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(NIC TA #07J1061)

Operational Review of the
Milwaukee House of Correction

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The resource person who provided the on site technical assistance did so through a cooperative agreement, at the request of the Milwaukee County House of Correction, and through the coordination of the National Institute of Corrections. The direct onsite assistance and the subsequent report are intended to assist the agency in addressing issues outlined in the original request and in efforts to the enhance the effectiveness of the agency.

The contents of this document reflects the views of Jeffrey A. Schwartz. The contents do not necessarily reflect the official views or policies of the National Institute of Corrections.

TABLE OF CONTENTS

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I. Introduction and Background:

In the Spring of 2007, Assistant Superintendent Joe McCarthy of the Milwaukee House of Correction (HoC) contacted the Jails Division of the National Institute of Corrections (NIC) to ask for technical assistance (TA). At that time, Mr. McCarthy was relatively new to Milwaukee HoC. He had been appointed Assistant Superintendent several months earlier after many years as a manager with the jail system in Nashville, Tennessee. Mr. McCarthy wanted a comprehensive review of the operations of HoC, with a particular focus on security issues.

Richard Geaither, a program manager in the Jails Division of NIC, was assigned this technical assistance project. He contacted Jeffrey A. Schwartz, Ph.D., of Campbell, California, about the project. Several phone discussions ensued among Joe McCarthy, Richard Geaither and Jeffrey Schwartz and all three individuals agreed that Dr. Schwartz would provide the on site technical assistance requested by HoC. (Dr. Schwartz has conducted operational reviews under NIC auspices of a number other medium-sized and large jails over the last 8 or 10 years. He has more than thirty years experience working with law enforcement and correctional agencies across the United States and Canada).

Due to scheduling conflicts, the actual technical assistance work was scheduled to begin in September, 2007 with the proviso that if some of Dr. Schwartz's other commitments were delayed or canceled, the work would begin during the summer. That did not occur and the on site work was initiated in early September, 2007 as initially planned. In the interim, in August, 2007, HoC had a well publicized escape, underscoring the importance of the security component of the technical assistance review.

II. Objectives:

A. To complete as comprehensive a review of the Milwaukee HoC as practical within the time allowances of the NIC TA project.

B. To place particular priority on security issues while conducting the operational review.

III. Method:

A. From the time of the initial phone conversations arranging this project, the consultant maintained phone and email contact with Joe McCarthy. Dr. Schwartz requested a variety of documents and other information about a HoC so that he could acquire some background and general understanding of the facility and organization prior to traveling to Milwaukee. Mr. McCarthy assembled all of materials the consultant requested and added other information he thought would be useful to Dr. Schwartz as background. Dr. Schwartz was able to review the HoC policies and procedures, its use of force policy, a variety of statistics about personnel issues and much more prior to undertaking the initial work on site.

B. Milwaukee HoC has more than 2,000 beds and more than 400 employees and the preparatory work and document review, as well several discussions with Joe McCarthy, proved invaluable in allowing Dr. Schwartz to arrive in Milwaukee with some basic understanding of local issues and to use the available time on site as efficiently as possible.

C. Jeffrey Schwartz and Richard Geaither had planned the project around two different weeks of on site work. Dr. Schwartz initially traveled to Milwaukee on September 3, 2007 and worked at HoC from September 4 through September 7, returning to California on September 8. He then returned to Milwaukee on September 24, again working on site for four days from September 25 through September 28.

There are distinct advantages to dividing the work on this kind of project into two segments and allowing a week or two in between. With a large jail, there is so much to review and there are so many major issues that only become apparent as the review is underway, that it is impossible to maintain a strict schedule or to work in a "straight line" fashion. Inevitably, there are unanticipated interviews that become crucial, areas of the jail that need to be revisited in light of new information, etc. After several days it is important to be able to stop, take stock of progress and identify the highest priority questions that remain unanswered or partially answered. Scheduling this work in two separate trips made that possible.

D. In general, the consultant used a combination of interviews, informal discussion, touring and observing areas of the jail and reviewing documentation to conduct this assessment.

On the morning of September 4, the consultant met in person with Joe McCarthy, for the first time. They discussed the staffing, population and layout of the HoC for a short time and then attended a previously scheduled meeting for all of the Sergeants in the organization. Following that, the Superintendent met with Ron Malone, the HoC Superintendent. (Willie Briscoe, the other Assistant Superintendent, was on annual leave that week and Dr. Schwartz did not meet with him until his second trip, two weeks later). After meeting with Superintendent Malone, the consultant toured HoC, talking with both staff and inmates. While these discussions with staff were usually one-on-one and sometimes with two or three staff, inmate discussions, particularly in the dormitories, sometimes turned into a small group of inmates talking with the

consultant. To the extent possible, the consultant observed procedures and practices as he looked through the facility. The consultant toured all of the floors and areas of the jail but with over thirty dormitories, he did not spend time in each separate dormitory, choosing instead to spend more time in a representative sample of the dormitories.

On Wednesday, September 5, Dr. Schwartz continued to interview a cross section of front line staff, supervisors and managers and to visit various areas of the jail. At the end of that day he left the jail but returned before 10:00 PM and remained in the jail until approximately 4:00 AM in order to spend additional time with second shift staff and particularly to have time with staff working third shift. (Correctional institutions tend to be substantially different evenings and weekends than day shift, Monday through Friday). Dr. Schwartz also sat in on two shift change briefings ("line-ups") that week.

Dr. Schwartz spent time both weeks at the Community Correctional Center (CCC), which is the location of the HoC work release program and the electronic monitoring program. While HoC is located on the outskirts of Milwaukee in a suburban area, CCC is located in the heart of downtown, adjacent to the County Courthouse.

E. During his first week on site, the consultant requested meetings with the County Executive, the Chief Judge, the Commander of the Sheriff's downtown jail (the Criminal Justice Facility, or "CJF") and the head of the county's Human Resources (HR) Department. The HoC Superintendent's office was able to schedule all of the meetings requested by Dr. Schwartz for his second week on site. He met with Scott Walker, the Milwaukee County Executive, Rick Schmidt, the downtown jail Commander, Chief Judge Kitty Brennan and Dr. Karen Jackson, the county's relatively new HR Director. These meetings ranged from approximately thirty minutes to over an hour and covered HoC issues as well as broader concerns with countywide criminal justice planning.

F. At the end of the consultant's first week on site, it was apparent the situation with "forcing" (assigning mandatory overtime shifts) was becoming an imminent crisis. The consultant sent the Superintendent a lengthy email containing the consultant's preliminary observations and recommendations regarding "forcing" practices. In a similar and related situation, the consultant's discussion with HR Director Karen Jackson centered on in-progress changes in the selection and hiring procedures for new correctional officers at HoC. Dr. Jackson requested a copy of any coverage of those issues in the consultant's final report and, rather than waiting several weeks, the consultant sent Dr. Jackson and Ron Malone a separate, immediate and detailed email with recommendations and conclusions about potential improvements in that hiring process. Both of these "interventions" were unusual for a technical assistance project but seemed necessary because of the urgency of the issues involved.

G. At the end of the second week at HoC, Dr. Schwartz met with Ron Malone, Willie Briscoe, Joe McCarthy and the HoC Human Resources manager, Ara Garcia, for a "closeout meeting" and reviewed some of his major findings, observations and conclusions as well as anticipating some of the recommendations that would be in the

final report. That same day, the consultant met briefly and informally with Nada Uzelac, the HoC food service contract monitor, and provided feedback on observations of the food service program.

The week following Dr. Schwartz's second trip to Milwaukee, October 1 through October 5, he requested some additional information from Joe McCarthy by email or fax and had phone interviews with several individuals he had not had time to contact while in Milwaukee. That same week, he also began work writing the technical assistance report itself, and conducted some additional phone interviews to clarify or expand information from the two weeks on site.

IV. Caveats and Limitations:

A. This report represents the opinions of the author, Jeffrey A. Schwartz. They do not necessarily reflect the views of the National Institute of Corrections or of the Milwaukee House of Correction.

B. The primary limitation in this report, and in the underlying technical assistance project, is time. HoC is a large, complex operation. It is not possible to see everything in eight days on site, let alone to understand everything well. The consultant attempted to be as comprehensive as possible but, inevitably, some areas received more attention than others. The consultant toured many areas and spoke with many staff and inmates but obviously not with all. (For example, the consultant did not observe/examine the HoC release procedures or the transportation unit). Thus, some opinions went unheard and many situations went unobserved.

C. This report is accurate to best of the author's ability. However, as a direct result of the time limitation described above, it is likely that there may be some observations or recommendations in this report which are incomplete, imprecise or just plain wrong. The consultant did cross check interview information against written data, corroborate information where possible, and the like. However, it was not possible to verify everything in two weeks. The consultant takes full responsibility for any errors in this report but ultimately it is the reader who must decide what is valid herein.

D. This report is not balanced. It devotes more space and attention to negative situations then to positive. There are a few reasons for this. First, the many things in a jail that are operating as they should do not stand out. However, the problems, errors and mistakes do stand out and attract attention. Second, it is more important to management that mistakes or problems be highlighted so they may be addressed, than that the "business as usual" portions of the operation are discussed at length. Certainly this report does discuss positive aspects of the operation and particularly attempts to identify unusual strengths within HoC. However, the reader should be aware of the bias toward problem identification from the outset.

E. Because of the broad scope of this report and the many subjects and areas discussed, the sections and topics of this report are not presented in any particular priority or order.

F. An early Greek philosopher pointed out that one cannot step into the same river twice. That is, the river is changed with time and is no longer the same river. That is true with this report. It reflects the consultant's best judgments about a situation at a point in time (September, 2007) but even during that month there were significant changes at HoC and, as time passes, parts of this report will less accurately portray HoC.

G. The titles of the various topics within this report are those that made best sense to the author. Some readers might prefer a quite different title for the same set of issues. A more serious but related caveat is that the areas and topics discussed "bleed over" into one another. Thus, a discussion in this report under "supervision and management" might almost as easily have been presented under "staff professionalism and morale" or under "leadership." Sharp boundaries and narrow definitions are not part of the natural order of things; they are imposed artificially in the service of organization and understanding. As that also suggests, this report as a whole attempts to paint a picture of the House of Correction but individual sections of this report, on their own, may be somewhat out of context.

H. Some of the most important issues confronting HoC are at the level of county government rather than internal to HoC. That is particularly true of matters such as personnel, administration, budget, facilities and offender population. For that reason, this project expanded to some extent beyond a traditional "operational review" in order to incorporate some of these larger and more long-term issues.

I. This report holds HoC to a high standard.

V. Acknowledgements:

A. The consultant received outstanding assistance and cooperation throughout this project and would particularly like to extend his gratitude to the staff of the Milwaukee House of Correction. This is a very difficult time for the HoC staff. As will be apparent in the body of this report, morale is not good and staff are working under severe pressures. Nevertheless, without exception, staff treated the consultant with professionalism and courtesy. They were helpful, candid and articulate about HoC and their own jobs.

B. At the beginning of this project, Joe McCarthy and Ron Malone committed that the consultant would have full access to any area of the jail at any time and they were good to their word. They, and Assistant Superintendent Willie Briscoe, all managed to make time available on the spur of the moment when the consultant had questions or wanted to discuss some aspect of the operation. They also made sure the consultant was comfortable in Milwaukee and offered much appreciated hospitality. Every time the consultant requested information, it was supplied quickly and thoroughly. Vicki Calk and Linda Liston, the two administrative support staff in the Superintendent's office, both provided a wide variety of on-going assistance to the consultant during both of his weeks at HoC. Dr. Schwartz is indebted for their help.

C. Scott Walker, the Milwaukee County Executive, Rick Schmidt, the Sheriff's Jail Commander, Karen Jackson, the county's new Human Resources Director and Kitty Brennan, the Milwaukee County Chief Judge, all made time available on relatively short notice to talk with the consultant about the House of Correction and related issues. Those discussions proved invaluable, informing the consultant about many of the countywide criminal justice issues impinging on HoC.

D. The consultant has conducted a number of technical assistance projects over the years with Richard Geaither of the NIC Jails Division as the Project Manager. As in the past, Richard was always available for consultation, always supportive and thoughtful with ideas about the project but never interfered with the agency's definition of the project objectives or the consultant's observations or conclusions. Richard Geaither, the Jails Division and this project are typical of the kinds of quick, practical and responsive assistance that the National Institute of Corrections provides to state and local correctional agencies. Though largely unknown outside of corrections, the Institute has been a long-term, implacable and profoundly important force for professionalism in American corrections.

VI. The Milwaukee House of Correction:

A. HoC is a county sentenced facility located 18 miles from downtown Milwaukee in suburban Franklin, Wisconsin. The facility was originally something of a traditional county work farm. That is, in the South and in the Midwest it was common to find major counties that had county workhouses or county farms (sometimes called "penal farms") outside the county seat and usually occupying a substantial amount of acreage. Prisoners sentenced to county time then worked at farming while serving their sentences. The current situation in Milwaukee is typical of these traditional workhouses and work farms. The farming operation has been curtailed over the years and there is now a small plot of land that is farmed with inmate labor. Inmates also provide the labor to operate a fish hatchery which is quite popular locally as it stocks local ponds and lakes, particularly during Milwaukee's summer festival season. The House of Correction location, which was once out in the country, is now clearly suburban. In fact, HoC is surrounded by relatively new housing developments including some of the most expensive new housing in the Milwaukee area.

B. In addition to the primary correctional facility in Franklin, the House of Correction also includes work release and an electronic monitoring ("ES") program housed in an old building in the middle of downtown Milwaukee, adjacent to the County Courthouse.

C. Structurally, HoC is quite unusual. In most counties in the United States, the jail system is run by the Sheriff. Increasingly, there are counties which have opted for an independent county department of corrections and in most of those counties the Sheriff has no responsibility for incarcerating pre-trial or sentenced prisoners. Milwaukee's jail system is bifurcated, a hybrid, with elements of both those alternatives. The County Sheriff operates the downtown jail, a traditional pre-sentenced facility, which does all booking for the county. The sentenced facility, HoC,

is independent of the Sheriff's Office and operates under the auspices of the County Board of Supervisors, reporting to the County Executive. In Milwaukee, the County Executive position is elected rather than appointed, and very strong; there are nineteen members on the County Board of Supervisors. Importantly, the Superintendent of HoC is an appointee of the County Executive, rather than the Board of Supervisors. Both the County Executive and the entire Board of Supervisors are up for re-election this coming April (2008).

D. The Milwaukee city population is about six hundred thousand people while the county population is just over nine hundred thousand. Like many Midwest industrial counties, Milwaukee County has actually lost population since 2000 (down almost 3%) while the state of Wisconsin as a whole has gained almost 4% population since the year 2000. The city of Milwaukee's population is 50% white and 37% African-American with an additional 12% Hispanic population. By contrast, the county's population is 58% white, 26% African-American and 11% Hispanic (by census figures).

E. With the exception of three small linear cellblock areas, all of the housing at HoC is dormitory style. The current facility includes three housing buildings, referred to as North building, South building and the Annex. The North building was constructed in 1949-51 and for many years the North building was the House of Correction. There are also older out buildings, including a boiler plant and a laundry and there is a very large water tower on the site. The North building includes fourteen dormitories with seventy beds in each and three older style, linear single-cell areas referred to as "cellblocks." The A and B cellblocks hold 29 inmates each and the O2 cellblock holds 24 inmates. A2 and B2 house a combination of disciplinary segregation, administrative segregation and protective custody male inmates. O2 houses female segregation inmates, inmates on suicide watch and is also used for overflow from A2 and B2 and for those inmates who prove most troublesome on A2 or B2.

The South building and the Annex were both built in the mid '90's. The South building includes twenty dorms with sixty bunks in each. The South and North buildings are connected by a second-story skywalk. The Annex has five additional sixty-bed dorms arrayed around an interior two-story tower or "pod" in the center of the floor area, with each of the five dormitories accessed from the circular central floor area. The Annex is a separate detached building and staff or inmates coming to or from the Annex have a lengthy walk across the institution grounds as they walk past the North building to enter or exit at the South building.

F. The population of HoC includes the Franklin facility but neither the work release inmates at CCC nor the offenders who are in the community under electronic surveillance. The "design capacity" of HoC (again, excluding CCC) is twenty-three hundred and forty beds. On the first day of the initial week of the consultants visit, the population stood at 2,207. That included 2,003 males 18 years or older, 154 females 18 years or older, and 49 male juveniles. Using different parameters with the same population, HoC held 1,746 convicted inmates and 460 pretrial offenders. A racial breakdown of the population on that day, September 4, 2007, revealed 1,504

African-American inmates, 570 White inmates, 115 Hispanic inmates, 14 Asian inmates and 4 Native American individuals.

G. CCC is a five-story tall, very old, brick over wood frame building that had been a hospital before that use was abandoned and it was converted to a work release center. The four male residential floors hold ninety beds each in small multiple inmate rooms off each side of the main corridor on each floor. The first floor is dedicated to female inmates and has sixty beds. At the time of the consultants visit, the ES program ranged from approximately 255 to 280 offenders but at times has been as high as 400.

H. The House of Correction has 472 authorized staff positions. Of these, 304 are Correctional Officer 1 positions, 36 are Sergeants, 27 are Lieutenants and 7 are Correctional Managers. Thus, the HoC authorized work force consists of 374 uniformed staff members, 3 top administrators and 95 civilian employees. These figures do not include contract employees.

I. The Sheriff's downtown jail (CJF) used to be staffed exclusively with Deputy Sheriffs. Some time ago, the Sheriff changed that and began to hire correctional officers to work in the jail, with Deputies moving to patrol and correctional officers filling in behind them in jail positions, by attrition. Correctional officers at CJF and at HoC are paid approximately 15% less than Deputies (Milwaukee County Deputy Sheriffs are paid significantly less than Milwaukee City Police Officers). While both HoC and CJF employ county correctional officers, and while the pay scale is the same for both facilities, there are some differences in job requirements or qualifications (for example, CJF requires applicants to be twenty-one years of age while the criterion at HoC has been eighteen years of age).

VII. Observations and Conclusions: Countywide Criminal Justice Issues

A. Criminal Justice planning and coordination.

1. Milwaukee County has no Criminal Justice master plan. That is surprising in a county as large and well established as Milwaukee. Until several months ago, there was also no County Criminal Justice Coordinating Council or other planning body. Some of the results of that situation are obvious; others are more subtle.

2. There is no other long-term plan for the Criminal Justice system within the county and there is also no informal consensus among county leaders about the direction of the criminal justice system. Since there has been no forum at which inter-agency issues might be addressed, some of the important questions have simply not been discussed. There is less communication between the various elements of the County Criminal Justice system in Milwaukee County than is typical in most large counties and inter-agency problems, and possibilities, often go unrecognized.

3. Milwaukee County has not engaged in system-wide jail population management. That is an expensive failure and one that has taken the county to the edge of a jail population crisis with few good answers.

   It should be noted that there are some ongoing efforts at population management for the jails and those are driven almost exclusively by the courts. The Chief Judge for some time has been convening a group that reviews pretrial cases that are delayed in getting court hearings or are otherwise in CJF longer than necessary. When a case is "on hold" because of a prosecutorial delay, Judge Brennen requires that the Deputy District Attorney in charge of the case appear personally at the meeting and explain the delay. The group then attempts to determine whether there are changes that might prevent that kind of delay in the future. These "case process review" meetings are coordinated by Holly Zbleski, who works for the courts and coordinates the pretrial release programs, including contract monitoring for the county's two primary pretrial services contractors, Justice 2000 and Wisconsin Community Services (WCS). The focus of the case processing review meetings is the number of days from arrest until initial appearance in court. For misdemeanors, the initial court appearance occurs within two days and it is seldom more than four days. For felonies, the consultant received an estimate that seventy to seventy-five percent of felony cases have their initial appearance in court within three days of arrest. Upon arrest and booking, a court office reviews the arrest report and will establish a bail which is good for seventy-two hours. Within that seventy-two hour window, the District Attorney's office may request a hearing on probable cause and a three-day extension beyond the initial seventy-two hours.

