, each of them as strong and effective as it can be:

\begin{itemize}
\item \textsuperscript{119} State Criminal Justice Profile: Arizona, Bureau of Just. Assistance, https://bjafactsheets.iir.com/State/AZ [https://perma.cc/3KCH-S6GN] (showing the rate of recidivism in Arizona as 42.4%).
\item \textsuperscript{120} Michele Deitch, Distinguishing the Various Functions of Effective Prison Oversight, 30 Pace L. Rev. 1438, 1439 (2010).
\item \textsuperscript{121} Id.
\item \textsuperscript{122} Id. at 1439–40.
\item \textsuperscript{123} Id. at 1441.
\item \textsuperscript{124} Id.
\item \textsuperscript{125} Id. at 1442.
\end{itemize}
A robust system of correctional oversight is one that is multi-faceted and multi-layered, serving each of the [eight] critical functions, and is one that involves numerous players both inside and outside the correctional agency. It involves sound internal accountability measures, complemented by credible and effective forms of external scrutiny.

While all these functions of oversight are very important, the function that I focus on in this article is the monitoring and inspection function. This monitoring function involves routine inspections of all prison facilities in the state—not just those with publicized problems—with an eye toward assessing the conditions of confinement, the state of the facilities, the quality of services, and how people in each facility are treated. The findings from these inspections are publicly reported and are used to help each facility improve its operations. The monitor’s role is to bring transparency to what is happening behind the walls, rather than imposing sanctions for wrongdoing, and to prevent harm through early identification and remediation of problems. Scholar Andrea Armstrong has argued that achieving transparency is the most critical objective of independent oversight, noting among other concerns that “[o]ur lack of information about the operation of [prison] facilities is costly” in both financial and human terms.

Perhaps the best and most fully developed example of an oversight body that conducts routine prison inspections is in the United Kingdom. The British Prison Inspectorate, part of the Home Office but independent of the Prison Service, has a statutory duty to inspect every adult prison, juvenile facility, immigrant detention center, and police custody facility in England and Wales at least twice every five years. The inspections are conducted with an eye toward determining “whether prisoners are held in safety, whether they are treated with respect for their human dignity, whether they are able to engage in purposeful activity, and whether they are prepared for resettlement back into the community.”

126. Since I first wrote these words, I have begun including an additional function—data collection and reporting—in this framework, and so I have increased the count from seven to eight.
127. Deitch, supra note 120, at 1444.
128. Id. at 1443.
129. Id.
130. Id.
133. Id. at 1542.
of several inspectors, including some with specialized expertise, and most visits span several days.\textsuperscript{134} Gathering the necessary information also involves surveys of the incarcerated population.\textsuperscript{135} The Inspectorate prepares a detailed report following each inspection, and the facility staff prepare a response that includes an action plan; the monitors continue to follow up on future visits to determine whether promised changes have been implemented.\textsuperscript{136} The British Prison Inspectorate’s work is complemented by a separate Ombudsman’s office that handles individual complaints and investigates deaths in custody and Independent Monitoring Boards composed of volunteer citizens who routinely visit and interview people in custody at a particular facility.\textsuperscript{137} The British Prison Inspectorate, established in its current form in 1982, has been the basis for correctional oversight bodies established in other Western countries as well, including in Scotland, South Africa, and Western Australia.\textsuperscript{138}

In contrast to our peer nations, independent oversight of prison conditions is still relatively rare in the United States.\textsuperscript{139} Only fifteen states plus the District of Columbia have independent oversight mechanisms designed to respond to a broad range of complaints of incarcerated people and/or to monitor and report on conditions of confinement.\textsuperscript{140} An additional two states have oversight bodies that handle a subset of correctional issues: in Florida, the focus of oversight is medical care; in Massachusetts, it involves use of restrictive housing.\textsuperscript{141} Notably, though, seven of these prison oversight entities were established or significantly revamped in the last decade, with most of these created by state legislatures since 2017.\textsuperscript{142} This rapid expansion demonstrates that there is growing national awareness of the need for routine monitoring of prison conditions, as well as recognition of the benefits that come from increased transparency and accountability. We are also seeing significant legislative efforts to create independent prison oversight structures in other states, including Texas, New York, Mississippi, New Mexico, and Florida, as well as in Arizona.\textsuperscript{143} There is clearly momentum

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134. Id. at 1541.
135. Id. at 1540.
136. Id. at 1542–43.
137. Id. at 1537–38; Deitch, supra note 68, (manuscript at 25).
139. See Deitch, supra note 68, (manuscript at 23).
140. Id. (manuscript at 70–71). Those sixteen jurisdictions are: California, the District of Columbia, Hawaii, Illinois, Indiana, Iowa, Maryland, Michigan, Minnesota, Missouri, Nebraska, New Jersey, New York, Ohio, Pennsylvania, and Washington State. Id. (manuscript at 71–72).
141. Id. (manuscript at 56 n. 196, 82).
142. Id. (manuscript at 72).
143. Id. (manuscript at 57, 73).
around the establishment of correctional oversight mechanisms in the United States, and it would not be surprising to see more states passing similar legislation in the coming years, especially as public concerns about the criminal justice system grow louder. The national uproar over police brutality in the wake of the police killing of George Floyd has quickly led to calls for expanded and strengthened oversight of the police; it is a small step from there to seeing the need for civilian oversight of all systems of law enforcement control over the lives of citizens.

Each state’s correctional oversight mechanism differs from the others in design and purpose. In this respect, prison oversight is similar to police oversight, where each oversight mechanism has been described as “different as a fingerprint.” All but three prison oversight entities are governmental agencies, consistent with the ABA’s call for public entities to serve this function. These oversight bodies are typically executive branch agencies, and they report their findings to the governor and to the Legislature. Most have the ability and a mandate “to conduct routine inspections of prison facilities,” while some of the others are designed solely to handle complaints from incarcerated individuals. Most oversight bodies are able to report on systemic issues that they learn about during inspections or the review of complaints. Some are called “Ombudsmen,” while others are set up as Commissions, Inspectors General, or Advisory Boards. My research, presented in a fifty-state inventory of correctional oversight mechanisms I originally prepared in 2010 and updated in a 2020 publication, has persuaded me that the names of these oversight bodies matter much less than the actual functions they serve. For example, the Indiana Ombudsman Bureau reviews individual complaints but does not typically go into prison

144. See Weihua Li & Humera Lodhi, Which States Are Taking on Police Reform After George Floyd?, MARSHALL PROJECT (June 18, 2020, 3:00 PM), https://www.themarshallproject.org/2020/06/18/which-states-are-taking-on-police-reform-after-george-floyd [https://perma.cc/L8KS-SA2Y].

145. Cheryl Corley et al., Examples of Reimagining Police Departments that Show Promise, NPR (June 12, 2020, 5:03 AM), https://www.npr.org/2020/06/12/875548066/examples-of-re-imagining-police-departments-that-show-promise [https://perma.cc/2JPH-789U].

146. See Deitch, supra note 68 (manuscript at 70–71).


148. Deitch, supra note 68 (manuscript at 71).

149. Id. (manuscript at 56).

150. Id. (manuscript at 60–61 tbl.1, 69–70).

151. Deitch, supra note 147, at 1764.

152. See Deitch, supra note 68 (manuscript at 48–55).
facilities, while the Washington State Office of the Corrections Ombuds conducts routine inspections and issues reports about conditions of confinement. Any state looking to establish a correctional oversight structure should begin by asking what it wants that entity to do and what authority it should have, not by trying to fit within a preconceived notion of what a certain type of oversight body does.

While there are many ways to structure an oversight body in order to provide transparency in correctional operations, the key to effectiveness lies in ensuring that the oversight entity has the tools it needs to conduct meaningful work. From studying the various oversight bodies in the United States and in other Western nations, I have identified nine fundamental criteria for effective oversight entities:

1. They must be independent of the correctional agency and be able to do their work without interference or pressure from the agency or any other body.

2. They must have a mandate to conduct regular, routine inspections of the facilities under their jurisdiction, and the authority to investigate and issue reports on a particular problem at one or more facilities.