4. Within the last several months, Milwaukee has initiated a new County Criminal Justice Coordinating Council. That is a positive and extremely important development. That coordinating council is still organizing and has not yet set long-term agendas or priorities but from all accounts, it is being taken very seriously and the right set of top county officials are participating. There is every reason to believe that many of the broader areas discussed in this report will be appropriate areas of focus for that coordinating council in the future. Many of the serious problems at HoC can best be approached by an inter-disciplinary and countywide effort.

B. Jail System Structure

1. The hybrid jail system in Milwaukee raises obvious questions and the most surprising aspect of the situation is that there has been no serious consideration of combining the county's jail facilities within one organization, whether that would be the Sheriff's Office or a county department. When the consultant inquired as to whether there had been consideration of combining CJF and HoC within one organization, several county officials said the matter had never really been considered. One individual suggested that HoC should be closed and that HoC, CCC and CJF should be combined in a new facility that would be built downtown, with easy access to the courts. Other county

officials had never contemplated that idea and found it implausible. A primary reason that consolidating the jail system has not been studied or discussed in detail in recent years is the lack of the county criminal justice master plan and the absence of a countywide criminal justice planning and coordinating body. Had either of these two existed, the question would inevitably have been examined in length, because it is obvious and important.

It would not be simple to combine HoC and CJF. They have both existed for a long time and each has it's own history and culture and the community is accustomed to them as different entities. Perhaps more importantly, either the Sheriff would have to give up hundreds of positions and millions of dollars in budget or the County Executive and the County Supervisors would have to make a concession of the same scope to the Sheriff. Thus, the implications would be daunting politically, financially, from a personnel standpoint, etc. This report did not make any attempt to analyze the costs and benefits of such a change and the consultant is not advocating for combining the two jail organizations. However, it does make sense for the county to rigorously evaluate this possibility.

As discussed in more detail in the section of the report on population management, the two separate jail organizations constitute a barrier to effective population management because neither entity really "owns" responsibility for the county's entire jail population. CJF does not regard population management as a high priority because they know they will be near or at their cap of 960 inmates and they also know that because of their consent decree, they will not be forced to exceed that cap. HoC is well aware of the CJF cap and does not see itself as having a major role in population management because HoC is a sentenced facility and is not in a good position to refuse inmates sent by CJF. The situation with state inmates is not appreciably different. HoC takes what comes. Even during the population crisis in mid-September, when the population at HoC exceeded the available beds by 60, HoC did not cut off the flow of state inmates. HoC does maintain ongoing communication with the State Department of Corrections about housing at HoC, but a decision about when and under what conditions transfers from the state would be stopped, has not yet been taken.

It is telling that the only two alternatives to incarceration (release programs) that are considered or worked with regularly by HoC staff are work release and ES. That is because HoC runs those two programs. The HoC staff are quite divorced from other county diversion programs, whether pretrial or post adjudication. Thus, programs that operate out of CJF or primarily "screened for" at CJF are largely beyond the ken of HoC.

There are other negative consequences of maintaining two separate county jail organizations. It is awkward to have two different classifications of correctional officers, both on the same pay scale but each with slightly different hiring qualifications, with the necessity of creating two different eligibility lists. There is little question but that something is lost in food

service, medical services and mental health services because each of those components serves both organizations but is paid for and managed by just one. The consultant does not have enough knowledge of the situation to speak to the question of duplication of services or redundancy of positions. Neither CJF or HoC has a large or bureaucratic top administrative structure. Below that level, it would take a detailed analysis to determine potential savings were HoC and CJF to be combined, and that was well beyond the scope of this project.

C. Population Management

1. Population management for jails is crucial because, in general, costs are a function of bed days. Minor fluctuations in jail population can often be accommodated as existing housing units become more or less full. However, there is a point at which additional housing units must be opened because of increasing population or, conversely, where one or more housing units may be closed due to decreasing population. Housing units must be staffed and in most jails eighty to ninety percent of the cost of operating the jail is attributable to salary and fringe benefits. If an additional housing unit must be staffed by one correctional officer around the clock, and if the average salary for a correctional officer, including benefits, is $55,000 per year, and if it takes six individuals (authorized positions) to staff that housing unit (or "post") on a 24/7 basis, then the real cost of opening a closed housing unit is somewhere in excess of $350,000 per year. Similarly, that is that amount of annual savings realized when the population decreases enough that a housing unit requiring one 24/7 correctional officer can be closed.

   The analysis above is also the rational for managing any given number of inmates in the smallest possible number of housing units. Unfortunately, there are some complications to that seemingly simple premise. Some inmate groups cannot be combined. A segregation unit ("lockup") may need to be kept open even though there are only a small number of inmates on the unit. They cannot be transferred back to general population dormitories. High security and low security inmates may not be able to be housed on the same unit safely, male and female inmates must be separated as are juvenile and adult inmates, etc. In general, HoC seems to be appropriately aggressive in closing dormitories when the population decreases enough to allow it.

   Active, comprehensive population management can substantially reduce jail costs. Also, when the jail population reaches capacity, the choices are to accept over-crowding, to send some inmates out of the jurisdiction on contract, to initiate emergency releases, or to build more beds. None of these choices are attractive. Over-crowding makes a jail harder to manage, more subject to violence and increases exposure to civil litigation based conditions of confinement claims. The problems with sending inmates out of the jurisdiction on contract, most often to privatization firms, have been widely publicized in Wisconsin because of the experience of the State Department of Corrections. Those problems do not need review in this report but it is worth

noting that it is more complicated and generally less attractive to consider contracting for beds outside the jurisdiction for jail inmates than for prison inmates because of the relatively high turnover and short sentences of the sentenced county inmates. Because of court appearances, it is not even an option for pretrial inmates. Building new jail facilities is extremely expensive and that may be the good news; the bad news is that operating the new, larger facilities is often a much larger on-going cost than the one-time cost of construction.

In addition to the financial arguments for population management, there are other, negative but well-recognized factors. When an individual is incarcerated on a relatively minor charge and is released pretrial, perhaps on "personal recognizance," that person may maintain his or her job. If the same person is held in a jail six or eight days, he or she may lose their job. Now unemployed upon release, the person is a much higher risk to commit another crime than if they had remained employed and more stable. The longer incarceration can also destabilize housing arrangements and positive personal relationships. That is not to argue that persons committing serious offenses should be released or that they should not receive serious sanctions from a court. In general, however, jail population management is concerned with misdemeanants and lower level felony offenders, all of whom will be returning to the community, most of them in relatively short order. (There is a population management issue with more serious offenders but that has to do with the speed and efficiency at which they progress through the court system and to a state prison sentence, rather than languishing in the jail with unnecessary delays in their criminal proceedings). Even with the misdemeanant population and the less serious felony population, there are legitimate and important issues about eligibility for release and about appropriate sanctions. Some of those issues are pragmatic and others are philosophical. It is reasonable to expect that those issues will be examined rationally and that there will be best efforts to arrive at some degree of concurrence about the answers to those questions. It is not clear that has happened in Milwaukee County.

2. The capacity of the jail system in Milwaukee County is 3,340 inmates. That number is composed of a nine hundred and sixty bed capacity at CJF and a twenty-three hundred and eighty bed capacity at HoC. The HoC capacity does not include CCC, so that the 3,340 bed total is really the county capacity in secure facilities.

   The CJF capacity of nine hundred sixty was established through a consent decree arising out of a case referred to as "Christensen." That capacity ("Cap") has actually been most helpful to CJF because they use it as something of a shield. When their population exceeds nine hundred and sixty, they immediately load lower security prisoners into vans or busses and transport them to HoC. HoC, in turn, sees itself caught between CJF and the state. The state regularly sends VOP's (violation of probation or parole) to HoC and expects they will be housed. From HoC's perspective, there is no control

about intake from the Sheriff's jail and limited if any control of VOP inmates from the state and HoC does not see population management as one of its primary functions or responsibilities. Interestingly, there has been long-term uncertainty in Wisconsin about who has the authority to decide which inmates may go onto electronic monitoring. There was some contradiction in state statutes about that question but a recent court decision has made it clear that the House of Correction has that authority. As a practical matter, the tradition at the House of Correction has been to use CCC and the ES program located there as the two "safety valves" to prevent over-crowding at the Franklin facility. That is, when the population rises near capacity at the Franklin facility, HoC begins to identify low-risk inmates and those approaching the end of their sentences so that they can be sent to CCC. CCC, in turn, then attempts to identify work release inmates who can be transitioned to ES to make room for the new arrivals from Franklin.

Unfortunately, this process is not instantaneous, or close. It takes time for HoC to identify those inmates who can be best moved to CCC and it similarly takes time for CCC to identify inmates to move to ES and to do intake and job finding for the new work release inmates. Further, HoC staff acknowledge that under population pressures, some of the inmates sent to CCC and ES do not meet the criteria for those programs established by the Board of Supervisors.

3. The proposed HoC budget for 2008 calls for closing CCC, which will effectively eliminate the primary safety valve for over-crowding in the system. That is, when the secure facilities (HoC and CJF) are at or close to capacity and there is an influx of new bookings at CJF, perhaps because of some Milwaukee PD initiative, HoC will be unable to move enough inmates quickly enough to ES (whether voice recognition, GPS or some combination) and the result will inevitably be an HoC population expanding beyond is currently designated capacity.

4. Population management in the Milwaukee County jails is, as one person there put it succinctly, a hodgepodge. There are a number of serious pretrial diversion programs, there are post adjudication alternatives to standard jail time, the county operates a 7-day a week "bail court" and there is screening of inmates for the various diversion alternatives.

   The most obvious problem is with screening at the front end of the jail system. When an arrestee is booked into CJF, there is no face-to-face interview with a pretrial services staff member as a required and integral part of the booking process. Instead, the county's primary pretrial services provider, Justice 2000 (a contractor), staffs CJF for screening purposes from 6:00 AM until 8:00 PM weekdays. The screening is a paper review rather than a personal interview.

   This approach is rife with problems. Inmates booked during the period the jail is staffed for screening may still be "missed" simply because the staff doing the screening are backed up. If an inmate is booked during the hours

that the jail is not staffed for screening then the case may be reviewed the next day, when screening staff are on duty, but that may not happen depending on staffing levels and the press of work. Since CJF has been operating at or near the cap of 960 imposed by the consent decree, it is common for CJF to send pretrial inmates to HoC in order to stay under the cap. To the extent that they can, CJF chooses the lowest risk pretrial inmates to send to HoC and it is exactly those low risk inmates that would be most likely to be identified for pretrial diversion. However, once they are physically at HoC, it is time consuming and cumbersome for the screening staff to travel to HoC to work with those cases and the probability increases that individuals who are otherwise appropriate for diversion will instead remain in jail.

5. For many years Milwaukee County operated a much more traditional pretrial screening program at CJF. Pretrial services staff would screen new bookings and then appear in court on some cases to advocate for release on personal recognizance (PR) bond rather than cash bail. An audit of the pretrial services system some ten or more years ago found that the services were expensive and provided little additional value because, in the vast majority of cases, the Court Commissioner would have established a PR bond rather than cash bail even without the intervention of a pretrial services staff. (Wisconsin has, by statute, a presumption of release on PR bond unless there is risk to the community, a history of failures to appear at prior court hearings or other contravening factors. To Wisconsin's great credit, there is also a statutory prohibition against private bail bondsmen). The response to the audit findings was to eliminate pretrial screening and to move those resources to "later" in the system, creating additional diversion programs. That view of the county's history is not accepted by all and some key individuals in the county argue that the audit finding was used cynically to reduce rather than to move resources and to disguise a philosophic move toward less use pretrial diversion of any stripe.

   There are at least 3 arguments that must be considered that suggest the change was not constructive overall. First, screening and identification must take place in order to find those offenders who are an appropriate fit for various diversion programs. That same work must be done whether it is done at the front end of the criminal process or later. If it is done at the front end, there is the possibility that some cases will be identified in which a difference can be made at the bail court or initial appearance. A second argument is that intervening with diversion alternatives as early as possible works better for the county and for the offender involved. For the county, even a few days of extra jail time that could have been avoided had the individual been identified earlier (for the same diversion or release program) can mean a substantial decrease in overall jail costs and less population pressure on the jail facilities. For the offender involved, the sooner the person is placed in a diversion program (provided the individual is eligible; this is not an argument to lower or reduce the criteria for eligibility for these programs) the sooner the person may return to work and perhaps avoid being fired, or returned to family contacts and maintain positive personal relationships, etc. The third argument is that

recommendations for various release options, diversion programs, intermediate sanctions, etc., may be statistically more successful when the screening is at the front end of the process and results in a recommendation to a Court Commissioner or Judge then when the screening is later in the process and results in a recommendation to the District Attorney's Office.

6. A cautionary note must be sounded about the overall population at HoC. HoC is supposed to be a county sentenced facility. At the time of the consultant's visit, the Franklin facility housed about 2, 200 inmates and over 450 of those were pre-trial. If the plan for a state contract for 192 beds at CJF is approved, it is predictable that the number of pre-sentenced inmates at HoC will increase, perhaps by over a 150 inmates. Thus, HoC is currently over 20% unsentenced and faces the prospect of rising to over 25% unsentenced. That is without consideration of the number of state inmates at HoC which also exceed 400. The problem is that state inmates are generally more difficult than county inmates and unsentenced inmates are, in turn, generally more difficult than sentenced inmates. Thus, a county sentenced population typically consists of low security level individuals completing relatively short sentences. HoC relies on being an unsentenced county facility and there is a strong argument that there would be more severe problems at HoC if the population were not county and sentenced. Unless changes are made, it may be a misnomer to refer to HoC as a county sentenced facility.

D. Information Systems

1. In Milwaukee County, HoC, CJF, the District Attorney's Office and the county courts each have their own computer system. With incompatible software, none of the four entities have access to each other's individual records or databases. The HoC criminal information system is a 14 year old software program that is, at best, antiquated.

2. The lack of software compatibility within the county is an impediment to jail population management, particularly since the staff with major responsibilities for offender screening and diversion are within the courts or court contractors and the offenders themselves are held at CJF and HoC.

3. The primary operational impacts of the lack of information system compatibility are probably within the courts and within the DA's Office. However, at HoC, one of the broad problems is the lack good direct supervision practices. In turn, a primary requirement for effective direct supervision is that the officer in a living unit must be able to serve as a resource for the inmates on that unit. In order to be a resource, the officer must have access to information about individual inmate cases and sentences. Since the preponderance of inmates at HoC are sentenced, the intake information developed at CJF will not include sentencing information. Even for unsentenced inmates, the officers within the HoC dormitories could not review the CJF information because of lack of compatibility. In reality, the question of software compatibility as it relates to direct supervision at HoC is

not reached, because there are no computers in the HoC dormitories, rendering compatibility questions secondary or irrelevant. The question is relevant for supervisors and managers at HoC because serious questions about individual cases may be escalated to a supervisory or management level. At that point, computer access is not an issue but software compatibility and information access remain problematic.

E. County Budget and Other Resources

1. It is clear that for the past several years Milwaukee County has been in an "austerity" posture. The consultant was told that the county has reduced its workforce by approximately 20% over the last five years. (The consultant's understanding of the countywide situation is exclusively from interview data. No review of financial records or other documents was undertaken and countywide issues are only within the scope of this technical assistance project to the extent that they influence HoC. However, the county's financial status and budget process have a huge impact on HoC, and it is within that vein that these observations are presented).

2. The genesis of the county budget difficulties appears to be past county practices with regard to retirement benefits and health benefits. Milwaukee County has historically had liberal, and expensive, benefit packages for county employees but dramatic increases in those benefits six or seven years ago resulted in what is now referred to as "the retirement scandal." As the consultant understands it, retirement benefits were increased by as much as one-third, the rules for taking some or all of a retirement account in a lump-sum payment were changed in a manner that was generally seen as less than financially responsible and lifetime medical benefits were extended. A large number of managers then retired from county employment, taking advantage of the new rules and benefits which some of them had advocated or helped make happen. There are many different interpretations of all of these events and, as usual, history is like beauty, and is in the eye of the beholder.

   What is incontrovertible is that the county faces a huge unfunded liability for retirement accounts and for lifetime health benefits of retirees. By fortunate or unfortunate coincidence, depending on your perspective, the new GASB (Government Accounting Standards Board) regulations now require public entities to "book" those kinds of liabilities, which was not true several years ago. The county has evidently struggled to arrive at an acceptable plan for dealing with the liability. Last year, the budget for HoC (and for other county departments) showed huge fringe benefit costs for each position, costs out of proportion to the actual benefits required for that position. The reason was that the county had decided to assess a blanket "surcharge" to each position to cover the pro rata cost of the unfunded retiree health benefits and retirement payments. Thus, a correctional officer position might be shown, for example, at a $40,000 annual salary and the fringe benefits for that position, rather than being, perhaps, $16,000 (equivalent to 40% of direct salary costs, a quite high figure for benefits) would be shown instead as $30,000, or 75% of the direct

salary costs. In that example, the $14,000 difference between 40% and 75% of direct salary costs had nothing to do with the actual cost of payroll deductions and benefits for that employee but were instead that employee's share of the county's costs for medical benefits and retirement pay for retired employees.

Those accounting decisions and assumptions artificially inflate the cost of labor. That allocation system works a disproportionate hardship against those county agencies, like HoC, that are labor intensive and the decision to use an "across the board" constant charge against every employee position, rather than to vary the charge assessed as a function of the level of salary of the particular position, biases costs against agencies that have a large number of personnel positions below the county's average wage. The county budget would then appear to reflect that HoC was costing an increased percentage of the overall county budget when that might have been exclusively an artifactual result of the accounting methods used. It would lead to pressure for HoC to reduce it's budget more than county departments with higher average salaries or county departments that are less labor intensive. The more obvious problem is that unfunded liability allocation distorts the real operating cost of HoC, making budget based management decisions potentially faulty and making it appear that HoC has incurred an increase in budget relative to prior years, when the opposite is the case.

As this report is written, it is not clear what the County will do with its large, primarily unfunded liability for retiree medical benefits and retirement benefits themselves. There has been consideration of OPEB bonds, which would appear to offer the County a method to "flatten out the curve" so that the liability against operating budget could be held at a relatively moderate and constant level (at the expense of extending that moderate liability some twenty-five or more years into the future). Those decisions are not the province of HoC and a discussion of the potential benefits and risks of that kind of bonding strategy, or of other strategies for this purpose, are far beyond the scope of this report. However, if the County finds a stable method for contending with those liabilities, and if they can be carried as a separate County budget item, rather than allocated among the County operating agencies, then there will be distinct management advantages to HoC. In short, HoC will then be able to manage against a budget reflecting its actual current costs.

3. Politics and political philosophy also have a direct impact on HoC. The County Executive was elected at the time of the "retirement system scandal" and he has been fiscally conservative and committed to not raising local taxes. The Board of Supervisors has traditionally been less conservative. While final approval of the county budget is the jurisdiction of the Board of Supervisors, the County Executive's office is responsible for preparing a proposed budget that is then recommended to the Board of Supervisors. There are many details, exceptions and the like, but the general budget picture for HoC is that they get an overall budget amount, or target, and must submit a budget at that level to the County Executive's office. It is largely left to HoC to determine

where and how to make budget reductions but over the last several years HoC has had to sharply reduce its budget. In an agency where personnel costs are over 80% of total expenses, that has meant losing positions.

4. The big picture is that HoC cannot increase its inmate population each year while at the same time losing staff positions each year. At least, that cannot continue without an unacceptable risk of dire consequences. A correctional institution is substantially less malleable then most governmental agencies. Inmates must be fed, showered, taken to recreation and afforded medical treatment. Those things are not only required by common sense, they are constitutionally mandated.

   There is no question but that efficiencies are possible at HoC. For example, there has not been a staffing analysis in recent memory. However, HoC lost a large number of positions in the county cutbacks the year following the retirement system scandal and since then HoC has continued to lose positions and budget in succeeding years. In addition to positions, costs for salaries, fringe benefits, food, utilities and other major budget items are subject to inflation. Major items of deferred maintenance have been denied year after year (rehabilitating the bathrooms in the North building at HoC, for example) and capital improvements have been similarly delayed or denied. In short, something has to give.

VIII. Observations and Conclusions: The House of Correction

A. Overview

1. HoC is a seriously troubled institution. HoC is not an institution under gang control, nor is it suffering a high frequency of escapes, suicides, weapons assaults, disturbances or other high level violent incidents. That is most fortunate, but it has far more to do with the fact that HoC is housing largely short-term, low-security offenders than with the success of HoC operations.

2. HoC is an institution with a bad history and a negative, counter-productive organizational culture. There are unmistakable remnants of a well-entrenched "good old boy" system. Management has not been analytic or data based and leadership has been strong externally but weak internally. The organization's statutory purpose is largely not being fulfilled and its mission statement is roundly ignored. To an alarming extent, supervisors don't supervise and managers don't manage. Systems such as the inmate grievance system and the inmate disciplinary system are broken, ineffectual or wrong-headed. Communication is weak and generally one-directional and staff professionalism is inconsistent and sometimes poor while staff morale is very low. Staff personnel issues and staff training have been handled poorly and the institution is in its worst mandatory overtime crisis in its history. Staff "prima donna" behavior is more often tolerated than dealt with. The inmate population exceeded available bed space during the consultant's visit and

population issues are an ongoing if intermittent crisis. The extraordinary use of overtime combined with the failure to budget realistically has HoC operating substantially over authorized budget.

3. Security at HoC is systemically poor. It needs a great deal of immediate attention and should be one of the highest priorities. Fire safety has been studiously and comprehensively ignored and represents a most serious threat to lives of inmates and staff. It should be accorded the highest priority. The institution was designed for direct supervision but it does not do direct supervision. That is a central failure. Staff/inmate interactions are sometimes excellent and, again, many staff do a very good job. However, too many staff, too often, treat inmates with disdain or disrespect or simply ignore them and there are a number of staff who are vocal about their negative and unprofessional attitudes about inmates; supervisors and managers are loathe to deal with those staff.

4. The HoC organization is unusually reactive and too seldom proactive. Decision making is slow and poorly defined so that some decisions are delayed so long that what would have been a good solution turns out to be ineffective. Other decisions are discussed serially with no decision forthcoming. The response to too many obvious questions is "Yes, we have a plan we have been considering for that", or "We are in the process of changing that." By contrast, little substantial change has been successfully completed. In fairness, with so many serious problems it is easy to be distracted by the "crisis du jour" and it is hard to maintain focus on agreed upon priorities. Management is not participatory and there are few practices at any level of the organization that appear designed to foster teamwork.

5. HoC is not without important and very real strengths. First, there are many able staff and most want nothing more than to do good work in a reasonable environment and take some pride in their jobs and their organization. (Some staff, although capable, have almost certainly been "lost" to the negativity, the low expectations and poor culture). The programs side of the house is another obvious strength. Programs are serious and well thought out and the program staff appeared to the consultant to be committed, productive and well managed. The large work release program and the electronic monitoring (voice recognition) program are both housed in a terrible old building but both are well run (except for issues such as security or fire safety) and seem to be effective. The main HoC facility in Franklin is another strength as it is well designed for direct supervision and for the kind of population HoC incarcerates.

6. In spite of the distinct strengths identified above, and more, the overall picture at HoC is one of many long-standing and deep-seated problems. It is a major challenge, daunting and perhaps even overwhelming. With the ability of the staff and the nature of the physical facilities, there is no question but that HoC could be a first rate correctional facility but that will not be quick or cheap or easy.

7. The current administration of HoC has been together for less than one year. The Superintendent has been in place for less than five years and one of the two Assistant Superintendents was an external hire and arrived about eleven months ago. The consultant found each of the three top administrators to be a person of commitment, compassion and good values; the situation they confront is largely not of their doing, but that will not make fixing it any easier.

8. HoC has lost staff positions and lost budget regularly over the last five years. At the same time, the HoC population has continued to grow and there has been increasing pressure to take unsentenced inmates and state inmates. Public budgets are difficult in most local jurisdictions across the country but there are real limits to the cutbacks that can be imposed upon a correctional facility unless its inmate population is decreased. That is because most of the cost of a correctional institution is in staff salaries and most of the staff salaries are for uniformed officers to supervise inmates. There has been little support for inmate programs in the HoC operational budget and no budget for other crucial areas ranging from emergency preparedness to staff training. With regard to the old adage, "You can pay me now or you can pay me later," HoC appears to already be at the "later" stage.

B. Mission

1. During the consultant's second visit to HoC, Chief Judge Kitty Brennan emphasized that the statutory mandate of HoC is to "Reform and Employ." In more than a week of prior discussions and interviews, no one else mentioned that.

2. HoC does have a mission statement. It reads: "The Milwaukee County House of Correction is dedicated to providing a safe and secure environment for staff, community and inmates. To this end, all under its employ will display professional conduct, which exemplifies honesty, integrity and personal responsibility. We will meet daily challenges, assuring that all persons are treated fairly, with dignity and respect, while afforded the opportunity and encouragement to reach their full potential."

3. That mission statement is incorporated into some of the literature and other documents about HoC and it is prominently featured on the portion of the county website devoted to HoC. While the mission statement is posted in the administrative area of HoC, it is not visible in most other areas of the facility.

4. Most importantly, the mission statement is roundly ignored. In the course of two different weeks at HoC, the consultant did not hear anyone ever refer to the mission statement. Further, there are practices and behaviors which are common at HoC which are directly contradictory to the mission statement but there is no recognition of this conflict. The organization is not accountable to its mission statement.

5. A mission statement can help unify and direct an organization (as can a vision statement, a statement of values and/or a statement of beliefs). However, a mission statement is only useful if there is staff buy-in, if it is well known and widely visible and if it is seen as seriously defining the organization's efforts. When these conditions are not met, a mission statement is just window dressing.

C. Organizational Culture

1. The Organizational culture at HoC is well entrenched but largely dysfunctional. Evidently, HoC used to be referred to in the community as the "House of Corruption." While the consultant did not hear that term used and it does not seem to have currency, it speaks to the historical image of the organization.

2. There are a number of negative aspects of the culture that are easy to identify. A good work ethic is both an organizational value and personal choice. Some staff take their job responsibilities very seriously and work hard. Other staff do not. It is not difficult to find staff members who "cut corners" without any thought that their poor work or lack of work could have most serious consequences. There are staff who are resentful when they have to work on the job and seem to want to do as little as possible. It must be emphasized that these are not the majority of staff, but the tradition of some staff performing poorly or intentionally shirking their duties is so ingrained that the better staff regard it as part of the landscape. They know better than to try to deal with it.

3. Another important but negative aspect of the organizational culture has to do with policies and procedures. At HoC, the policies and procedures manual is so badly out of date and contains so many irrelevant or inaccurate provisions, it is generally ignored. Since most policies and procedures have been out of date or simply missing for many years, HoC staff operate primarily by past practices. Predictably, with no clear authority or reference defining a particular practice, the variation in the way in which staff define or perform various job duties is much larger than is desirable.

4. Accountability is another long-standing problem with the culture at HoC. It is a concern at every level of the organization. A telling example can be found with "Cyridian," a new countywide software package for payroll and some related HR functions. The county evidently committed to this new software system and purchased it some time ago, perhaps over a year ago. Since then, the various county departments have been sending key people to training on the new system and then bringing training into the departments to reach affected staff. Most county departments have also spent many months planning the transition to Cyridian. None of this applies to the House of Correction. HoC essentially ignored the county directives. They did no training and no planning. At the time of the consultant's visits, staff in the payroll and purchasing areas were growing somewhat frantic wondering what

was going to happen because they were then one month away from the "go-live" date of the countywide trial when the new software was supposed to be used fully, but in parallel with the old system until glitches could be straightened out. As the HoC top management became aware that they were many months behind the rest of the county, and had no plan, there was no sense of "who dropped the ball?" or "who should be held responsible?" Instead, the reaction was closer to "things happen," and "we will have to deal this."

5. The lack of accountability at all levels of the organization may predictably be tied to a lack of clarity about responsibilities and generally low expectations about performance.

6. A lower level example of the accountability problem has to do with post orders. Most medium-sized and large correctional facilities have post orders, although certainly not all. It is possible to hold front line staff accountable for their day-to-day duties without post orders but it would require current, well-written and practical policies and procedures. At HoC, policies and procedures are not current or helpful and there are no post orders. A set of draft post orders was created recently by one person in the organization and the consultant did read those. Some of the drafts, such as the draft post order for the O2 cellblock officer position, were excellent, detailed and thoughtful beginnings. Others, depending on who drafted them, were superficial and not particularly useful. There is no agreed to process specifying how those draft post orders will be reviewed and modified by other staff or management and finally approved, there was no one in charge of the effort and there was no time table for review or approval. That is also characteristic of the HoC culture. Without effective policies and procedures and without post orders it is not surprising that supervisors and mid-managers do not expect to hold subordinates accountable on performance issues and front line staff do not expect that they will be held accountable.

7. In the absence of accountability about performance, what has been substituted is a focus on personnel issues, tardiness, abuse of sick leave and refusal to follow orders (particularly orders to work overtime shifts). There is one clear exception to the disciplinary focus on personnel issues. When there is a serious bad incident, particularly if it goes public and is high profile, everyone recognizes that there will likely be severe disciplinary consequences. That, in it self, is not surprising and some of that occurs in almost every large organization. However, at HoC, means that a correctional officer is being disciplined and perhaps terminated for doing something or failing to do something that other correctional officers working the same position had been doing in the same way for a long time. Further, it may well be that supervisors and managers were well aware of the inappropriate procedure or problem for a long time and did nothing about it. Then, because of a specific bad incident such as the August escape, a few correctional officers on duty at the time of the escape and perhaps a supervisor or manager on duty, will be subject to termination while the other staff who operated in the same manner

and the other supervisors and managers who allowed the situation to persist, face no accountability at all. Beyond that, it raises the question of the accountability of top management for maintaining a climate in which security issues are not a high priority and managers and supervisors have not been expected to monitor performance issues.

In the case of the drug related murder alleged to have been committed by a CCC inmate in October of 2007, several CCC staff have been suspended pending disciplinary hearings. It appears that these staff were using practices and procedures which were clearly inappropriate but which were the common practice at CCC. Thus, the real reason these staff are being disciplined is that they were on duty when something bad happened, not that they did something unusual. Further, the consultant's understanding is that the disciplinary hearings for these staff members have been scheduled for June, 2008. If that is correct, it is unconscionable. (To have a disciplinary termination "hanging over their heads" for that length of time).

8. "Prima donna" behavior is another facet of the culture at HoC. That has evidently been true for a long time. The perception of many staff is that managers and administrators pay attention primarily to those staff who complain or create problems. Again, the history and expectation at HoC appears to be such that it is acceptable to let personal problems intrude on the job, to "go off" on another staff member or to allow personal relationships to dictate how one approaches the job.

9. Much of the favoritism that used to characterize HoC is now gone, but remnants of that former "good old boy system" remain intact. It appeared to the consultant that the staff continue to believe that managers and top administrators use a great deal of favoritism in both permanent and day-to-day assignments, but this did seem to be true. However, there are social cliques among staff that have been allowed to flourish for years although they have been disruptive to the work environment. For example, there are two particular groups of staff that do not get along with each other outside of work. However, each group "hangs out" together, drinks together, parties together and there are dating relationships within the group. Over the years, there has been a soap opera quality to this situation as people have fallen out of or into favor with a particular group, abandoned one group for the other, etc. When the two groups have mixed at social events, there have sometimes been bad feelings and then there then may be subsequent confrontations in the work place and refusals to work with specific other staff. Within the last year, HoC finally asked county HR for help with that situation and HR staff arranged and paid for a consultant to attempt some conflict resolution meetings with members of the two groups. The consultant was less than fully successful and county HR is now exploring additional options for that problem. In the big picture, that situation is not particularly significant but it is another indicia of the HoC culture that something that unprofessional was able to develop in the first place and then persist for a matter of years.

Another point of contention for some staff is the last large group of promotions. Although they were made before some top administrative changes, there is a concern that in some cases promotions were decided upon personal relationships rather than performance or ability. That perceived favoritism is not current but its results are.

10. With deep concerns about favoritism and about social cliques within the organization, it is natural to question the role of race and gender within the culture. The answer would appear to be positive: neither race nor gender are major "drivers" of the organizational culture. That is not to say they play no role and that the organization is gender neutral and race neutral. That is not true anywhere. However, the social cliques seem to be interracial and cross-gender and the common complaints about favoritism are not race or gender based. It should also be emphasized that after two weeks at HoC, the consultant is not in a position to provide definitive answers or, in fact, more than impressions on these difficult questions.

11. Twenty and thirty years ago and beyond, most correctional organizations were largely personality driven. That is, a jail or a prison was often defined by the personality of its leader. Today, many correctional agencies strive to be policy and procedure driven and the best organizations are usually driven by mission and values. Without real policies and procedures, HoC appears to be driven by some combination of history, personalities and an unfortunately negative culture.

D. Leadership

1. An analysis of leadership at HoC is best approached with separate considerations of external leadership and internal leadership.

2. External leadership, the manner in which HoC leaders deal with the Board of Supervisors and the County Executive, the State Department of Corrections, other county agencies and the community (rather than how external leaders deal with HoC), is generally very positive. HoC top administrators work closely with the courts, the Sheriff's Office and CJF, the County Executive's office, the Board of Supervisors and the State Department of Corrections. The HoC administration sees these working relationships as crucial, and attempts to be responsive and cooperative. The Superintendent personally commits a substantial portion of his time to the HoC external agenda and he is visible, sophisticated and effective in these settings.

3. Internal Leadership at HoC is not good. The best summary is that leaders are ultimately responsible for the strengths and weaknesses and successes and failures of their organizations. Thus, without going into great detail, the HoC leadership is ultimately responsible for the organization's performance. As is clear throughout this report, HoC is a troubled organization and its performance is not good. It has been argued that the first responsibility of

any leader is to instill the culture of choice within the organization. HoC's leaders have not done that.

4. There are some major issues at HoC that are directly attributable to leadership. The lack of clear assignments, responsibilities and expectations is one of these. The ensuing lack of accountability is another. The top leaders in the organization are too seldom visible and they do not insist that other managers maintain high visibility within the facility. Communication is poor and in some areas nonexistent. When there is communication, it is one-directional. Planning is a major weakness of the organization. Personnel issues have been handled badly and management is viewed as anti-staff. Labor management issues are more bitter and divisive than the issues suggest may be necessary. Many operational issues do not appear to be given high priority by the organization's leaders. The organization is "balkanized" by shift and rank and assignment; the development of leadership and leaders is not supported at the various levels of the organization. It is not an organization in which staff can flourish and everyone including the inmates, ultimately pays a price for that.

5. HoC leadership is not particularly analytic. Meetings and informal top management discussions seldom involve review of data. Other than tracking daily inmate population and staff use of involuntary overtime, there is little reference to numbers by management. Management seldom initiates requests for new data or new analyses. As a result, most decisions are based upon history and past practices or are made through some combination of subjectivity and intuition.

6. One of the key responsibilities of leadership in a correctional organization is public information. That term subsumes media relations, community relations and a variety of other forms of official communication representing the organization to the outside world. At HoC, public information is handled almost exclusively by the Superintendent. Ron Malone is comfortable with public appearances and with working with the media and he has excellent experience in those areas. However, there is no staff member at any lower level who works with the media or the public on a regular basis and if the Superintendent were on leave when a major incident occurred or if he was unavailable because of his responsibilities managing an ongoing crises, there is no one designated to step in. Mid-managers and managers in the organization have not been trained in public information. Also, because public information is the province of the Superintendent, it tends to be heavily weighted towards reactions to newsworthy incidents (and in corrections, those are unfortunately negative incidents most of the time), and there is no one attempting to get some of the positive stories about HoC out to the public with any regularity. HoC has no annual public information plan or specific goals and objectives.

7. Top management at HoC has not been good about responding to major incidents. When there is an escape, a suicide or some other major incident at

a correctional facility, it is important that the top management get to the facility as quickly as possible and provide visible leadership during the immediate aftermath of such an incident. That is not the tradition at HoC. On some serious incidents, some of the top administrators have taken hours to arrive at the facility or have not come out at all.

8. It is of concern that HoC has received a number of other inspection, audit or technical assistance reports but has not made optimal use of them. The Chief Judge prepares a detailed annual inspection that has for that last several years identified key issues that remain unresolved. There are at least two reports from Ronald Shansky, the Court Monitor on the jail medical and mental health case, which have identified ongoing serious issues. It is not so much that the problems identified in these reports are not fixed but rather that they do not seem to be a day to day or week to week concern. HoC does not take advantage of much of the technical assistance that it receives and that is not a good state of affairs.

E. Staff Professionalism and Morale

1. Staff professionalism is not an isolated characteristic. At HoC, staff professionalism is to some extent a result of factors such as the organization's history, culture and leadership. It is also closely tied to other important aspects of the HoC operation, such as staff-inmate relationships.

2. Professionalism is low at HoC. That generalization applies across the various levels of the organization. That conclusion should not be surprising because most staff do not see themselves as professionals; instead, their view of the job is closer to a blue-collar perspective.

3. At over 2,000 beds, HoC qualifies as a "mega-jail" but it feels smaller and more isolated than that would indicate. The Superintendent participates in the NIC Large Jails Network but, beyond that, there does not appear to be much involvement in professional organizations within American corrections. A small number of staff, primarily mid-managers, have been involved in the Michigan jail association but the organization does not regularly send managers to either the American Jail Association or the American Correctional Association meetings, correctional journals were not evidence in offices at HoC and staff had little awareness of national issues or trends in corrections or what other large jails were doing. The consultant encountered one example of that when he first arrived. When Joe McCarthy had been hired as an Assistant Superintendent almost a year earlier, the rumor had persisted that he was being brought in "to get HoC accredited." During the consultant's first week on site, when he would tell staff members that he was there for an NIC technical assistance project, a number of staff said, "yes, you are here to start accreditation," or words to that effect. The staff did not know that ACA does accreditation and that NIC does not.

4. Shortly before this TA project began, HoC had established a policy prohibiting staff from reading personal books or magazines while on the job. Prior to that memo, it had been common practice for correctional officers to read books or magazines on night shift in the dormitories. The consultant talked with several staff who thought the new policy was stupid and that reading a book or a magazine was realistically the only alternative to falling asleep.

5. Evidently, there still is or has been some kind of a "Big Losers pool" among the staff with perhaps thirty to sixty officers participating. The pool was run by a Sergeant. The existence of this pool has been well known for a long time but, rather than stopping it or holding the organizers accountable, it has simply been tolerated. That speaks strongly to expectations about staff professionalism. The consultant also heard some details about Fantasy Football at HoC. A staff member described that pool as requiring a $100 entry fee and said that the staff members playing included some Lieutenants. In addition to the question of whether or not such activity constitutes illegal gambling, there is no question that it works against staff professionalism. Staff who do not choose to participate are often resentful of such activities and discussions of the football pool, or whatever game is involved, will frequently overshadow considerations of work-related issues. There is the potential for problems collecting money associated with these gambling enterprises and for conflicts about in the way in which the enterprises are being administered.