3. Monitors must have a “golden key,” giving them unfettered and confidential access to facilities, prisoners, staff, documents, and materials, and they should have the ability to visit any part of a facility at any time of day without prior notice.

4. They must be adequately resourced, with sufficient staffing, office space, and funding to carry out their monitoring responsibilities, and the budget must be controlled by the monitoring entity.

5. They must have the power and the duty to report their findings and recommendations, in order to fulfill the objective of transparency, and they should control the release of their reports.

6. They must take a holistic approach to evaluating the treatment of prisoners, relying on observations, interviews, surveys, and other methods of gathering information from prisoners, as well as on statistics and performance-based outcome measures.

7. There must be a means of fulfilling both the investigative function and the monitoring function, in order to provide

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accountability for past wrongdoing in individual cases and to prevent future problems. These functions need not be performed by the same oversight body.

(8) The agency must be required to cooperate fully with the oversight body and to respond promptly and publicly to its findings.

(9) The person who leads the oversight agency must be appointed for a fixed term and can be removed only for good cause.155

These essential elements are entirely consistent with the ABA Resolution’s “Key Requirements for the Effective Monitoring of Correctional and Detention Facilities.”156 Any jurisdiction seeking to establish an oversight body should use the ABA guidance and the criteria detailed above almost as a checklist to ensure that these factors are taken into account during the legislative process. These are the features that provide an oversight body with “teeth” to do meaningful work.

D. Recent Trends in Correctional Oversight

As noted earlier, seven independent prison oversight bodies have been established in the United States in the last decade, as well as at least ten jail oversight entities, which suggests a surge of interest in this issue.157 Notably, it seems that there is a trend of designing recent prison oversight bodies using an Ombudsman model, with Washington State, New Jersey, and Minnesota all adopting this approach.158 Texas also adopted this model for oversight of its juvenile corrections system in 2007 in the wake of a huge scandal.159 And at least three states (Texas, Mississippi, and Arizona) have considered legislation to establish similarly designed entities in the past year.160 But unlike the traditional Ombudsman concept, which originated in Scandinavia and is primarily designed to review individual complaints from incarcerated people, these newer Ombudsman agencies are also charged with conducting routine inspections of prison facilities, assessing systemic problems in the

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155. The first eight of these criteria are taken directly from Deitch, supra note 96, at 302–03. I have added a ninth criteria based on more recent research.
156. AM. BAR ASS’N, supra note 112, at 2.
157. Deitch, supra note 68, (manuscript at 60–61 tbl.1).
158. Id. (manuscript at 57).
160. Deitch, supra note 68 (manuscript at 57).
agency, and reporting their findings. I tend to think of them as hybrid models of oversight, despite their name: they serve the dual functions of monitoring prison conditions and investigating complaints of people in custody and their loved ones.

For example, Washington State’s Office of Corrections Ombuds (OCO) was established in 2018 to reduce litigation arising from the poor treatment of people in prison. Its mission is to provide information to incarcerated people and their families, promote awareness of their rights, identify areas of systemic concern, make recommendations for the governor and legislature, and assess the prison agency’s compliance with relevant statutes and policies. The OCO is charged with investigating complaints regarding the health, safety, treatment, and conditions of confinement for incarcerated people and must release a report of findings regarding each complaint. The office released its first annual report in November 2019, and the report identified numerous systemic areas for improvement in the corrections agency, including recommendations related to re-entry programming, family connections, health services, mental health and disciplinary actions, access to programs for people with disabilities, and access to healthy food. The OCO is staffed with ten full-time employees plus interns and has an annual budget of over $1.2 million.

The 2019 statute that established New Jersey’s new Office of the Corrections Ombudsperson (OCO) (significantly revamping a prior office) drew on the Washington State statute. The New Jersey OCO has similar responsibilities to the Washington OCO and similar powers, including golden key access to the facilities. But its enabling statute goes further than Washington’s statute in a few important respects. First, the New Jersey statute creates an explicit obligation for the Ombudsperson to conduct inspections of prison facilities. Second, the Ombudsperson has a mandate to collect and analyze data relating to complaints regarding the prison.

161. Id. (manuscript at 57).
165. CARNs, supra note 162, at 16–28.
166. Id. at 8.
169. Id. § 52:27EE-28.2(b)(7).
agency.\textsuperscript{170} And third, the statute established an appointed Advisory Board to advise the Ombudsperson.\textsuperscript{171}

Notably, both the Washington State and New Jersey oversight bodies were designed with the ABA’s elements of effective oversight\textsuperscript{172} in mind: champions for oversight in both states took care to ensure that these new entities had the necessary authority and mandates to make their work meaningful and to enhance transparency and accountability for the corrections agency. Specifically, the statutes in both states designed the Ombudsmen to be independent of the agency under their oversight, gave them golden key access to the facilities, established a mandate for the offices to make systemic recommendations and to report their findings publicly, and provided them with reasonable resources to conduct their activities.\textsuperscript{173} Another notable feature of these statutes is what is not included: neither entity is intended to review or assess employee discipline.\textsuperscript{174} The work of these oversight bodies is intended to be forward-looking to prevent harm; they are not about assessing blame.

The Ombudsman model is certainly not the only workable structure for effective external scrutiny of a corrections agency. For example, the California Inspector General, the Pennsylvania Prison Society, the Correctional Association of New York, and the Ohio Correctional Institutions Inspection Committee all help bring transparency to prison conditions, and to varying degrees have been effective at identifying and responding to the concerns of incarcerated people.\textsuperscript{175} But whatever its structure, every oversight body in the country has faced challenges in conducting its work, often due to a lack of financial and staffing resources, insufficient authority giving them access to inspect the facilities, or to insufficient insulation from political pressure.\textsuperscript{176} Following the guidance of the ABA Resolution and the elements of effectiveness highlighted in subsection (c) above would be the best way to guard against those challenges.\textsuperscript{177}

\textsuperscript{170} Id. § 52:27EE-28(a).
\textsuperscript{171} Id. § 52.27EE-28.6.
\textsuperscript{172} AM. BAR ASS’N, supra note 112, at 2–3.
\textsuperscript{173} §§ 52:27EE-26(a), -27(b)(10), -28.3(a), (d)(1); WASH. REV. CODE §§ 43.06C.005–070 (2019).
\textsuperscript{174} N.J. STAT. ANN. §§ 52:27EE-26 to -28.6 (2019); WASH. REV. CODE §§ 43.06C.005–070 (2019).
\textsuperscript{175} Deitch, supra note 68 (manuscript at 61, 75–77 tbl.4, 83–85).
\textsuperscript{176} Id. (manuscript at 80–85).
\textsuperscript{177} See supra text accompanying note 112.
IV. DESIGNING AN OVERSIGHT ENTITY FOR ARIZONA

Calls for independent oversight of Arizona’s prison system have been growing in recent years as news headline after news headline has kept problematic prison conditions at the forefront of public consciousness in the state. As advocate Caroline Isaacs, who works with a statewide advocacy group, the American Friends Service Committee of Arizona (AFSC-AZ), has observed, Arizona “has virtually no performance standards for corrections and no mechanism for oversight or accountability.”178 The absence of such an oversight mechanism will make it extremely hard for the state prison system to gain the trust of citizens and families, given the agency’s recent history, even with a new leader at the helm. But even with the best leader and even once the problems have been addressed, for reasons described earlier in this article, oversight provides an essential check on the operations of every corrections agency and yields great benefits for policymakers and corrections officials, as well as for incarcerated people.179