6. Surprisingly, Milwaukee County has no nepotism policy. HoC has no controls on nepotism either through department policy or accepted practice. It is common to find two or member of the same immediate family in the HoC workforce and there are a few families where there are several family members working there. A related issue is that there are well-known, long-term romantic relationships among some members of the workforce and that includes supervisors and managers. This situation creates serious, predictable problems. First, there is a widespread perception of bias and favoritism. When someone is supervised by a direct family member, or a romantic partner, decisions will be seen as influenced by that relationship even if they are in fact fair and objective. A second problem, and one that is particularly difficult when one of the people involved in a close relationship is a supervisor or manager, has to do with favors and retaliation. If, for example, a Correctional Manager has a long-term romantic relationship with a Sergeant, staff will inevitably believe that the Captain will do favors for friends of the Sergeant and that the Captain may retaliate if another staff member gets "crosswise" with that Sergeant. At HoC, the perception of staff is that these kinds of problems are frequent and strongly interfere with orderly running of the operation. The consultant heard a number of complaints of this type, with names and other specifics attached, but made no attempt to investigate the validity of those complaints and does not know which of the allegations he heard has merit. However, this is an area in which perception is reality.

7. Nepotism is more frequently a problem with correctional institutions than with many other public agencies. Some correctional facilities are the largest employers in a multi-county rural area. For jails and prisons, the work is unusual and not something the average person thinks about. Thus, many applicants seek the job because they know someone already employed there. Also, existing employees recognize that the work pays relatively well for the level of academic requirements and that the benefits and job security are excellent. Existing employees will recommend the job to family members or friends who, because of their relationship to an existing employee, know that the job is not the terrible situation portrayed in movies and television. For those reasons and others, it is common to find two or more family members employed by the same correctional facility. However, most facilities have policies requiring immediate family members to work different shifts or prohibiting them from being in each other's chain of command. HoC has no such controls.

8. Some HoC managers do not model professionalism. One staff members said "The Lieutenants and Correctional Managers on this shift don't like each other and don't get along worth a damn. They don't even try to hide it but they tell us to put all our personal issues aside while we work." That was not an isolated comment. (The consultant did observe managers who were personable but clearly "all business," but that was not the norm).

9. Incidents of inappropriate sexual behavior with inmates are too frequent at HoC. The topic has not been stressed in training, as it should, and HoC has not availed itself of the substantial amount of excellent resource material on the subject that is available without charge through NIC.

10. Morale at HoC is low, as would be anticipated from other areas of this report. There are some positive events and signs. There is a monthly employee appreciation meeting with awards. The consultant did not have an opportunity to attend one of those meetings. There are other meetings for employee recognition, such as the FTO (Field Training Officer) recognition luncheon that the consultant did attend. That event was informal but well planned and well done, with appreciation plaques for the FTO's and an excellent catered lunch. Importantly, the Superintendent and both Assistant Superintendents attended the meeting and all three spoke sincerely about their gratitude to the FTO's for a job well done. It was an excellent example of a very positive employee recognition, good communication and clear leadership.

11. The new HoC HR manager is planning to conduct a broad employee job satisfaction survey. That is also an excellent idea, although it is likely that the results will not be pleasant to review if the atmosphere is as it is now. Still, it is important to get past some of the rumors and stereotypes about staff reactions and staff morale and get specific data on what is bothering staff and what they hope to see in the way of changes.

12. There is no question but that the major cause of negative morale among staff at HoC is the situation with forcing. That is the topic that staff talked most about and are most concerned about. It has driven some staff to resign and it has other experienced staff considering resignation. Sometimes an organization may face a major hardship and it serves to pull staff together and morale can actually improve in the face of adversity. That has not happened at HoC and the poor handling of the situation by management has led to some staff against staff reactions and exacerbated the distance between staff and management. According to data collected immediately after the consultant's second week on site, the perception of the mandatory overtime problem may be substantially worse than the reality, but that perception has been almost universal and overwhelming and has made the job and the workplace unpleasant for most staff.

13. Some of the most negative influences on staff morale are generated by a relatively small number of correctional officers and first line supervisors. They spread inflammatory rumors which, after they are repeated enough, create an ugly tone and cause more reasonable staff to begin to question what is going on. For example, the consultant was told in detail by a few different staff that the top administrators were evil individuals who were intentionally creating the worst situation possible in order to force experienced staff to resign so that they could do what they wished with the "newbies," or so that they could privatize the jail function and close HoC. The consultant heard even worse, and they were not the kind of gripes and complaints about top management that are to some extent present in most organizations. While such stories were preposterous, lacking in logic and factual foundation, the cumulative impact has a corrosive effect on the rest of the staff. It is unfortunate that the staff and groups of staff engaged in that kind of rumor mongering will not take responsibility for the impact of their actions.

14. Management efforts at staff appreciation and staff recognition are to be applauded but it is unlikely they will gain much traction until there is some relief from the overtime situation. Also, while they are very positive, they are not enough and management will have to make strides on a number of other fronts, just as there are other substantial morale problems which are currently camouflaged by the overtime crisis.

F. Management and Supervision

1. This an area that is in need of profound change if HoC is to become an effective, high functioning organization. It is axiomatic that first line supervisors are the heart of any organization. It is also well established that there is almost nothing that management can do that cannot be undone or otherwise defeated by supervisors and mid-managers. At HoC, the supervisors and managers are not in open conflict with the top administration but, as it stands now, they are clearly part of the problem rather than part of the solution.

2. In almost all organizations, there is a bright line at some level of the organization which separates management from the rest of the workforce. That line may be between correctional officer and Sergeant or it may be between Correctional Manager and the top administrators. At HoC, the situation is unusual and there appear to be two such bright lines. The first is between Sergeant and Lieutenant. The Sergeants are aligned more closely with correctional officers than with Lieutenants and the Lieutenants, in turn, are aligned more closely with the Correctional Managers than with Sergeants. The second bright line is between Correctional Managers and the top administration. The Correctional Managers work very closely with the Lieutenants but not at all closely with the top management of the institution.

3. To a large extent at HoC, supervisors don't supervise and managers don't manage. There is no stability with regard to the assignment of correctional officers to specific dormitories or other posts. Thus, a Sergeant is responsible for a different group of subordinates almost every day. The Sergeant also has an unrealistically large span of control. None of these factors makes it easy for the Sergeant to be an effective supervisor. Added to the problem is the history of the institution. Sergeants were at one time "lead officers" rather than true supervisors. Sergeants would work in dormitories, they would work meal relief and they would work other correctional officer posts at times. Then the Sergeant classification was changed to a traditional first line supervisor role but absent training, role models or historical expectations, it is not clear that HoC ever fully accomplished that change.

4. The Sergeants are responsible to evaluate correctional officers but the performance appraisals are something of a sham as a particular Sergeant may evaluate officers with whom he or she has had little contact over the course of the year. Most of the performance appraisals are "pro forma" but they are a source of contention among correctional officers because some Sergeants tend to rate everyone lower than other Sergeants. As a correctional officer, your performance appraisal may depend more on which Sergeant rated you than on your performance.

5. Without supervising the same group of correctional officers regularly, the Sergeants are less motivated to attempt to do on the job training, to provide ongoing evaluative feedback, to be concerned with career development issues for their subordinates, and the like. The Sergeants at HoC do not feel empowered, and they have not been. If the agency is to be reformed, Sergeants will have to play a pivotal role in that change.

6. Lieutenants appear to be similarly misused. In general, the Lieutenants are so busy with scheduling and overtime related issues that they are unable to function as mid-mangers and second line supervisors. The consultant was frequently in and out of the South Lieutenant's office where scheduling is done and it was not unusual to find four or five Lieutenants, or Lieutenants and Correctional Managers, all trying to schedule the next shift and track call-ins on the current shift. Much of this work is clerical and certainly does not

require the skills or experience of a Lieutenant. The Lieutenants are themselves frustrated. It is not like they do not know they are being misused. With most of the mid-management and management staff occupied with scheduling, there is little management presence on the floors and little management attention to larger problems and longer-term issues.

7. Another consequence of this situation is that small problems and particularly personnel issues, get discussed among a number of managers rather than being handled decisively by the first manager confronting the problem. The way in which the mid-managers and managers work encourages escalating rather small problems to an unnecessary level and also encourages diffusing small problems among a group of managers in an inefficient manner.

8. The highest ranking staff member on duty evenings, nights and weekends is a Correctional Manager. In theory, a Correctional Manager should be the Shift Commander. However, there are often two Correctional Managers on duty and there is no policy or practice that specifies which of the two is, in fact, the Shift Commander. That is a particular problem for emergency situations because reality is that in a fast developing crisis, good people with excellent skills and experience may still differ dramatically on a life and death decision, with no time to consult. In such an emergency, it is essential that staff know who is in charge and empowered to make the decision and it is also imperative that the managers on duty know exactly who is in charge.

9. Setting aside the question of emergency response, it is not obvious why there is a need for more than one Correctional Manager on duty at a time unless there are some clear delineations of duties. There are seven approved Correctional Manager positions at HoC. One of those positions is assigned to CCC. That leaves six positions at the Franklin facility and that should be the correct number for staffing one Correctional Manager post on a 24/7 basis, including relief for sick leave, annual leave, etc. Since Correctional Managers do not use sick leave or personal leave days as often as the average staff member, and are less likely to still be on military reserve status, there should be some moderate excess of Correctional Manager shifts available over the course of a year, perhaps 75 to 100 shifts in a year, where there would be two Correctional Managers on duty. However, it appeared to the consultant that there were two Correctional Managers on duty much more frequently than that.

10. The twenty-seven approved Lieutenant positions should equate to one 24/7 position at CCC and approximately four 24/7 positions at the Franklin facility. If six of the twenty-seven Lieutenant positions are assigned at CCC to provide one Lieutenant on duty around the clock, then the remaining twenty-one positions are at Franklin. One of those is assigned to programs, which makes excellent sense. Another is assigned to the powerhouse, which makes no sense. (At one time in the past, inmates who worked in the powerhouse lived in that building. This civilian steamfitters and the head boiler operator supervised the inmate work crew with the boilers but were

also responsible for supervision of the inmate crew in its living area. In light of this, the positions were changed to correctional officer positions with the chief boiler operator classified as a Lieutenant. Inmates have not lived in the powerhouse for some time but HoC continues to carry six correctional officer positions and one Lieutenant position that are in actuality steamfitters and a boiler plant supervisor).

11. That leaves nineteen undifferentiated Lieutenant positions assigned to the Franklin facility (all of these figures reflect rounding the 5.85 actual relief factor to 6.0). That is why the consultant typically saw four and sometimes five Lieutenants on duty and in the scheduling office. The consultant could find no rationale for this staffing pattern. The three to five Lieutenants who may be on duty on a particular shift do not have specific responsibilities as might be expected (one Lieutenant in charge of the North building, two Lieutenants in charge of the two sections of the South building, etc.). As a result, the Lieutenants spend a great deal of time together on scheduling and overtime issues and a minimal amount of time touring the facility, supervising Sergeants or talking with line staff and inmates.

12. Even if some of the Lieutenants had specialized assignments, as would be typical for a jail the size of HoC (inmate discipline, the inmate grievance system, internal affairs, etc.), there would still appear to be more Lieutenant positions then are necessary or justifiable. On the other hand, there are far too few Sergeants positions. Of the thirty-six authorized Sergeant positions, CCC requires one Sergeant position 24/7 and a second Sergeant position two shifts and seven days. That accounts for ten of the thirty-six positions. The Annex at Franklin accounts for another six positions (The Sergeant position at the Annex is assigned to the central booth, essentially eliminating the possibility that Sergeant will supervise the officers working the five Annex dormitories. That seems to defy common sense). Another 24/7 Sergeant is dedicated to the booking and transportation area, accounting for another six authorized positions. If the K-9 and training Sergeant position is accounted for, that leaves a total of thirteen Sergeant positions, maximum, for all of the Franklin facility, excluding the Annex. (That figure of thirteen Sergeants also assumes that all Sergeant positions are filled and that the consultant has not missed other specialized Sergeant assignments). Thus, there are one-third fewer Sergeants than Lieutenants to supervise the Franklin facility. In reality, Sergeants are scheduled beyond the level of the authorized positions, in order to provide three "floor Sergeants" on every shift (excluding the Annex). The span of control for these three Sergeants makes it impossible for them to effectively supervise even if everything else were in order, which it is not.

13. At the Lieutenant and Correctional Manager level, the result of having everyone on duty responsible for everything, is that at the individual level no one has ownership, and at the organizational level there is no accountability.

14. Some Lieutenants and Correctional Managers have negative and even ugly attitudes towards front line staff (just as some front line staff have negative

and even ugly attitudes about inmates). This is not universal and should not be taken as an indictment of all Lieutenants and Correctional Managers, or anything of that kind. However, these negative attitudes are a kind of poison that has a disproportionate negative influence on the climate of the institution. It is note-worthy that other Lieutenants and Correctional Managers who are themselves supportive and professional about staff, do not attempt to intervene with their peers. Such interventions should be the role of the top administration, but they do not have enough presence on the floor of the institution to consistently deal with such issues.

15. Quite apart from the negative attitudes discussed above, some supervisors and managers have very poor interpersonal skills and do not know how to supervise effectively. Once again, that should not be surprising in an organization that has ignored supervisory and management training while providing too many wrong role models and very little supervision or mentoring at these levels.

16. Supervisors and managers often ignore and implicitly condone "prima donna" behavior on the part of subordinates. That is not surprising since that kind of behavior is part of the culture of the organization and certainly one of the expectations at HoC.

G. Communication

1. Lack of communication is a problem that cuts across ranks and functional areas at HoC. The issue is not poor communication but a lack of communication. The communication that does occur is almost exclusively in one direction, from the top down. Communication from the bottom up is not expected or supported.

2. HoC does have shift briefings ("line-ups"). That is very positive because some correctional facilities have been unable to establish shift briefings because of budget or related considerations. The shift briefings at HoC should be an opportunity for a great deal of two-way communication. The consultant sat through two such shift briefings and found that they fall far short of their objectives or potential. Lieutenants and Correctional Managers had to be directed to be at the front of the room with the manager conducting the briefing, rather than leaning against the wall at the back of the room. Most line staff are not positive or professional and project a "just give me my assignment" attitude. There is little or no discussion between line staff and managers. The information transmitted about inmate problems from the prior shift is minimal if there is any information of that sort at all. Line staff use the opportunity to talk with other staff about forces and overtime issues.

3. The morning of the first day of the consultant's first visit happened to coincide with a meeting of all Sergeants, which the consultant attended. It turned out to be the first such Sergeants meeting in years. It was an excellent

idea to hold a meeting for all Sergeants and the Sergeants themselves responded very positively.

The meeting was run by a Correctional Manager and a Lieutenant and began with announcements and one-way communication. Two of the three top managers were not in attendance (one was on annual leave). As individual Sergeants began to react to some of the issues covered by the Lieutenant and the Correctional Manager, the meeting turned into a good general discussion. It was obvious that there was a substantial reservoir of opinions, suggestions and problems that the Sergeants had been storing for lack of an appropriate venue in which they could discuss such matters. In the big picture, the meeting was less significant because of the specific issues discussed (taking Sergeants out of the dining halls; Sergeants' responsibilities for evaluating correctional officers; etc.), than for establishing a precedent of an all Sergeants' meeting with an opportunity for open discussion.

4. Two officers, on different occasions and in different locations, described to the consultant the details of written suggestions they had submitted to the HoC administration. In both cases, the officers said that they had never had any response. One of the two officers said that he had submitted several written suggestions until he learned, in his words, that there would never be any response and that evidently no one even read them.

5. Rumors abound at CCC. There is no established method for rumor control. When management hears of some new rumor which is far from accurate, top managers express frustration or irritation but they do not do anything to solve the problem. There is an almost constant procession of important issues about which the staff get no official, accurate or current information. During the consultant's two weeks in Milwaukee, the issues afoot included the population cap, the closing of CCC, the shift of ES to GPS, accreditation and changes in the correctional officer hiring process. The saying is "nature abhors a vacuum," and at HoC the communication vacuum is quickly filled with rumors.

6. There are a number of groups of staff that should meet on a regular basis. For some groups it may be appropriate to meet weekly while other groups may only need to meet quarterly. For example, the PSW's do not meet with the top administration nor do they meet with the uniformed supervisors and managers. They do meet with nursing supervisors and, partially as a result, they maintain close positive working relationships with the nursing staff. The top administrators do not meet with the Correctional Managers regularly, nor with the Lieutenants. The exception is a department heads' meeting. Assistant Superintendent Briscoe chairs a well-established department head meeting that occurs monthly. The consultant was able to sit in on one of those department head meetings and found it well organized and productive. In general, when there are regular meetings at HoC, draft agendas are not circulated in advance as an opportunity for participants to add to the agenda or prepare for the meeting and no minutes of the meeting are kept or distributed to help with

communication to staff not at the meeting, nor to document assignments or deadlines.

H. Staff-Inmate Relationships

1. This is a relatively simple issue at HoC. Much of it has been presaged by earlier portions of this report and will not need reiterating. Staff-inmate relationships are generally not good.

2. The consultant observed many staff who were excellent with inmates. Some staff were very impressive in terms of the skills they used working with inmates in the dormitories. The majority of staff are clear and direct and reasonable with inmates. They use humor but they also use respect. An example may be helpful. The consultant accompanied two managers in route to respond to an ongoing fight in one of the dormitories. When the consultant and the managers arrival, the inmates in the fight had just been sprayed with OC and one of the two inmates had been put in restraints. One of the K-9 units had responded and was in the hallway. There were several supervisors and mangers in the dormitory as well as two or three correctional officers. The inmate who appeared to be the perpetrator was treated clearly, strongly and safely, with no hint of verbal or other abuse. The inmate who appeared to be the victim and who was bleeding from a bad cut as well as showing the effects of the chemical agent spray, was also handled as professionally as possible, with care and acknowledgement of his injuries. As the second inmate was being restrained and taken for assistance, many of the other inmates in the dormitory were still on the floor and staff got them back on their bunks with clear strong direction, so that clean up of the fight area could begin. While staff deal with worse incidents, this was a serious situation and no minor scuffle. It also had the potential to escalate into something much uglier and more dangerous. Staff-inmate relations and communication in this kind of a crisis are obviously more challenging than during day-to-day regular supervision. The excellent staff work the consultant observed throughout this incident was much higher profile but characteristic of the majority of staff-inmate interactions the consultant saw during his two weeks on site. The majority of staff deal with inmates well and there are a number of staff who are most impressive in this regard.

3. On the other side of the ledger, there are at least two clear problems. The first problem is perhaps becoming a familiar refrain for the reader. There are too many staff who do not work well with inmates. Unfortunately this is a substantial number of staff and it undermines and nullifies the good work that is done by the larger number of staff. The inmate who is dealt with decently and professionally for two shifts but then has a third shift with an officer in the dormitory who is uncaring, unresponsive, demeaning and or punitive will have a view of staff that is disproportionately shaped by that third staff member. While the staff members who treat inmates badly do not want to acknowledge it, it is also a central issue in staff safety. Unfortunately, it is sometimes the good staff member who is injured because he or she has

had the misfortune to follow a staff member who spent the shift "driving on" inmates.

4. Some of the staff who deal badly with inmates may do so because they lack the skills and the training to do otherwise. It is likely, however, that that does not account for most of the bad staff-inmate interactions. More commonly, the staff member who is bad with inmates either does not care or is purposely being disrespectful, or punitive. The consultant observed many examples. Some staff swear at or with inmates. Some staff have made an art form of "zingers," smart retorts and one-upsmanship (the "you should have thought of that before you did your crime" school of inmate supervision). Too many staff fall back on the threat of group punishment in response to a problem from an individual inmate, a particularly poor practice in dormitories, which can increase tensions and danger levels while decreasing staff creditability and authority.

5. The second problem is more structural and affects those staff who are very good with inmates as well as the staff who are not. That has to do with the failure of HoC to practice direct supervision and the decision not to use stable, medium term assignments of individual staff to particular dormitories. It is hard to develop or capitalize on positive staff-inmate relationships when there are no staff-inmate relationships. The amount of rapport or trust that an officer can develop with an inmate during an 8-hour shift is trivial compared to the kind of relationships that develop when an officer is assigned to the same dormitory for three or four or six months at a time.