In late 2019, AFSC-AZ produced a detailed proposal to establish a Citizens Advisory and Oversight Board for the Arizona Department of Corrections.180 The framework proposed that this Citizens Advisory and Oversight Board be composed of nine members, each serving a two-year term, and that the members include a representative of a prisoner rights organization, an academic, and a person who was formerly incarcerated.181 No member could be a former employee or contractor for the prison agency.182 Appointments would be made by the governor’s office and by the Legislature.183 The Board would meet in open session at least once per quarter and would take public comment.184 Additionally, the Board would have quarterly open meetings with Arizona legislators, the governor’s office, and the state supreme court.185 In terms of its duties, the Board would conduct random tours of ADC prison facilities; review ADC budget allocations and expenditures; accept input from incarcerated people, officials, and the public; issue public reports of its monitoring visits; and advocate for necessary improvements in ADC operations and monitor the agency’s implementation.
of such changes. The proposal further details the powers that this Board would need to have, including unimpeded and unscheduled access to the facilities, financial records, the Inmate Management System, grievances, medical records, and staff. Further, the Board chair or a quorum of the Board would have the power to compel testimony by any person affiliated with ADC. The state would allocate $250,000 per year to cover the Board’s expenses. Members would receive reimbursement for travel expenses but not a salary.

The model proposed by the AFSC-AZ is innovative and thoughtful, and the interest in involving citizens in the oversight process is appropriate and reasonable, though this is arguably a great deal of work to expect from a group of volunteers. Though there is no other entity in the United States designed exactly like this, the duties and powers that the Board would have are consistent with many of the essential elements for effectiveness described in the ABA Resolution and in this article. Most prison oversight bodies in the United States are designed as independent government agencies, not as boards, but there are a few exceptions. Hawaii’s new oversight entity, for example, is structured as a commission with appointed members. Unlike the proposed Arizona Board, though, Hawaii’s Correctional System Oversight Commission includes members who have been affiliated with the prison agency, including a recently retired director of the agency. The failure to draw a bright line excluding former agency employees from the Commission has been critiqued by reform advocates in Hawaii. The Hawaii Commission also makes provision for a full-time staff member, which seems wise, given the extensive amount of work likely to be involved in these oversight activities. Another example of a citizen’s advisory board is the Missouri Citizens Advisory Committee on Corrections. Like the AFSC-AZ’s proposed framework, the membership of the Missouri Advisory

186. Id. at 6.
187. Id. at 6–7.
188. Id. at 7.
189. Id.
190. Id.
191. Deitch, supra note 68 (manuscript at 71 tbl.3).
193. Id.
194. Id.
195. Id.
Committee is composed of private citizens serving on a volunteer basis, but its work is limited to reviewing a set of grievances selected by the prison agency.\footnote{Id.} Although the members hold their meetings in different prison facilities and are taken on tours, their work does not involve inspections of the facilities.\footnote{Id.} It seems obvious that the vision for the Arizona Advisory Board goes well beyond the limited scope of Missouri’s model.

Another model with some similarities is in Massachusetts, which has a Restrictive Housing Oversight Committee, established in 2018.\footnote{MASS. GEN. LAWS ch. 127, § 39(G) (2018).} That Committee has broad access to prison facilities so it can gather information and develop recommendations regarding the impact of restrictive housing on people in custody and assess rates of violence, self-harm, and recidivism.\footnote{Id.} While there are some civilian members of this Committee, most of the members are key stakeholders with relevant professional affiliations, including the Commissioner of Corrections and the Secretary for Public Safety.\footnote{See id.; see also AFSC-AZ REPORT, supra note 14, at 6.} The Massachusetts Committee also has a more limited scope of work than envisioned in Arizona.\footnote{See Deitch, supra note 68 (manuscript at 71–72 tbl.3); Deitch, supra note 147, at 1815, 1873, 1896–97.}

Three non-governmental oversight bodies—the Pennsylvania Prison Society, the Correctional Association of New York, and the John Howard Association of Illinois—also rely on citizen volunteers to conduct routine monitoring visits.\footnote{See Deitch, supra note 68, at 71.} All have either longstanding statutory authority to inspect prisons or a long-term informal arrangement with the prison agency that allows for monitoring and reporting on conditions.\footnote{Deitch, supra note 68, at 71.} But unlike what is being proposed for Arizona, these are non-governmental entities, they have paid staff in addition to volunteers, and they do not have as robust a set of powers.\footnote{Deitch, supra note 147, at 1815, 1873, 1896–97; AFSC-AZ REPORT, supra note 14, at 6–7.}

Other somewhat analogous citizen advisory boards include the Independent Monitoring Boards in the U.K. and various jail oversight bodies in the United States (such as the brand new Essex County (N.J.) Correctional Facility Civilian Task Force), which rely on local citizens to inspect facilities
and make reports of their findings. But these entities are each responsible for a single facility, not all the prisons in a state.

The AFSC-AZ’s proposal made it into a draft bill (Arizona House Bill 2069) by Representative Walter Blackman, which would have created a Corrections Oversight Committee. However, the introduced version of the bill did not mandate that the Committee include an appointee who was formerly incarcerated, and it did require that the ADC Director be a member of the Committee, which undermined the Committee’s independence from the agency it was meant to oversee. Those two critical changes caused the AFSC-AZ to withdraw its support from the bill in this form. Another significant difference between the filed bill and the AFSC-AZ proposal is that the bill also required the appointment of a Corrections Ombudsman, whose role would be to provide contemporaneous public oversight of ADC’s staff disciplinary actions and the internal affairs process. Not only is this function not one that was envisioned by the AFSC-AZ, it is not a function of most other prison oversight bodies, with the notable exception of the California Inspector General, and it is not a function of any other Ombudsman’s Office.

Representative Blackman also filed House Bill 2894 (HB 2894), which would have created a different type of correctional oversight body: the Office of the Independent Corrections Ombudsman. As described in this bill, the Ombudsman would fulfill a very different function than envisioned by HB 2069, a good reminder that the name of an oversight entity matters much less than the function it serves. As proposed in HB 2894, the Ombudsman’s office would have the authority to access ADC facilities at any time without prior notice, review ADC documents, conduct confidential interviews with staff and incarcerated people, and set up a hotline and other methods to

206. Deitch, supra note 68 (manuscript 25, 59–60).
207. See id.
209. Id.
211. See Ariz. H.B. 2069.
212. See AFSC-AZ REPORT, supra note 14, at 5–6; see also Deitch, supra note 68 (manuscript at 61).
214. See id.; see also Ariz. H.B. 2069.
receive complaints. The Ombudsman would be required to collect and analyze data about safety issues and the treatment of incarcerated people; conduct regular facility inspections; and issue public reports with findings and recommendations to which the ADC would be required to respond with a corrective action plan. House Bill 2894 also created a Corrections Oversight Commission, composed of representatives from the various groups originally included in the AFSC-AZ proposal (including a formerly incarcerated person and not including the ADC Director). The function of that Commission would be to appoint the Ombudsman and to hold an annual public hearing to present, review, and discuss the Ombudsman’s reports. The bill further authorized funding in the amount of $1.5 million per year to support the Ombudsman’s activities. The bill had the support of a number of criminal justice reform advocates, including FAMM, which helped to develop the legislation.

As filed, HB 2894 was a strong bill that would have established one of the most effectively designed prison oversight mechanisms in the country. It was significantly preferable to HB 2069, because it clearly established the oversight entity’s independence from the prison agency and provided for a full-time professional staff to perform the extensive duties envisioned by the bill. It established that the role of the Ombudsman is to be forward-looking and to aid in the improvement of agency operations, rather than to focus on disciplinary actions for wrongdoing. Like HB 2069, HB 2894 preserved a critical role for civilians acting in a volunteer capacity to aid in the oversight process. But rather than asking the volunteers to conduct what is extraordinarily time-consuming work if it is done properly—inspecting prisons—their role is to ensure that the person selected to be Ombudsman has community support and confidence and to amplify the Ombudsman’s findings and recommendations through public hearings. This unusual but thoughtful structure gives the community a meaningful role in oversight, while also ensuring that adequate resources exist to conduct effective oversight.

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216. Id.
217. Id.; see also AFSC-AZ REPORT, supra note 14, at 6.
219. Id.
220. FAMM, supra note 14, at 1.
221. See Ariz. H.B. 2894.
224. Id.; Ariz. H.B. 2069.
225. See Ariz. H.B. 2894.
inspections, handle complaints, and analyze data.\textsuperscript{226} The design of the oversight mechanism contemplated by HB 2894 builds on the recently established oversight models in Washington State and New Jersey, discussed earlier, and is consistent with the oversight trends we are seeing around the country.\textsuperscript{227} Moreover, the bill incorporates the ABA’s essential elements of effectiveness into the authority and powers of the proposed Ombudsman’s Office.\textsuperscript{228} In doing so, it provides the oversight body with “teeth.”