I. Budget and Fiscal Control

1. HoC does not have it's own budget and fiscal control section or manager. Instead, HoC uses the manager who is in charge of fiscal matters for the Sheriff's Office. The good news is that the manager, John Priebe, was the budget person for HoC for a number of years and is very familiar with HoC. The bad news it that Mr. Priebe spends 90 or 95% of his time on the Sheriff's Office and very little time working with HoC. He had an accounting subordinate at HoC but that person left months ago and the position has not yet been refilled. (In fact, the consultant used the accounting office at HoC as a place to make notes, store documents and use the phone and computer, because it had been unoccupied for months).

2. It does not make sense that HoC has no manager for budget and fiscal control. While John Priebe knows HoC well and knows the county's financial processes very well, he freely admits that he has little time for HoC and that his identification and loyalties are with the Sheriff's Office. That is a key point because there are a number of issues where there is natural budget tension between the Sheriff's Office and HoC and having those issues decided by a Sheriff's Office employee does not necessarily bode well for HoC's finances. An excellent example of this kind of divergence of interests may be found in the negotiations involving the State Department of

Corrections, CJF and HoC. The state wants to contract for 192 beds at CJF. At the time of the consultant's visit, the issue had not been decided but the county was viewing the proposal favorably. The plan was to split the revenue from that contract between CJF and HoC. In reality, CJF would then get half the revenue from the contract with essentially no expenses associated with providing those beds. The extra services for that contract will actually be provided exclusively by HoC. That is, since CJF is already operating at capacity, setting aside 192 dedicated beds for the state contract will not increase CJF staffing or food service or inmate clothing costs. What will happen is that the dedicated block of state beds at CJF will mean that at any given time HoC will be housing 192 extra inmates that would have had space to be housed at CJF, were it not for the state contract.

3. Other serious problems are inevitable with no fiscal manager for an independent organization with a budget in the tens of millions of dollars. There is no one for top managers to talk to and discuss budget issues with on a regular basis. Similarly, there is no one to alert HoC administrators about looming budget problems, unusual opportunities or simply to provide frequent budget feedback. The predictable result of the situation is that the level of budget familiarity among HoC top administrators is unacceptably low.

   A budget should be neither more nor less than an organization's annual operational plan, expressed in fiscal terms. The budget should be actively managed. Monthly budget reports should be carefully reviewed by all top managers. In organizations with exemplarily fiscal management, budget preparation and budget management are both "pushed down" to the lowest level functional managers.

4. The HoC overall budget for 2007 is approximately $53,500,000 with a $3,800,000 abatement offset and a $4,600,000 direct revenue offset. (By contrast with the HoC $53,000,000 overall budget for 2,200 inmates, the Sheriff's downtown Jail, CJF, had a 2007 budget of $49,000,000 for 960 inmates).

5. Overtime is budgeted for 2007 at $1.5 million dollars. Overtime use has been running substantially above that amount. In 2006, HoC overtime was approximately twice the number of hours budgeted but that was partially offset by 75,000 fewer "straight-time" hours used than budgeted (Milwaukee County evidently does not budget for an anticipated level of unfilled positions). Actual 2006 financial figures for HoC showed expenditures at 4% under the budgeted amount and revenues at 7% over budget for the year, with a net tax levee surplus of $754,000.

6. The 2007 HoC budget reflected a reduction in staff of 5 correctional officer positions and the proposed 2008 HoC budget calls for a reduction of 36 positions, primarily resulting from closing CCC.

7. In 2007, planned revenue generation by HoC is $4,600,000. The largest contributions to HoC revenue are from fees for ES services, fees for boarding and supervising CCC work release inmates, fees for housing municipal prisoners and some state revenue for state prisoners.

8. The state of Wisconsin has taken the position that they are not responsible for paying HoC for housing VOP's (probation or parole violators). While that has been the historical practice, the consultant was unable to get a clear explanation for any statutory basis that would allow the state to place state inmates at HoC without reimbursement.

9. HoC receives approximately $60 per day for municipal inmates housed there and evidently receives approximately $50 per day for those state inmates that are reimbursed. The consultant was unable to locate any studies that had been conducted indicating that those reimbursement amounts represented the actual costs of incarceration to the county. On the face of it, it appears that the state reimbursement is substantially below the average costs per day per inmate at HoC and that the municipal reimbursement figure is also low but closer to break even.

10. There is no focus upon or push for revenue generation at HoC. If the abatement charges are subtracted from the HoC overall budget, then HoC revenues are approximately 9% of the operating budget. Some jails generate more than 30% of their operating budgets in revenues.

J. Personnel Issues

1. Personnel functions at HoC are a mixture of county personnel department responsibilities and HoC responsibilities.

2. The two key people in the HoC personnel equation are both new. The county's Personal Director, Dr. Karen R. Jackson, is new to Milwaukee and Wisconsin and brings a fresh perspective to a set of traditional and somewhat entrenched personnel policies and procedures. The consultant was very positively impressed both that Dr. Jackson sees her role as change agent and that she is committing time and resources to try to straighten out some of the problems at HoC. Ara Garcia became the new Personnel Manager at HoC several months ago but she came from a different county department within the county personnel system. She is a County HR employee but assigned full time to HoC. It is difficult to fully describe the situation she inherited. Policies and procedures are badly out of date in some cases, in others there are no written policies and procedures. Actual practices have been inconsistent and seldom follow those policies and procedures that are in writing. Documentation was missing almost everywhere and there were no reports or statistics generated on a regular basis. It appears that the personnel area at HoC was essentially unmanaged and that a set of idiosyncratic personnel practices evolved over time without regard for applicable regulations, statutes or laws. Ms Garcia is faced with a dilemma: she must

clean up the rather overwhelming mess and develop appropriate new polices and procedures for HoC personnel matters while she contends with some of the major HoC crises in areas such as hiring, involuntary overtime and abuse of various types of leave. It is an unenviable position and she will need close administrative support and staffing assistance.

3. Hiring

a. HoC has been in an acute involuntary overtime crisis but authorized positions is allowed to remain unfilled for many months. The hiring process is the responsibility of county personnel up to the point of the background investigation and final hiring interview, which are conducted by HoC. The hiring process has been unduly lengthy, often several months or more, which has left positions unfilled and exacerbated the HoC overtime crisis.

The cost of a lengthy hiring process is decreased quality of the recruits eventually hired. That may seem counterintuitive because a longer hiring process would seem to speak to high standards. In actuality, the length of the process is independent of the standards used and the longer the process, the fewer good candidates will remain when a hiring decision is finally made. The best candidates in a given applicant pool, based on skills, abilities and experience, will be attractive to other employers. They will have their choice of most of the jobs they apply for and if HoC is the last to make hiring decisions, most of the best qualified applicants will have accepted jobs elsewhere. The hidden factor is that those candidates who are the most self reliant and persistent will not risk waiting on a single application that takes months for a decision. They will apply to multiple sites and many of those employers will make decisions much more quickly than the House of Correction.

Even within the county employment process for a correctional officer, HoC has managed to position itself badly. An applicant may apply once and test once for four different county positions: Deputy Sheriff, Correctional Officer at CJF, Correctional Officer at HoC and Correctional Officer at the county juvenile facility. Although the same written application, written test and written psychological are used for all four positions, different hiring criteria and standards are applied for the various jobs. Because of the delays in its background investigation, HoC is frequently the slowest of the three hiring entities to make an employment decision. The Correctional Officer job at HoC is also generally viewed as less desirable than Deputy Sheriff or Correctional Officer at CJF.

b. All of these factors, taken together, indicate that the best applicants in a given pool will have already accepted jobs elsewhere by the time HoC is prepared to make an employment offer. Thus, the slow hiring

process not only contributes substantially to the overtime crisis but also costs HoC the availability of higher quality candidates. Until quite recently, it does not appear that either county personnel or the HoC administration were attempting to deal with this issue.

c. The county personnel department and HoC are now working together to modify and streamline the hiring process for correctional officers. The rumor circulating among a number of the correctional officers is that there has been a decision to reduce standards. In reality, the major change that has been discussed involves switching from a police selection instrument to a selection instrument (written test) that has been developed for and validated upon correctional officers rather than law enforcement personnel. It should produce an increase in quality to the extent that there are substantial differences. The second part of the rumor is that the psychological component of the testing is being discontinued. Again, the reality is that the discussions have involved switching from the psychological written exam that accompanied the police officer test to a psychological exam that has been designed for and validated upon correctional officers. In short, if the current plans are followed, there will be a psychological component which should represent a better standard than the materials that have been used previously.

The selection of correctional officer recruits is a complex topic but there are two straightforward principles which may lead to clear decisions about modifications of the process at the HoC. The first principle is that, all other things being equal, the faster the selection process, the better quality applicants the agency will have to choose among. That is, most individuals looking for employment as correctional officers want a job as soon as possible. They may have lost a previous job or they may have recently moved into the area or there may be a number of other reasons for their application, but most applicants for this kind of job want and need a job offer quickly. Thus, there are two critical time frames associated with this kind of hiring. The first is the time from the completed application to the offer of employment. The second is the time from the offer of employment to the time the applicant is to report for his or her first day of work. Typically, the first of these two is more crucial.

The second principle that applies to this situation is that the various hiring criteria should be logically sequenced. That is, it makes no sense to have two hundred applicants take a physical exam that costs the county $150 each only to later find out that a criminal records check that is quick and free eliminated sixty of those applicants and that an $8 urinalysis screening for illicit drugs eliminated twenty-five of the remaining applicants.

The accelerated hiring process currently being discussed by the county's Human Resources staff with the House of Corrections administrators is exactly the right direction. However, the consultant believes the hiring process can be shortened substantially more than the ongoing discussions may contemplate. The goal should be to redesign the hiring process so that the total time from the point at which an applicant completes and turns in an application to the time HoC is prepared to make that applicant an offer of employment is ten working days or less.

d. Any analysis of a hiring process should begin with deconstructing the process into its component parts. For the correctional officer position at HoC, the components parts consist of a completed application, a verification of minimum eligibility standards (driver's license, age, etc.), a written test, a separate psychological written test, a criminal records check, a urinalysis screen for illicit drugs, a physical exam, a background investigation and an interview with the background investigator. In addition to those components, some other correctional and law enforcement agencies also include an oral board, a polygraph exam and a psychological interview component of the psychological screening. The use of the background investigator to conduct the candidate interview is quite unusual and few other agencies use that procedure. As for sequencing at HoC, the application and the written exam are at the front end of the process and the background exam and the interview by the background investigator are at the end of the process but there is no specified sequence. The entire process has been extremely lengthy, ranging from three months to six or seven months, or even more, with the lion's share of that time taken by the background investigation. However, that does not include the time an applicant may have to wait between filling out an application and the scheduled administration of the written and psychological exams. That delay can add an additional three months to the process.

The written exam that has been in use is a nationally available proprietary exam designed to select police officers. The written psychological exam has been the California Personality Inventory ("CPI"), also using police officer norms and standards. The two written exams together take five to six hours for most applicants to complete and a substantial number of applicants walk out without completing the exam because of its length. The change that is currently contemplated is to switch to a nationally available exam designed for and validated with correctional officers rather than police officers. It can be scored on site rather than sending it back to the corporate proprietor for scoring, as is currently required. The written psychological component proposed is substantially shorter than the CPI and has also been normed for correctional officers rather than for police officers. The shortened administration time for the new

written tests along with a much-improved turnaround time should be an important improvement.

The county is not currently interested in a polygraph exam or in a face-to-face psychological interview as part of the psychological screening.

There is widespread recognition among HoC staff that there should be an oral interview board for new hires, as is common practice, rather than the interviews conducted by the background investigator as is currently done at HoC. The background investigator already has responsibility to talk with the applicant as part of the backgrounding, and the investigator's "take" on the applicant will to some extent be expressed in the background report. When the investigator completes the background investigation and then undertakes a general selection interview, the chance of bias is very high. The results of the background investigation will too often color the interview results. Also, the investigators are primarily retired law enforcement officers. Law enforcement careers and corrections careers are distinctly different. The investigators do not know corrections or HoC as well as HoC staff and are not in the best position to conduct those final interviews, nor should they be conducted by one person.

Another strange organizational custom at HoC is that the Superintendent's Executive Assistant is in charge of the recruit hiring process. She works with the County's downtown HR office and reports to the Superintendent on hiring matters. She engages and schedules background investigators, corresponds with applicants, etc. The HoC Personnel Director is "out of the loop." That makes no organizational sense. The Executive Assistant is experienced and knowledgeable about recruit hiring, and there is no particular reason she should not work on recruit hiring, but there is every reason that activity should be within the personnel area of HoC.

4. Overtime

a. When there are not enough regularly scheduled staff to fill the mandatory positions on a shift, the rest of the positions must be filled by staff on overtime. In most correctional facilities, overtime is a sought after commodity because most staff want to make extra money. When a lot of overtime is available and the situation persists, staff stop volunteering because time off the job becomes more important to them than the extra salary. In a situation in which the regularly scheduled staff and the staff volunteering for overtime do not equate with the number of the posts which must be filled, involuntary or forced overtime is the only option. Different institutions use different terminology for involuntary overtime. At HoC, it is referred to as a "force." The forcing situation at HoC reached crisis proportions some time ago and has grown slowly but steadily worse.

b. By most accounts, the current overtime crisis is the worst in the institution's history although two different staff members with years of experience told the consultant that the situation had been substantially worse when the South building at Franklin has first opened. Everyone acknowledges that forcing has been an intermittent and somewhat cyclical problem over the last ten years or so at HoC and that this current situation is clearly the most serious during that time.

c. There are several rules governing the way in which forcing works. Staff may be forced for either four hours or eight hours, depending on the institution's needs. Staff can only be given a "force" when they are at work. That is because most staff use answering machines to screen calls at home and it would be difficult to reach them to order them to report for an overtime shift. Also, if staff are at work, they can be notified in person and sign an acknowledgment that they have received notice of the mandatory overtime. Then, if staff refuse to work or do not appear, HoC has the necessary documentation with which to hold staff accountable. Another rule is that staff can only be forced a maximum of three days in advance. Also, staff are forced within their regular shift and unless that shift is exhausted, the institution does not force staff assigned to one of the other two shifts. Staff may not be notified of a force until an hour prior to the end of a current shift. That is, an officer may be working first shift (8:00 AM to 4:00 PM) and that officer may be notified at 3:00 PM that he or she is being held over for an additional eight-hour shift. Similarly, an officer may not find out that he or she is being forced on one or both regularly scheduled days off until late in the shift on the day prior to the two days off.

d. The impacts of the overtime situation on staff can be profound. Most obviously, staff working twelve or sixteen hours a day, particularly if it is two more days in a row, are over-tired and may be a danger to other staff, to inmates or to community safety. While some staff have excellent endurance and some staff volunteer for large amounts of overtime, no one is as quick or alert or observant after sixteen hours as they were during their second hour on the job. Staff who are over-tired or frustrated and angry about the overtime will sometimes allow that frustration to affect the way they deal with inmates, and they may be short tempered or disrespectful or worse. Not infrequently, the situation also will have a negative impact upon relationships among staff.

Most staff have families and the impacts of this situation on family life cannot be overstated. Young children do not understand when a parent does not see them for days at a time. The lack of time at home puts a severe strain on some marriages and the consultant talked to more than one officer whose spouse had said "It's me or that job.

You choose." When someone works sixteen hours and must then be back at work after a break of eight hours, they really do not have eight hours to recuperate. Counting the time to drive back and forth from home to work, the time to change into and out of uniform and the time to eat, the officer is lucky if he or she has six hours left. Should the officer use that time to spend with a spouse and family or should the officer just try to get some sleep?

Perhaps the group of staff for whom the overtime situation is worst is the single parents. It is one thing to arrange childcare for a regularly scheduled forty-hour a week job. It is quite an other thing to try to find childcare for eight hours in the night or in the early morning hours, on one to three hours notice.

e. For some officers, the forcing can get to the point where there are no acceptable alternatives. For the officer who is a single parent and has "burned out" family, friends and every other available night time childcare option, it may come down to a choice between being disciplined for disobeying a direct order or leaving young children unsupervised. Hopefully, the officer chooses the children.

f. There is no single cause for the forced overtime crisis. It is a combination of authorized but unfilled positions, extraordinary use of family medical act leave, extremely high use of sick leave and the large number of staff unavailable because of industrial accident leave (IOD).

g. There is no question but that a substantial number of staff are abusing sick leave and other types of leave. An informal analysis of sick leave showed a disproportionate number of staff calling in sick on days contiguous to regularly scheduled days off (RDO's). Over one hundred staff (of approximately 330 filled uniformed positions) had used Family Medical Leave Act within the last year and a large number of staff had been approved by their own doctors for "Intermittent FMLA." ("Intermittent FMLA" is a doctor's directive that the employee in question be given a certain amount of time off every month, either on a regularly scheduled basis or at the employ's discretion, based on a medical finding that it is a medical necessity that the employee not work a full-time schedule). That is a highly unusual and extraordinary situation in most law enforcement or correctional agencies, but it is common at HoC. A substantial number of the staff approved for Intermittent FML are on the basis of migraine headaches. Migraine headaches can be disabling, and produce vomiting, loss of consciousness and other server symptoms. However, the incidence of disabling migraine headaches in the general population is quite low, except at HoC where it evidently afflicts some twenty percent of the uniformed workforce. A substantial number of the Intermittent FML directives are approved by a small number of physicians. During the first week of the consultant's visit, fifteen

uniformed staff members were on IOD and there had been more than one hundred IOD claims over the course of the year. The conclusion is inescapable that serious staff abuse of various kinds of leave exists, although the consultant reviewed no information on individual cases and cannot make judgments about which staff claims are legitimate and which are not.

h. The mandatory overtime situation, along with the obvious abuse of sick leave, FMLA and IOD has had a serious impact not only on staff morale but also on staff relationships. Those staff who pride on themselves on a good work ethic and excellent attendance resent the staff who do not come to work. They are not hesitant to make judgments about who is and who is not abusing FMLA and the like. The strained staff relationships add to an already unhealthy and stressful environment. Ironically, some staff argue persuasively that it is the forcing and the negative atmosphere and lack of concern from management that make the situation so stressful that psychosomatic illnesses are a reality and force staff to take time off and use medical leave or FML for their own well-being.

j. Just to quantify the situation, the first evening that the consultant was at HoC, the second shift had twenty staff working forces and the day shift lieutenants had gone through fifty-five names in order to identify the twenty individuals who could be forced.

k. During the first weeks visit, the consultant was disturbed to find that management was doing little with the forcing situation and that it did not appear to be a top priority. Instead, the administration seemed to accept the situation as something close to inevitable and primarily regarded it as a result of the forty-some unfilled positions. (It is not just management that believes this. The common wisdom at HoC among most staff is that once recruits are hired into the open positions, and trained, the forcing will end. Like much that is common wisdom, that is a myth. Even if forty-five open positions were filled and turnover could somehow be stopped, which is unlikely, that would only produce eight available new staff for each shift, on a 24/7 basis. While that would make a substantial positive change in the situation, the current rate of forces per shift is substantially more than eight. The reality is that the staff on sick leave, IOD and FML have more to do with the forcing than the open positions do). It is also possible, even likely, that overtime has been inadvertently built into the schedule (because the number of authorized positions may not square with the minimum staffing requirements and established staffing and scheduling patterns).

In the absence of visible management initiatives or concern, staff have developed their own methods of dealing with the forcing. Some staff volunteer for four hours OT prior to the beginning of their regular

shift, hoping that they then won't be forced at the end of their shift. Often, that tactic does not work and the staff member is still forced for an additional four hours at the end of the regular shift. The most constructive strategy has been to protect days off by trading with other staff. Thus, staff member A is forced for eight hours on her day off but staff members B and C are both scheduled to work that day and each takes four hours of A's force so that A still has the day completely off. In turn, officer A works for four hours for officer B and four hours for officer C, at their discretion but usually to help protect their days off. At CCC, with a much smaller work force and much better staff-staff relationships, that strategy alone has been sufficient to protect almost all staff days off. At Franklin, the strategy works for some groups of staff but either partially or not at all for other staff.

Another strange HoC personnel practice has been a rule that allows staff to call in once for three days off sick. That is, an individual may call in on Monday to say that he or she is sick and will not be at work that day and that he or she will also be sick the next two days. Since an officer cannot be contacted at home for forcing, and since forcing may not be done more than three days in advance, and since the practice has also been to not require medical documentation for up to three days of sick leave, savvy staff have recognized that these rules, taken in concert, offer a bullet-proof way to protect one's regular days off. If an officer calls in sick for three days and does that on the third day prior to his or her scheduled two days off, then the officer is not present to be forced on either day off and the result is five days in a row off, the first three on sick leave and the last two as regular days off. The loophole works terribly for HoC and for other staff because in order to protect two days off, the officer must feign sickness on three other days, creating three unnecessary forces. Perhaps the most alarming strategy for contending with forces is paying another officer to take the overtime. The office working the overtime then receives both the overtime salary at time and one-half and what ever amount was paid by the officer originally assigned the overtime. That practice appears to be increasing. At the time of the consultant's visit, the going rate seemed to be $50 per shift but the consultant also heard one upset correctional officer talking about paying $100 to anyone who would take his shift. A system of cash payments from staff to other staff raises the specter of a variety of kinds of corruption as well as serious conflicts of unpaid debts and more. It cannot be allowed to continue.

5. Recruitment

a. In attempting to deal with the staff shortages at HoC, County HR expanded its focus beyond the correctional officer selection process and quite appropriately was beginning (at the time of the consultant's visit) to work on correctional officer recruitment. County HR has a

relatively new staff member, Dashal Young, assigned to recruitment and the consultant spent a substantial amount of time with him discussing the specifics of recruiting for correctional officer positions.

b. Nationally, the most effective recruitment technique for correctional positions is the use of the existing correctional workforce. That is the source of a large number of applications for correctional positions even if no special recruitment efforts are made. Experience also shows that applications generated by the existing workforce (friends, relatives, etc.) are much more likely to be successful applicants then is true of the general applicant pool. People who apply because they have learned about the job from a current employee tend to be much more knowledgeable and realistic about the nature of jail work than other applicants.

c. There is a potential problem with applications generated by the workforce in that they tend to perpetuate the current composition of the workforce. Thus, for an agency that is trying to changes it's workforce in the direction of hiring more members of under-represented groups, applications generated by the current workforce may work against that objective. HoC already has an impressively diverse workforce and changing the composition of the workforce is not an issue. Thus, it makes sense for HoC and HR to consider enlisting members of the current workforce in a recruitment effort. Some agencies have encouraged that by providing tangible incentives.

d. Again, based on national experience, mass-media advertising and other attempts to reach the general population may produce relatively large applicant pools but the qualifications and success rates of those large applicant pools will typically be low. Targeted recruiting has usually proved a more efficient and effective method to get quality applicants. Recruiting aimed at members of the military who are discharging or about to discharge has been very fruitful for some agencies and recruiting at community or junior colleges and technical colleges may also be effective. The problem with recruiting at four-year colleges and universities is that too many individuals are anxious for a first job and will sign on but the turnover rates will be very high as they find higher paying jobs or jobs that are closer to their fields of interest.

6. Retention

a. For all of 2006, separations among uniformed staff totaled 41 staff out of 374 authorized positions, or 11% on an annualized basis. Through the first seven months of 2007, totals for uniformed separations were 25, which would extrapolate to a yearly total of 43, or about 11.5% annual turnover. (These figures assume that the computerized database is accurate. The consultant made no attempt to verify that but there were other personnel records computerized at HoC that were

sufficiently inaccurate to give pause. Also, the printout of separations from service is titled "Terminations" but actually includes retirements, resignations and forced terminations.)

b. The morale issues at HoC along with some of the labor management conflict lead people to assume that turnover is very high and retention is a critical problem. Actually, 11% turnover is not particularly high, as there are correctional institutions that have annual turnover between 30 and 40% in uniformed positions. The 11% figure is not optimal and it is also true that many correctional organizations are at 5 or 6%, or below, but 11% is not a cause for alarm.

c. The HoC HR Director's plan to initiate exit interviews is an excellent idea and can be a rich source of information about problems which might otherwise go unnoticed.

7. Staffing

a. A staffing analysis has not been done at HoC in recent memory.

b. There are many aspects of the staffing patterns that do not appear to be logical and which might be changed to proved efficiencies or better staff coverage.

c. As discussed earlier, there appear to be too many Lieutenants and not enough Sergeants.

d. The Correctional Officer position in the medical reception area might be replaced with a civilian employee.

e. It appears there are far too many maintenance employees for the size of the facility, particularly considering that a substantial amount of maintenance work is done by outside contractors.

f. Master Control may justify two officers rather than one, particularly on first and second shifts.

g. A reduction in the number of K-9 officers would potentially offer an increase in the number of officers available for "rover" or "utility officer" assignment.

h. Shift differentiation may not be drawn as sharply as possible at HoC. That is, there may be posts which are currently 24/7 which could be modified to be two shifts per day rather than three or five shifts per week rather than seven.

i. All of the above are examples rather than specific findings. They point to the need for a current and comprehensive staffing analysis. With

the difficult financial situation in Milwaukee County a given, it is most important that HoC use its available staff resources as effectively as possible.

K. Staff Training

1. Staff training was difficult to assess. Information that should have been documentary was instead anecdotal. Crucial training records and training materials were not available. The departmental training officer, a Sergeant, has been in place for some ten years. As a result, the discussion of training issues was often more personal than dispassionate.

2. The State of Wisconsin requires twenty-four hours of in-service training for all correctional officer staff each year. Among the documents that the consultant requested prior to his first visit to HoC was a summary of training by year and by job classification. HoC had no such document available and, instead, the consultant was sent a voluminous listing of all training received, by individual employee. According to that record, a number of the Correctional Managers and Lieutenants had fallen far short of the required seventy-two hours of in-service training in the prior three years. (The record for one Correctional Manager reflected a total of 20 hours of training in the last three and one-half years, for example). The training officer said that the training had almost certainly occurred but had likely not been recorded in the training record which was not necessarily complete or up to date. The training officer indicated that he had hand-written notes which would document which training those Lieutenants or Correctional Managers had attended and that he could add them to the computer-based training records. One recent year, the supervisors were given some sort of 180 questions, "fill in the blank" type exam instead of attending part or all of an in-service program. The consultant never gained any understanding of the purpose of the test, how the results were used or why the test would be an acceptable substitute for actual training. A request to review that exam was not successful. Since the state partially subsidizes the required annual in-service training, they have the right to audit the in-service program for compliance but they have never conducted such an audit at HoC.

3. Sergeants and Lieutenants have attended the twenty-four hour in-service program designed for front line correctional officers. No one remembers any time in the agency's history when it has provided any training designed for first line supervisors, mid-managers or managers. Joe McCarthy, as a relatively new Assistant Superintendent with many years experience at other facilities, reacted strongly to that state of affairs. As a result, the plan for next year is to present a twenty-four hour block of training for Sergeants and Lieutenants that is designed for them and distinctly different from the twenty-four hour in-service program that will be given to correctional officers. That is a major step forward but there are still serious questions about the plan. The current plan does not include Correctional Managers. In light of the historical failure to offer any supervisory or management training, that does

not make sense. Also, it is an opportunity to have the three supervisory and management ranks together and some team building should be a byproduct of the actual training. Second, the outline for the supervisory and management training is very preliminary, but it is so far entirely composed of management assessment tools ("what's your management style?", or more cynically, "management by fortune cookie") and management game playing exercises. So far, there is no indication that there will be any "there" there. That is, the obvious need is for an emphasis on substance and on how to supervise and manage effectively. The priority should be on skill training rather than on game playing and questionably relevant diagnostic instruments. The skill training, to the extent possible, should be corrections-specific.

4. The in-service training that has been conducted represents a major investment. That is, each year the cost to train 350 staff is in the neighborhood of $250,000 simply to pay for relief staff to fill the posts of the staff who are attending training. That number assumes that the positions are backfilled with staff at straight time because training requirements are figured into the relief factor of 5.85 (for a 24/7, seven day post) used for the department's budget. The current staffing and overtime crisis suggests that almost all of the backfill for training will be accomplished at overtime rates and that would make the costs of the in-service program, strictly for participants' salaries, over $300,000 per year. In short, a training program for all staff is extremely expensive even though most of the costs may be hidden because they are within the budget. Those costs do not include the cost of the department's training officer, training supplies, guest instructors or the like. It is exactly because most staff have such limited opportunities for training and because mandatory in-service training programs are so expensive for the agency, that training should be very carefully designed and every training hour used as efficiently and effectively as possible.

5. The consultant was able to review topical outlines of the twenty-four hour in-service training that had been done for the prior few years. However, in spite of repeated requests and commitments, the consultant never got any teaching outlines, lesson plans, reading assignments or the like that would have allowed review of the actual content of the training. It is possible, although unlikely, that such materials existed at the time of the training but have been misplaced or lost since then. It is also possible that such materials never existed and that the instructors primarily "flew by the seat of their pants" with the exception of portions of the in-service that repeated externally available curricula, such as the state's "Principles of Subject Control" (POSC).

6. Based on the operation of the facility, the highest priority training need for front line staff is direct supervision. That subject was covered in the in-service training within the last few years but there is no documentation and no curriculum material. More disturbing is that the facility does not practice direct supervision and individual staff members have no consistent understanding of the principles of direct supervision. The departments training officer described the direct supervision training as a game of dodge

ball. The point the training was designed to make was that the officer in a dormitory is in a position where he or she receives many more questions, requests and approaches than can be accommodated and that the officer must learn to avoid or deflect most of those. Unfortunately, that principle (if there is such a principle) is antithetical to any reasonable notion of direct supervision. That is, one of the central principles of direct supervision is that the officer in the housing unit does deal seriously with almost all of the requests, approaches and questions that inmates have and that over time, those questions and requests diminish to a manageable number as the officer has satisfied more and more of the existing requests and questions. The failure to practice direct supervision should have been a good clue that the training was ineffectual.

7. There are positive sides to the training that has occurred at HoC. The in-service program has not been simply a repeat of the last in-service program, as is true year after year in too many correctional agencies. Further, the training officer has been fully committed to making the training creative and fun for the staff, in his words, training "outside the box." That is an important objective and it is also one that is often ignored. Too much training in corrections is deadly dull. However, for in-service training to be even minimally effective, it must teach things that staff did not know prior to the training and those things must result in staff performing better on the job. In other words, there must be some core training content which is important, directly job related, worthwhile and which is not already known to staff. Even if training does meet those minimum criteria, bad methodology can render good training content useless. However, no amount of slick or fun training methodology can salvage training which does not meet those minimum criteria.

8. There are other examples of the elevation of training methods above training substance. Last year's twenty-four hour in-service program included a half day segment on "first responders." That would be important and valuable training, since the department does not have specific protocols for responding to a call for assistance or an alarm. It would be particularly helpful if it were part of a move toward adopting a first responder system, which the department currently does not employ. Instead, the training had nothing to do with first responders and actually consisted of questions and discussion about how staff felt their first day on the job, what they thought the job would be like, etc. That was likely an interesting and involving discussion but it was not clear that it conveyed important, job related material and it failed to cover the training subject that had been agreed to earlier. Another in-service training segment was devoted to the well known "blue eyes – brown eyes" exercise on race and prejudice. While that exercise is very powerful if well done, there is no indication it was done in response to specific problems among staff or between staff and inmates, or that it was a part of any initiative on race relations from management. There has been a bit of training on emergency preparedness and that too was disconnected from any department initiative or specific departmental emergency plans.

9. It is informative that until very recently, management has exercised essentially no oversight of staff training. Managers and administrators have not reviewed training curricula in advance nor have they sat in on training to assess its quality, relevance or staff reactions to the training.

10. Staff training has had almost no budget. Last year, a budget of $24,000 was requested and only $8,000 was approved. Actually, what is called a training budget is in reality something quite different. Normally, a training budget would cover the costs of outside instructors, the costs of copyrighted or other proprietary curricula, external training sites, curriculum development costs and costs for training equipment and materials. Of these, the HoC training budget appears to deal exclusively with equipment. Some of that equipment is for training purposes but much of that equipment is for other departmental needs that the training officer is involved with but which are not directly training related. HoC needs a realistic training budget and that budget needs to be dedicated to training purposes.

11. In addition to a heavy reliance on game playing, exercises and discussions focused on feelings, the in-service training has also had an over reliance on defensive tactics and subject control procedures, familiarization with the canine program and a few other topics that appear to be chosen because of the training officer's involvement in those areas rather than in response to agency-wide needs. There is a serious question as to the balance of the curricula that have been presented.

12. In most agencies, the training officer position is time-limited and used as a career development opportunity. The two most important reasons for that are that the training officer position requires familiarity with budget and with aspects of policy and procedure and requires working relationships with top administrators and knowledge of agency-wide direction and specific initiatives. All of that is in addition to the requirement to become proficient at developing training, evaluating training, coordinating trainers and determining training needs. Thus, the training position requires a skill set far different from that of the typical first line supervisory position, and it encourages breadth of perspective and develops skills in establishing inter-agency contacts, and much more. It is usually an excellent professional growth assignment.

    The second reason the assignment is best if time-limited is that if a training officer is replaced every two years or less, the person often is just getting comfortable and effective when they are rotated to some other assignment. On the other hand, if an individual is left in a training officer position for more than four years, they often lose credibility with front line staff and supervisors because it has been so long since they have been "on the floor." Also, when someone is identified long-term as a training officer, it can be a dead-end assignment and the person's potential for advancement with other kinds of duties will go unexplored.

13. There are other peculiarities about the training officer position at HoC. It reports to a Correctional Manager rather than to a Lieutenant, presumably because there is no Lieutenant in charge of administrative services or coordinating HR and training. The Sergeant positions have been affected by the overtime crisis as much as correctional officers but when the training Sergeant is "forced," he works that overtime shift as a training Sergeant rather than a floor Sergeant. The consultant did not find any reason there was a need for overtime work by the training officer or how an extra shift in that capacity would relieve the staffing crisis on the floors.

14. Training on security procedures may be an even more urgent need than direct supervision training.

15. HoC does not run its own training academy. The Sheriff's Office runs a training academy for Deputies and Correctional Officers and HoC recruits attend that academy. The academy curriculum recently expanded from three weeks to four weeks. The consultant did not have time to review that program in any detail.

16. When a recruit is hired by HoC, that individual must wait for an academy class to start, which can be a few months. In the interim, the new employee will first complete an orientation week of training in a classroom setting at HoC and then will complete a three week-long FTO program, also conducted within HoC. During the FTO program, the recruit is assigned to an experienced officer and always works with that officer. The officer is expected to provide hand-on training to the recruit as well as evaluating the recruit's performance.

    This is a very good concept. The biggest problem at HoC has been that some of the officers selected as FTO's have been poor role models. It does not make sense to identify someone as an FTO if that person has been unprofessional, or has abused sick leave or is outspokenly negative about the department. Beyond that, the FTO program is generally a strength and most of the FTO's enjoy their training responsibilities and take them most seriously. The program could be strengthened by formalizing the evaluation aspects of the supervision and by specifying the correctional tasks the FTO was responsible for teaching to the recruit and then observing while the recruit performs those tasks.

L. Direct Supervision

1. Direct supervision is one of the most serious and far reaching problems at HoC. The physical facilities are well designed for direct supervision but the bottom line is that it is not practiced. It would be erroneous to consider HoC a direct supervision facility.

2. There is little remaining argument across the United States that direct supervision is the most effective and most efficient method of working with

general population jail inmates, where appropriate. There was a time when direct supervision was a new concept, and controversial, but that time has passed and the answers are in. There is no need to summarize that discussion in this report.

3. All of the dormitories at HoC are "open bay" style and all employ double bunks. While the sheer density of the inmates creates more problems then is true in comparable capacity closed bay, single bunked dormitories, visual supervision is much easier with the open bays. The newer dormitories, in the Annex and in the South building were constructed for a maximum of sixty inmates per dorm, while the older dormitories in the North building were designed for seventy inmates each. Dormitories and modular or podular living units of sixty to seventy population are generally optimal for direct supervision. A smaller population is an inefficient use of staff and a larger population begins to tax the individual staff member's ability to practice direct supervision effectively. The dormitories have reasonable officer stations and the location of those stations is good for supervision of the dormitory. The major drawback to the HoC dorms is that the officer stations do not have computers. That is a barrier to direct supervision because the officers have no easy access to the kinds of information that inmates need. If an inmate wants to know when his next court appearance is scheduled or how much bail has been set, or what his release date might be, the officer has no good way to get that information and provide it to the inmate. The officer can call a Sergeant or Lieutenant, who may then be able to get some limited information from the HoC computer system, or the officer or a supervisor may be able to call the courts or the DA's office if it is during business hours, but few officers will do that and it is an awkward process.

4. HoC only assigns female correctional officers to supervise female dormitories although both male and female officers may be assigned to male dormitories. The consultant was unable to determine why this disparity exists, except that it has been that way for a long time. In the male dormitories, there are no privacy screens in the toilet or shower areas, resulting in an unnecessary loss of privacy for male inmates and an unnecessary requirement that female officers frequently observe naked male inmates.

5. There are a number of well-established core principles of direct supervision but none of these are practiced at HoC. There has been some minimal amount of training labeled "Direct Supervision" but except for a two to four hour dodge ball exercise, the consultant is unaware of the substance of the prior training. It could not have been effective, because the staff simply do not know about direct supervision, including at supervisory and mid-management levels. It should be no surprise that front line correctional officers do not use direct supervision methods when they have not had appropriate training, mentoring or supervision on the topic. It is not what is expected in the dormitories.

6. Most staff stay at the desk, or officer station, almost all the time when they are in a dorm. They do not "work the floor." Some officers are extremely good with inmate requests and try to deal with inmate problems. However, there are enough staff who are rude, disrespectful or just "don't want to hear it" that the expectation in the dormitories is not one of frequent interaction with the staff.

7. Central to direct supervision is the premise that the officer assigned to a dorm gets to know the inmates on that dorm, and visa versa. That should be true not only for the three officers assigned to the various shifts in a dorm five days a week, but also for the relief officers. That does not happen at HoC because the recent tradition is to assign staff to different posts very frequently. Thus, a particular officer may be assigned to a specific dormitory for one day or for three days, but seldom for more than a week. This practice is more evidence that HoC staff have no idea how direct supervision is supposed to operate or have not seen it as important.

   The frequent rotation of staff across posts was an outgrowth of officer complaints about favoritism in the assignment of posts. This would appear to be an example of the wrong solution to the right problem. Favoritism was, and continues to be, a problem perceived as chronic by a substantial number of staff. Also, while some staff are willing to work anywhere and do not much care which posts they are assigned to, the majority of staff differentiate strongly among posts. For example, the dormitory posts in the North building are generally seen as least desirable. That is little surprise since they are the dirtiest, most poorly maintained, most crowded and generally house more difficult inmates. There are other posts which are widely viewed as easier, less work or otherwise more attractive. In fact, when an officer is "forced" for a subsequent day, the officer's ability to get another staff member to fill in and exchange assignments is heavily dependent on the post that the officer has been forced onto. Instead of dealing with the favoritism problem, whether real or perceived or both, in some direct manner, the HoC solution undercut the foundations of effective inmate supervision.

8. It is not necessary to review the details of direct supervision practices because that is not the intent of inmate supervision at HoC. What is practiced is much closer to traditional indirect supervision, with the exception that the officers are stationed inside the dormitories rather than in a control room or off the unit. The officers do not see their role as providing information or other resources for the inmates on the unit. Inmates on a number of different dormitories complained that it is common for officers to sleep at their desks during night shift and that they become upset with inmates who wake them up. Inmates also complained that officers frequently resort to group punishment of the entire dormitory even when the problem was an individual inmate or a small group of inmates. The consultant did witness more than one situation in which an officer on a dormitory quickly threatened group sanctions when a small number of inmates were not responding quickly enough to the officer's direction.