Unfortunately, despite the extraordinary need for correctional oversight in Arizona, neither bill progressed at all during the legislative session.\textsuperscript{229} Whether the bills were derailed due to the COVID-19 crisis that occurred mid-session or whether they simply lacked support is not clear. What is clear, though, is that Arizona is well-positioned to make progress on this oversight issue during the next legislative session. The starting point for future discussions should be the language from HB 2894.\textsuperscript{230}

Arizona needs an independent correctional oversight mechanism that, at a minimum: (1) provides for routine monitoring of conditions of confinement; (2) establishes a workable complaints system; (3) requires the collection and reporting of critical data; (4) allows for systemic assessments and recommendations; (5) requires public reporting of findings and recommendations; (6) requires the prison agency to respond to reports with a corrective action plan; (7) empowers the oversight body by ensuring golden key access to the facilities, confidential access to incarcerated people and staff, and access to files and other agency data; (8) insulates the oversight body from political pressure; (9) provides a meaningful role for citizens in the oversight process, by helping to ensure both transparency and accountability for the work of the oversight body; and (10) is sufficiently well-funded to carry out its duties. The Ombudsman structure, as detailed in HB 2894, accomplishes these important goals.\textsuperscript{231} These goals are consistent with both the ABA’s recommended approach\textsuperscript{232} and with the lessons provided from extensive research I have conducted about other oversight bodies in the United States and around the world.\textsuperscript{233}

Having an oversight mechanism of this nature would be an essential complement to the oversight of the federal court in conjunction with the

\textsuperscript{226} Id.
\textsuperscript{227} See id.; see also Deitch, supra note 68 (manuscript 56).
\textsuperscript{228} See Ariz. H.B. 2894; AM. BAR ASS’N, supra note 112, at 2–3.
\textsuperscript{229} See Ariz. H.B. 2894; see also Ariz. H.B. 2069.
\textsuperscript{230} Ariz. H.B. 2894.
\textsuperscript{231} Id.
\textsuperscript{232} AM. BAR ASS’N, supra note 112, at 2–3.
\textsuperscript{233} See, e.g., Deitch, supra note 68 (manuscript 87–88); Deitch, supra note 147, at 1762; Deitch, supra note 96, at 302–03.
Parsons litigation, and as discussed in Part II, would fulfill an entirely different function.

CONCLUSION

Let me end this article with a cautionary note: independent oversight is a critical part of any effort to ensure the safe and humane treatment of people in custody, but it alone will not solve a correctional agency’s problems. The independent oversight body can help shine a light on those problems so that those in power—corrections officials, lawmakers, and the governor—can ensure that they get fixed. The problems can and should get addressed without the need for court involvement, especially if they are identified early. Correctional leaders need to use the information provided by an oversight body to prioritize areas for improvement. Lawmakers need to dedicate the necessary resources to ameliorate problems that need funding. The governor needs to ensure that the agency head is responsive to the needed reforms. The oversight body’s role is to enhance transparency; the other stakeholders are responsible for holding the agency accountable.

Raising Arizona’s commitment to a safe and healthy prison system fundamentally requires several steps: (1) reducing the size of the incarcerated population; (2) treating all people who live and work in these facilities with dignity and respect; (3) shifting from a punitive culture toward a rehabilitative approach; (4) providing sufficient funding to support safe physical conditions, access to physical and mental health care, rehabilitative programming, and adequate numbers of well-trained staff; and (5) ensuring meaningful and permanent independent oversight of the prison system. Until all elements of this approach are in place, Arizona will continue to see its prisons in news headlines, be hauled into court, pay extraordinary fines and settlement awards, and face the consequences from a high recidivism rate. There is much work to be done. An effective correctional oversight body can help prioritize the tasks ahead.