9. The result of the failure to use direct supervision is that at the Franklin facility the individual dorms are more difficult to supervise than necessary, there is more use of disciplinary segregation than necessary, the "tone" of the institution is more angry and resentful than necessary and there are more fights and other negative incidents than need to happen.

M. Security

1. A detailed discussion of security issues at HoC is not included in this report. Rather, that detailed security analysis has been presented to Superintendent Ron Malone informally and confidentially, and outside the scope of this technical assistance project. Although a review of security was specifically asked for as one of the components of this TA project at it's initiation, too many of the security issues have the potential to facilitate an inmate escape attempt or to otherwise increase the probability of some violent incident if the discussion reached inmate eyes and ears.

2. The details of security weaknesses cannot be responsibly presented herein, but that does not hold true for some general observations and conclusions about security practices at HoC. Security at HoC is very bad. The problems are many, and they are widespread and deep. The consultant once reviewed a large correctional institution and wrote words to the effect that good security practices had foundered upon the twin shoals of staff convenience and staff complacency. That conclusion is at least as true of HoC as the institution it was originally written about. Many well run correctional institutions invoke the adage, "In a correctional institution, security is everyone's first order of business." At HoC, security does not appear to be anyone's first order of business. That is not to say that some staff do not work hard on security issues. They do. However, major security lapses are so frequent that staff either don't know they are security problems or have learned over time that "that's just the way it is." Most of the responsibility for this situation must rest with supervisors, managers and administrators. Supervisors and mid-managers do not review security practices on a routine basis. If they did, the majority of the situations the consultant observed would not have been present. The usual question of the degree to which supervisors and mid-managers hold line staff accountable, is close to irrelevant at HoC because no one can be held accountable for problems that are never identified. Managers and administrators, in turn, do not spend time on the living units and do not see the glaring security weaknesses. There has also been no expectation of a security emphasis in meetings, in information the administration requests or conveyed in other ways. It is as if staff at the supervisory level and above have made a conscious decision that security issues are so simple, so basic and so universally well understood that no one need waste time on them, when the exact opposite would actually be true. It should also be noted that when the spotlight does fall on the bad security practice, the tendency is to discipline the correctional officer who made the security mistake, rather than to determine whether the problem is a general practice rather than an isolated

incident and to hold the supervisors and managers who tolerated or condoned the practice accountable.

3. Some security practices at HoC may be corrected quickly or easily. The general security situation, however, will not be corrected in weeks or months. Some of the individual issues will be technically challenging and some may require capital improvements or other serious budget outlays. However, while specific security matters and practices are corrected, the parallel problem will be to work with staff attitudes, perceptions and expectations about security. In short, the organizational culture about security matters must be changed.

N. The Escape

1. Well after NIC had agreed to fund this technical assistance project but well before the consultant was scheduled for his first trip to Milwaukee, HoC had its first escape from inside the Franklin facility in many years. (The name of the inmate who escaped has been publicly available in media accounts of the escape but is not relevant to this report). The escape occurred in the J2 dorm of the North building at Franklin, during the night of Friday, August 3 or early morning Saturday, August 4, 2007. There is a supply closet for janitorial supplies off the day room of most of the dormitories at HoC, and the supply closets typically have a window to the outside. The windows have security screens on the outside of the window. This inmate spent enough time in the supply closet that he was able to pry the security screen off the window. He broke the screen off, allowing him access to the exterior of the building and onto the grounds of HoC. He went over the razor wire on the fence at the west emergency gate and evidently escaped from that location. The inmate's escape was not discovered quickly, in part because he had fashioned a dummy from bedding and clothing and placed the dummy under bedclothes on his bunk.

2. The escape raised a number of security issues. HoC decided almost immediately after the escape to change the security screens so that they were on the inside of the building windows rather than on the outside. Reasonable security monitoring of the facility should decrease the possibility that an inmate could work on compromising a security screen intermittently over a long period of time.

3. The investigative report on this escape is as seriously flawed as are the security procedures leading to the escape itself. The problems with that report are discussed in some detail in the section of this report on internal affairs and investigative capacity.

4. There is clear evidence that staff did not follow procedures in logging inmates on and off the living unit. However, that error – along with a number of other procedural mistakes – does not appear to be a proximate or major cause of the escape. Rather, these errors stand as testimony to the lack of

consistency and non-compliance with policies and procedures that are endemic at HoC. These kinds of chronic failures should not be regarded as an indictment of any particular correctional officer but rather as a systemic problem of the supervisory and management staff.

5. On the night of the escape, counts in that dormitory could not have been conducted properly. A count requires that a staff member sees flesh and movement from each inmate. Unless the inmate who escaped was much more involved with high technology than the facts indicate, the dummy would have shown neither.

   There are strong indications that the inmate workers on the dormitory were largely unsupervised. The supply closet almost certainly had to be left unlocked and unmonitored at some points for the escape to occur as it did. Inmate reports suggest that there was sufficient noise coming from the supply closet that it should have alerted the staff member in the dormitory, but it did not. Inmate reports also suggest that there were attempts by other inmates to inform staff on the unit that there was an impending escape attempt but that such warnings were not heeded.

6. The overall picture is one of poor safety procedures, particularly lacking in checks and balances, combined with a most disturbing level of staff complacency.

7. Fortunately, the inmate did not hurt anyone in the community and, due to some excellent police work by the Milwaukee Police Department, he was apprehended rather quickly.

8. The inmate who escaped is now being held at Dodge Correctional Institution, which is the central intake and reception facility for the Wisconsin State Department of Corrections. A Captain at that facility interviewed the inmate about the escape and a summary of the interview was then transmitted to HoC. The Captain at Dodge provided HoC with very detailed information. The inmate appears to have been candid and forthcoming as the information he provided to the Captain is consistent with the facts about the escape as HoC knows them. (The Captain did an impressive job working with the inmate).

   The inmate noted that he had planned the escape for approximately two months. He also noted that once he had decided to escape, he found several different ways that he thought would work. He said he spent over three weeks working on the window and the security screen in order to break the screen free of the building. He was able to that because his work as an orderly cleaning the unit was almost always unsupervised. Staff did not attend to where he was or how long he was off the floor. He was able to set up a continuing noise distraction so that the sound of his working on the window and security screen were masked. He was able to get dark clothing so that he would not be trying to escape in his orange inmate garb and he was

also able to get a broomstick and other supplies he thought he needed. He did not have a plan to defeat the perimeter fences but was able to find a way over them on the spot. Finally, the inmate described several other weaknesses of HoC security that he believed could have been used for escape purposes.

O. Fire Safety

1. Fire safety is the most serious problem the consultant encountered at HoC. There is no fire safety "system" and, like emergency preparedness, fire safety practices are based on the mistaken belief that "it can't happen here." Fire safety is exceptionally deficient both at the Franklin facility and at CCC, but the risk of loss of life is far greater at CCC because of the nature of the building.

2. CCC is a very old building that appears to be brick over wood frame construction. With old wooden doors and windows, wooden furniture and linoleum, there is every reason to believe that a fire could spread through the building very fast. With five floors and approximately ninety residents per floor, the stairwells might well become unusable due to rising heat and smoke, before the upper floors were able to evacuate.

3. HoC had a staff member in charge of fire safety but that position was abolished some years ago. Inexplicably, those duties have not been assigned to any supervisor or manager as collateral duties. When the consultant asked for fire drill records and fire inspection records, it turned out there were none. No one the consultant spoke with at CCC ever remembered a fire drill being conducted there. At the Franklin facility, no one could be specific about a fire drill occurring in the past few years. Evidently, there is or was a county employee who is stationed at the Milwaukee airport and who, at one time, conducted annual fire inspections, at least at Franklin. The consultant was told by one manager that the individual in question had retired or moved, and was no longer at the airport while some staff thought he was still there. It did not matter because fire safety has been so bad that if inspections were done, they must have been superficial and ineffectual or the situation could not have persisted.

4. At CCC, evacuation routes are not posted on most of the floors. The fifth floor fire hose has not been inspected in over a year. There is nothing that indicates that when the fire hoses were inspected, they were actually unfolded from the fire cabinets and charged to make sure they would hold pressure. From the appearance of the stand pipes, hoses and fire cabinets, it did not appear that had been done even at the times that an inspection occurred. CCC does have exit lights with battery back-up power. On the third floor at CCC, the fire extinguisher had no card or inspection date, the stairwell fire extinguisher and hose cabinet were missing the inspection card or the card was in the bottom of the cabinet off of the fire extinguisher. Emergency doors are not tested regularly. Inmates receive no orientation information

about fire evacuations. Alarmingly (pun intended) the fire alarm system at CCC has not been tested in the last 6 months on second shift and it is not clear that it has been tested in recent years. One staff member said he understood the CCC fire alarm system had been broken for a number of years.

5. The situation with fire safety at the Franklin facility is marginally better than at CCC, but remains a serious problem. One supervisor tried to convince the consultant that fire drills were done on some kind of regular basis and that the on-duty Lieutenants were responsible for conducting fire drills. Aside from the fact that it would make little sense to have on-duty Lieutenants conducting fire drills since they would be unlikely to all have the necessary expertise to identify problems, specify areas for improvement, evaluate equipment and otherwise assess performance during a fire drill, the explanation did not sit well with the consultant. Upon further inquiry and observation, it was established that fire drills simply have not been conducted for the past few years at the Franklin facility. As mentioned in the maintenance section of this report, flammable materials are not inventoried and are often stored outside the flammable cabinets which are themselves overloaded and open.

6. On the positive side, HoC does have a sufficient number of SCBA's (self contained breathing apparatus, or "air packs"). The SCBA's are stored in locations close to housing units or other areas that might need to be evacuated. They are stored in pairs and staff are taught to work with SCBA's in pairs, using a "buddy system", which is important and correct. Most, but not all, fire extinguishers and fire hoses at the Franklin facility were carrying current inspection tags. Again, the consultant did not determine how the inspections of fire hoses were carried out, or by whom. The Franklin facility is sprinklered in the newer areas (the Annex and the South building), which is a major advantage. Also, the buildings are no more than two stories from the ground and evacuation would be much easier than CCC. That does not mean, however, that the facility does not have a significant risk of a multiple fatality fire.

7. The simple reality is that without fire drills, and actual evacuation drills at that, an institution will not know whether or not it could evacuate safely until it finds out during a serious fire. Even with the best of preventive efforts, bad things can happen and a large correctional facility can fill with life threatening smoke in a matter of a few minutes. The ability to move large numbers of inmates out of a correctional facility in a quick and orderly manner may be all that stands between that facility and deaths. Fire drills not only offer practice to staff and inmates alike so that evacuation procedures are familiar rather than something located in a notebook somewhere, evacuation drills also highlight problems in preparation and procedure that nothing else will uncover.

8. It is not clear to the consultant why officials have not ordered CCC closed unless and until the fire danger was mitigated.

P. Emergency Preparedness and CERT

1. HoC's emergency preparedness and disaster planning is itself rather disastrous. It is disturbing to find a facility with almost 2,500 beds with no realistic emergency planning and no functional emergency response capacity. There is a CERT team on paper but not in reality. The armory is as bad as any the consultant has ever seen and contains little that would be useful in a crisis. What little is in the armory would likely be inaccessible to staff in any event. There are no emergency policies.

2. There is a document called "Emergency Preparedness Plan", dated November, 2000 and covering the Franklin facilities but not CCC. There is no emergency plan for CCC. Initially, the consultant thought there was also no emergency plan at Franklin because supervisory/mid-management staff did not know where such a document might be located. The departments training officer located a copy for the consultant and expressed surprise that it was hard to locate because he believed it had been issued to every Lieutenant and Correctional Manager.

3. The document is not really an emergency plan. It is primarily a fire plan. The entire document is twenty-five pages followed by about ten pages of appendices, primarily on fire, with that followed by sixty or seventy pages of evacuation diagrams. The twenty-five page body of the document includes about fifteen pages on fire issues and about ten pages devoted to all other kinds of emergencies.

4. As a fire plan, the emergency preparedness plan is thorough and detailed in many areas. It would provide a good basis for developing a fire plan but as it stands currently, it has serious limitations. It is out of date and, for example, refers the reader with questions to the HoC Safety Specialist, a position that has not existed for some years. Some difficult issues are unaddressed, like evacuating the cellblocks if that became necessary. The fire plan is also based on the older concept of separate and free-standing emergency plans for every predictable kind of emergency rather than the newer and more effective concept of a generic ("all risk") emergency plan with off-shoots or appendices, detailing the differences in response to various emergencies. Even the substantial amount of material on fire safety and fire response that is well thought out and specific to HoC, is close to irrelevant because the preventative procedures called for (fire drills, training, etc.) aren't followed. The response guidelines would not be helpful because staff are unfamiliar with the document.

5. With regard to other kinds of emergencies, the "Emergency Preparedness Plan" is generally not useful. The document does not mention disturbance or riot situations nor does it include anything about hostage incidents. There is,

however, a section on situations involving contaminated food and water. The consultant was unable to find any rationale for omitting disturbances, riots and hostage incidents in the emergency plans of a very large correctional facility. The brief coverage afforded two selected emergency situations is potentially helpful in some cases (for example, the evacuation directives in the tornado section) but most of these sections are superficial or incomplete. The plans presented also assume that only HoC will be affected by the emergency conditions and that all community agencies and resources will be available to assist HoC. In many cases, that is not a safe or realistic assumption.

6. The analysis of HoC emergency plans presented above is not exhaustive. At a practical level, it would not be unreasonable to simply consider HoC as having no institutional emergency plans.

7. HoC does not have crisis (hostage) negotiators.

8. HoC has no disturbance control or other tactical capacity. There is a CERT team but it exists primarily in name only. It was organized a number of years ago with some fanfare and appropriate enthusiasm. As happened with a few other areas, a supervisor initially described the CERT team to the consultant as if it was well organized, trained and fully functional. Looking a bit further, the consultant found that none of that was accurate. The team has not trained on an in-service basis in a long time and there has been no CERT Academy or basic CERT training course in recent years, so as original members of the team leave the agency or become unavailable through promotion or special assignment, there are no replacements. There are still CERT team members on each shift and, in the event of a situation like a cell extraction, a Lieutenant or Correctional Manager may give preference to those CERT team members for that kind of assignment but that appears to be most of what has survived as CERT. When CERT was originally organized, it was intended to be a disturbance control level team rather than a tactical or weapons team. Even at its zenith, the HoC CERT team did not practice missions such as hostage rescue.

9. In the event that HoC did need a weapons team, it is not clear which law enforcement agency they would rely upon. There are no inter-agency agreements regarding weapons teams, snipers, negotiators or other forms of inter-agency assistance that might be critical in emergency situations.

10. HoC has an armory, of sorts, but every aspect of the armory situation is of deep concern.

11. The consultant asked a manager to see the armory. That manager asked a second manager how to get into the armory. The second manager drew a very large set of keys but neither manager knew how to open the armory door or which key worked in the lock. After trying perhaps twenty keys unsuccessfully in the lock, one of the two managers was explaining to the

consultant that the armory key must be on some other ring, when one of the last keys unexpectedly worked. If an emergency were to occur at HoC on an evening or weekend, there is a reasonable probability that the manager or managers on duty would not be able to get into the armory for a long time, perhaps until help arrived.

12. The logbook in the armory that is supposed to record entry, exit and checkout of armory equipment, showed no entry in the last three months. There was no inventory in the armory and neither manager accompanying the consultant knew whether an inventory existed, where it would be kept if it did exist nor who is responsible for the armory.

13. The armory was dirty and badly disorganized. On top of one table or cabinet was an open carton containing hundreds of rounds of live ammunition. Old twelve-gage shotguns were stored in a locking rack. The key to that rack was not on the large key chain that contained the armory door key and neither manager knew where the shotgun rack key might be found. The twelve-gage shotguns looked as if they had not been cleaned in years.

14. The consultant was particularly concerned with the lack of intermediate force alternatives available to HoC staff. While there are individual aerosol chemical agents available (primarily OC) there is almost nothing between that and lethal force. In particular, the kinds of intermediate force options that might be useful if an inmate had a weapon, or if HoC were faced with a disturbance involving large numbers of inmates, were simply lacking. The armory contained a total of two or three gas throwing grenades but they were many years out of date (they were dated 1995) and would be unsafe or unreliable to use. There were no launched chemical agent projectiles, either for a 37 or 40 mm launcher or even for a twelve-gauge. There was no pepper ball system. There were no rubber bullets, beanbag rounds or multiple baton rounds. There is no stun shield. As the small group was preparing to leave the armory, the consultant opened a case that was on the floor, under a bench and under some other things. To everyone's surprise, the case contained a 37 mm launcher, which both managers had said that HoC did not possess. The drawers and cabinets in the armory were something of a treasure hunt. Some contained junk, parts of weapons or old documents. Others contained large quantities of new equipment, primarily equipment for a CERT team, but still in packing material and unopened although some of the items had been received years ago. There was a very substantial amount of money wasted on this new equipment that had never even been unpacked.

15. Looking beyond the distasteful state of the armory at HoC, there is a most serious problem that could have tragic and disastrous consequences. Even though HoC is a minimum and medium security facility that primarily houses short-term sentenced offenders, it also must be recognized that it is a 2,300 bed correctional institution. A hostage incident, a disturbed inmate with a weapon and a major disturbance are all well within the realm of possibility, as are other crises, disasters and large-scale emergency situations. HoC has

essentially no capacity to respond to one of these situations. That inability to respond appropriately is made more serious by HoC's location in a small suburb some twenty miles from the center of Milwaukee. If a major emergency erupted at HoC, both Milwaukee PD and the Sheriff's Office would send mutual aide but there would not be a large number of law enforcement units on site within 5 minutes as is true for many jails. HoC cannot substitute a belief that "It can't happen here" for a reasonable level of emergency planning and preparation and for a reasonable emergency response capacity.

Q. Use of Force

1. Arguably, the use of force policy is the most important single policy in a correctional agency. It is the policy that is likely to be at the heart of situations leading to major lawsuits, staff disciplinary proceedings and front page publicity. The use of force policy, along with use of force practices, also help establish the tone and climate of an institution and the nature of staff-inmate relationships, for better or for worse.

2. The HoC use of force policy is a three and one-half page document that was last revised thirteen years ago. It is poorly written, inconsistent and substantially incomplete. There are areas where use of force practice differs from the policy. Fortunately, where use of force practices diverge from the use of force policy, it is the practices that are more appropriate.

3. A complete analysis of the problems in the HoC use of force policy would be quite lengthy. Several examples should suffice. Policy authorizes use of force in only two situations and those do not include escape, enforcing legitimate institutional rules and regulations or protecting state property. The policy does authorize force to "subdue and restrain" an abusive person which is a serious policy error and legally impermissible. (For example, an inmate on A2 or B2 is verbally abusive toward staff. Using force to "subdue and restrain" the abusive individual would be unnecessary and an illegal use of force). Authority for the use of force rests with the security manager but there is no longer any such position at HoC. There are no limitations on what force may be authorized and the exception ("in an emergency…") would, for example, authorize a line level employee to use lethal force to attempt to resolve a hostage situation, even though that might be contrary to the efforts underway. The policy uses a "rigid" use of force continuum and requires staff to escalate one step at a time, which is sometimes impractical and/or dangerous. There is a section on handcuffs and a separate section on mechanical restraints. Handcuffs are required when transporting an inmate from a dormitory to segregation but if the inmate is escorted from segregation to medical, restraints are at the discretion of the shift supervisor in that situation, according to this policy. There is no requirement in policy that officers using instruments of force (e.g. baton) have successfully completed training with that instrument of force. There is no policy distinction between reactive uses of force and planned uses of force. The

policy is silent on corporal punishment, positional asphyxia and a number of other important topics.

4. Cell extractions are relatively common in many correctional facilities and frequent in some. At HoC, they are rare, which is as it should be in a minimum and medium security short-term sentenced facility (although that is not the case in some county sentenced institutions). At HoC, by far the most common use of force is breaking up fights among inmates. When inmates do not respond to staff orders to stop fighting, the officer on the dormitory will usually wait for staff backup before attempting to intervene. Even then, staff will typically use OC spray rather than physically separating inmates. That is an excellent practice as it is safer for staff. However, since correctional officers and sergeants do not carry OC spray, staff must wait for a lieutenant to arrive to use chemical agents. Even thought a lieutenant is usually on the scene quickly, the extra time waiting could lead to a serious inmate injury or even to a situation escalating from a small fight to larger disturbance. The use of force policy requires that a Correctional Manager rather than a lieutenant be present on the scene, assess it and then authorize the use of chemical agents. Fortunately, that policy requirement is ignored and the practice makes more sense.

5. Use of force reports are written as major incident reports on a Form 92. It is a better practice to use a separate form for use of force reports so that they can be easily analyzed, summarized or the like. The only way to get data on use of force incidents at HoC would be to manually review each individual "92" to determine which were use of force incidents. That would be an unwieldy task.

6. Use of force reports, as far as the consultant was able to determine, have not been reviewed regularly. That is a grievous mistake and everyone involved is fortunate that use of force practices have not gotten out of hand because of the lack of accountability. With the arrival of Assistant Superintendent McCarthy, there is a new but informal procedure in which use of force videotapes are reviewed by both Assistant Superintendents. However, that only applies to those situations that are videotaped; other uses of force receive no more scrutiny then any other form 92 incident report.

   There was in the past some controversy about the manner in which mentally ill inmates were restrained when they were wild and otherwise uncontrollable. HoC decided to use a restraint bed for this purpose and specified that the use of a restraint bed must be authorized by a physician or psychiatrist. During the consultant's second week at HoC, he and Assistant Superintendent McCarthy reviewed a use of force videotape showing staff repeatedly using OC spray on a seriously disturbed and noncompliant inmate. Once subdued, the inmate was put on the restraint bed. The incident happened in the evening or at night. No one called one of the psychiatrists or physicians for approval of the use of the restraint bed. It was not clear whether those involved in the situation ignored the requirement for authorization or

whether they were unaware of that requirement. The videotape had been reviewed by at least a few staff and they too ignored the question of authorization. This was a single situation but it is an exemplar of the lack of policy accountability that permeates HoC.

7. The department has a separate policy on "deadly use of weapons." This policy was most recently revised some seventeen years ago, not at the same time that the use of force policy was revised. Not surprisingly, the two polices do not compliment each other. In general, it is more useful if policy provisions on lethal force are part of an overall use of force policy. The "deadly use of weapons" policy is poorly thought out and poorly written. For example, the policy clearly prohibits the officer from using his or her firearm to stop a crime from being committed by anyone other than the prisoner being transported. Thus, if an officer were guarding a prisoner during transportation or at a hospital and if there was a planned and armed attempt to free the prisoner by family members or confederates, the officer is specifically prohibited from using the firearm to protect himself or herself, even if being fired upon. That flies in the face of common sense and any reasonable officer would use the departmentally issued firearm for self defense in that circumstance, but it is less than responsible to publish and then maintain policy that would prevent staff from defending themselves.

   The section of the policy on the use of lethal force to prevent escape uses a federal constitutional standard for police, which is much more restrictive than the standard used throughout the country by staff of secure correctional institutions. That is, the HoC policy requires that the officer "has reasonable cause to believe the inmate has committed or is attempting to commit a felony involving the use or threatened use of deadly force", or that there is substantial risk of death or great bodily harm if the inmate's apprehension were to be otherwise delayed, or that the inmate is an imminent danger to the community at large (which must be decided at the time of the escape). Following this policy, could an officer use lethal force to stop an inmate from escaping if the inmate were simply running away from the officer? The inmate is committing a felony but it is not a violent felony and the inmate does not have a weapon. Thus, the first of the three criteria does not apply. The other two criteria turn on the nature of the inmate's record or committing offense. Usually, the officer escorting the inmate will not know that. Is the prisoner pretrial or sentenced? Is he a misdemeanant or a felon? A strict reading of the policy would prohibit the officer from using a firearm to stop an escape unless the prisoner were effecting the escape with deadly force or a weapon. That, however, is not HoC's intent. Beyond placing officers in untenable positions, this kind of policy has the potential to create exposure to civil liability for the agency.

   The policy is silent on important, even crucial, issues such as a "clear shot" provision and a provision mandating administrative leave following an officer involved shooting. The policy is unfortunately not silent about personal firearms, permitting them as long as HoC is notified about make, model and

ID number. (The policy only permits .38 caliber or .357 caliber side arms, reflecting the date this policy was approved. Today, most police and correctional agencies choose to purchase semi-automatic handguns. It is generally a mistake for policy to specify brands or models of firearms or defensive equipment. If the policy instead references an approved list, then that list can be updated without rewriting and reissuing policy). Permitting the use of personal firearms is, for HoC, unnecessary and fraught with serious potential problems and liabilities.

R. Inmate Programs

1. There are far more strengths than weaknesses with the area of inmate programs at HoC. The area is under the direction of a civilian manager who works closely with a uniformed Lieutenant assigned full-time to inmate programs. Organizationally, that makes eminently good sense. The civilian manager is also responsible for inmate programs at CJF, which does not make good sense, but since the program activity at the downtown jail is minimal, the arrangement works to the detriment of CJF but is not a particular problem for HoC. (It is essentially the opposite of the arrangement with fiscal and with medical and mental health services).

2. In contrast to many areas at HoC, inmate programs are well thought out, closely monitored and actively managed. When the consultant inquired about specifics, facts and figures were readily available. When there was any uncertainty about a specific issue, an immediate phone call from the manager to one of the front line program people provided the answer. Responsibilities within the program area were clear and accountability seemed excellent. Morale and professionalism were substantially better for the program staff than is true for the uniformed staff. Some of that may be in the nature of the job. That is, if you are a teacher, you are probably teaching jail inmates because you want to rather than because you have to. Some of the HoC program staff are volunteers and most of the rest are working with offenders because they find it rewarding.

3. Relationships between program staff and security staff are generally positive. There are some of the typical problems with program staff arriving to teach a class or run a group finding that security takes so long to escort the inmates to the program location that program staff member must leave without actually working with the inmates. That problem has become more frequent with the acute staffing shortages. The program staff the consultant spoke with were complimentary about the uniformed staff and the kinds of suspicion and intentional interference with program activities that occurs in some jails did not seem to be a problem for HoC. Jan Brylow, the programs manager at HoC, emphasizes the importance of security issues to her staff members for their own sakes and also so that they will understand the needs and concerns of the security staff. Those efforts on her part appear successful.

4. The overarching concern within the programs at HoC is the relatively small capacity of the programs, individually and as a whole, relative to the size of the HoC population. This is closely related to Chief Judge Brennan's concern that for most inmates, HoC does not fulfill its statutory mission of "employ and reform." With most farm operations closed or closing and the fish hatchery quite small, HoC jobs are, with a small number of exceptions, limited to the usual correctional facility employment: kitchen workers, living unit orderlies ("swampers"), etc. If inmate programs represent the "reform" side of the agency's mission, then the large majority of inmates will be neither employed nor reformed.

5. The reasons for the sharp limitation on the overall size of the inmate programs are not subtle. First, as is the case with many local correctional facilities, the facility was built with almost no program space. A very unfortunate carryover from the early days of direct supervision philosophy and modular/podular jail design is the belief that dayroom space in a living unit equates with program space. That assumption had been disproven long before the mid '90's, when the HoC Annex and South building were constructed but to this day, many jails continue be to designed with almost no program space. One partial solution at HoC has been to run classes or groups in closed dormitories. That creates some problems for the program staff because the physical layout is not as good as a classroom, there may be too much staff and inmate traffic past the dormitory being used and everything needed to run the program must be carried in and out every session by the program staff member. That solution also creates extra management work because dormitories open and close as the overall HoC population waxes and wanes, for maintenance and rehabilitation or for other reasons. When a dormitory in use by programs is reopened for housing, for example, a new location must be found on short notice. During the consultant's visit, when every dormitory was populated for the first time in HoC's history, there were no new program locations available as existing program dormitories were given back to housing. Some programs had to be canceled simply because of the lack of space.

6. A second reason for the limited program opportunities at HoC is budget. Almost all inmate programs are paid for by grants, by other community agencies or from some other external source of funding. The HoC librarian is paid for from the HoC operating budget but she is part-time. There are approximately 250 volunteers involved in inmate programs and there could be more if there were space available. With that many volunteers, the volunteer coordinator at HoC is a key individual who keeps many disparate activities organized, but she herself is a volunteer rather than a full-time staff member. That is surprising. The consequence of this situation is that there is always uncertainty "hanging over the heads" of the program staff because they are responsible for writing grants, working with local agencies and otherwise figuring out how to maintain stable inmate programs without any central core of stable financial support. Thus, there is a tenuous nature to inmate programs at HoC that should not be lightly dismissed. With a few

personnel changes, HoC could find itself without anyone with the skills or the commitment needed to write successful grant proposals, convince other organizations to spend their operating budgets in part on HoC activities and recruit, retain and manage hundreds of volunteers.

7. The third obvious limitation on inmate programs has to do with the nature of HoC. As a county sentenced facility, inmates are typically serving a maximum sentence of one year but most inmates are serving much shorter sentences. The kinds of programs that are potentially successful in state prisons with long-term inmates, may not be relevant to a local facility with short-term offenders. Educational, vocational and treatment programs that require three to six months for completion are appropriate but have a limited audience within the HoC population. The challenge is to maintain more programs that can make a realistic difference for an offender but which can be completed in thirty to ninety days. While the program area is one of the obvious strengths at HoC, it is also a serious challenge.

8. The two largest HoC inmate programs, by far, are work release and ES. Work release has a capacity over 400 individuals and the program has been that large at times. At the time of the consultant's visits, ES was managing just over 250 offenders but that program also has been as large as 450 people on a number of occasions. Thus, work release and ES together have the capacity to involve about one-quarter of all HoC supervised or incarcerated offenders.

9. The current plans to close CCC include a somewhat facile and unexamined assumption that the inmates currently on work release will transition to the new GPS supervision system and become part of the revamped ES program. That is, the plan now being discussed involves changing the current voice monitoring system to a GPS based ES system. Then the inmates who have been maintained at CCC on work release would be put on GPS monitoring and maintained and supervised at home, much as the ES inmates have been supervised. This move would allow the closing of CCC and the elimination of some staff positions. The primary motivation for making this change was not that the work release program was ineffective, but rather to save money. A secondary impetus for the decision was the aging condition of the CCC building itself. Another factor in this equation has to do with the land that CCC occupies. If CCC could be closed, the county could realize a great deal of money from the sale or lease of that land, although those moneys would flow into the county general fund and would not help the HoC budget. It is likely that the very recent high profile drug-related murder allegedly committed by a CCC work release inmate will only add to the pressure to close CCC.

10. Closing CCC will not be as simple as it may appear. First, HoC has done no planning for this change. There is something of a disconnect here because the closing of CCC and the elimination of the majority of the staff positions allotted to CCC, was part of the tentative budget proposal submitted to the

County Executive's Office by HoC in the June/July, 2007 timeframe. It was not until the beginning of November, 2007, when the County Executive's recommended budget was transmitted to the Board of Supervisors that the HoC management began to react to the proposed CCC closing and plan to put ES inmates on GPS rather than voice recognition. No contact had been made with GPS venders and HoC had no information on whether it might be more effective to combine the existing voice recognition system with additional GPS capacity, whether the GPS system would require a very large capital outlay to accommodate the number of offenders planned for that system, how staff would be used and how many staff would be needed to operate an effective GPS monitoring system, etc. On the work release side, there is a similar lack of information and planning. The Board of Supervisors resolutions specifying which categories of inmates are eligible for the two programs, work release and ES, are not identical. No one has discussed that and there is no data on the percentage of inmates that have been eligible for work release but would not be eligible for ES. Quite apart from the criteria established by Board of Supervisors, there are practical considerations. There are inmates who can get a job or who can return to a previously held job, but may have a much harder time finding a place to live. The charge at CCC for room and board is substantially less than an individual will have to pay for a cheap apartment or a cheap hotel room, plus food. The offender will also be paying for ES. ES requires advance payment for a few weeks of ES charges and almost all hotels and apartments want payment in advance. This may work for the offender who has family and a home in the community but it presents serious barriers for the inmate who does not have family and an already existing place to live.

11. The decisions about staff cuts in the new budget, based on closing CCC, were arrived at without programmatic discussion with the CCC staff. The ES program is far more than simply checking the computer to see which offenders have been in wrong locations at wrong times. That is true whether the monitoring system is based on random phone calls to the offenders home and the use of voice recognition technology or whether it is based on the newer GPS technology. In either case, the bulk of the staff time must be devoted to intake and processing of new cases (which is somewhat more time intensive with GPS than with voice recognition), and with regularly scheduled meetings between staff and offenders who are on ES. These meetings are essential if program failure rates are to be kept low. The GPS equipment, services, software and the rest of the system have not yet been chosen for HoC and the consultant is not a specialist in ES methodology but at first blush it would appear that the staff cuts in the new HoC proposed budget are unrealistic for the size of the ES program contemplated.

12. The current ES voice recognition system at CCC receives inmates who are court ordered for ES and also receives inmates from the Franklin facility who are not court ordered but who are approved for ES by the Correctional Manager in charge of CCC. Most inmates are scheduled for a meeting with a staff member once a week for the duration of their time on ES. Problem

inmates may be scheduled two or three times per week for such meetings. Typically 35 to 50 inmates come in for meetings during the day shift and perhaps another 25 inmates will be scheduled for second shift meetings. When the inmate arrives, the inmate and the staff member together review the printout from the computerized voice recognition system, which will document any occasions on which a computer generated call was made to the inmate's residence during hours that the offender was required to be at his residence, and where the phone went unanswered or a voice match was not made. (Prior to the meeting, staff will have used the computer software to play back the recordings of each occasion when the phone was answered but a voice match was not produced. Often, staff can tell that the voice does belong to the offender in question but that the offender was half asleep or there was background noise or there was some other identifiable reason that the voice recognition was not successful. Typically, staff will not take a case back to the judge until there are several violations. The judge may then continue the case on ES or may cancel ES and the individual will either go back to HoC or move into CCC as a residential work release inmate. That reflects an additional problem with the plan to close CCC and put all of the work release inmates on ES. A significant number of the work release inmates at CCC have had ES specifically canceled by one of the judges for a prior ES series of violations. Also, population pressure at HoC has resulted in pressure to find HoC inmates who could be put on ES. The reality is that CCC has not always been able to find enough inmates who meet the criteria specified by the Board of Supervisors and has frequently taken inmates who violate those criteria.

13. Increasingly, inmates have been approved for ES based on childcare or elder care rather than a regular job in the community. The CCC staff still must verify that there are children or an elder adult needing care, and where they live, just as staff would verify a job in the community. However, those offenders who are in the community on childcare or on elder care do not pay for their ES services. The rest of the ES population pays $139 per week for their electronic monitoring equipment and services, with three week's charges payable in advance as a condition of starting the program.

14. One of the issues that cuts across many of the inmate programs at HoC is scheduling. The inmates in an anger management class or substance abuse class may come from eight or ten different dormitories. Inmates eat by dormitory and with relatively small dinning halls, the time from the beginning of a meal to the end of a meal is considerable. For many programs, it is not practical to schedule at a time that overlaps with any of the feeding but if the noon meal, for example, lasts more than two hours then there may not be a great deal of time between the end of the noon meal and the beginning of the evening meal. That tends to compress the program schedule which in turn places a higher priority on available space. This problem could be partially alleviated by designating program dormitories and trying to move inmates so that those participating in the same programs were housed, to the extent practical, in the same dormitories. That has not been explored at HoC.

15. Programs are the one area where activities are run coeducationally. However, male inmates can be sent unescorted from their dorms to a program area while female inmates must be escorted at all times while in transit. For that reason, it is easiest to use one of the dorms that is not in operation as program space, particularly for those programs involving female inmates and particularly if the closed dorm is close to the female dorms. Even with male inmates, attendance and punctuality are serious challenges for the program staff. A list is generated each day showing which inmates on each dorm are to be released at what time and to which program activities. Some dorm staff are very good about that but other dorm staff must be called and specifically asked to send one or more inmates to a particular program. In addition to these issues with inmate attendance, some of the volunteer staff may have to wait up to thirty minutes in the lobby of HoC while waiting for clearance to enter the facility.

16. Education for inmates 17 and under is handled by the local Franklin schools and they are paid by the State Department of Public Instruction. There are two teachers and four aides at HoC under the auspices of the Franklin School District and all six individuals have Special Education credentials. The instruction is highly individualized and most of it is basic literacy. Classes are two to three hours a day with four separate classes (one morning, two in the afternoon and one in the evening). In 2006, Franklin High School enrolled 368 students at HoC. The average enrollment was thirty days per student. In terms of outcomes, the Franklin school program resulted in 40 GED's and 15 high school graduates. Additionally, 2,600 inmates were assessed for educational and vocational needs and 273 inmates completed a 3-week job seeking skills program. These are most impressive figures. Fifteen percent of the students enrolled in educational programs received a high school degree or a GED and that is a high percentage for a jail population.

17. The Milwaukee Area Technical College (MATC) handles adult education, which is a combination of literacy classes and GED classes. HoC has secured an Adult Education and Family Literacy grant for most of the costs and MATC pays the remainder of those costs. There are seven part-time instructors through MATC and there is some ESL work as well as the primary areas of GED and literacy. MATC uses two classrooms at HoC Monday through Saturday.

    The MATC learning center enrolled 244 students in 2006 and 70 of those earned GED's. While these students were likely at a somewhat higher beginning educational level then the students served by the Franklin School District, the 30% GED graduation rate is also extraordinarily positive for a jail population.

    The Chair of the education department at MATC and the Dean over these areas, have both been extremely supportive of the work at HoC.

18. There are a number of other programs at HoC. Parenting classes started in September separately for male and female inmates. There are anger management and substance abuse classes as well.

19. The Chaplain at HoC is full time and is paid for by a Lutheran church group. The Chaplain also works with religious volunteers and there are a variety of small programs offered in the chapel. The chapel is quite large and very well maintained and represents the most attractive program space at HoC.

20. HoC has two noteworthy vocational training programs. For men, there is a welding program with a full time instructor. That program is six months duration and is limited to typically eight or nine students. Program completion takes several months. The welding program is an exception to a problem discussed earlier, as all of the inmates accepted into that program are housed at the same dormitory so that their schedules will coincide. The welding program has had a very high graduation rate and, more importantly, a very high rate at which the graduates find welding jobs in the community upon release from HoC. In fact, data from 2005 indicates that thirty students enrolled in the welding program and twenty-nine students successfully completed.

    The comparable female vocational training program is a print shop. A few more women work in the print shop then in welding but because of the relatively small number of women at HoC, it is difficult to find enough women who will be incarcerated there long enough to complete the print shop training and who are interested in a serious job. Thus, some of the women in the print shop are there for several months and taking part in a training program while another small group of women work there more as semi-skilled or unskilled labor and will not be at HoC long enough to complete formal training. Also, the market for print shop employees is not as competitive as the market for trained welders, and the print shop has not had the kind of successful community job placement rate that the welding program has had.

21. Another major program at HoC focuses on offenders with mental health and substance abuse problems. That program involves both assessment and treatment. In 2006, data from January through June suggest that 1,100 offenders were identified in need of release planning and approximately half of those did have plans developed and presented to a Judge. That resulted in 173 offenders released with a plan and savings of 4,500 inmate bed days. The treatment side of AODA provides cognitive behavioral treatment to mental health inmates incarcerated for four months or more at HoC, with the program designed around substance abuse issues as well as mental health issues. In 2006, that program was working with somewhat more than 100 inmates per year and was restricted to male inmates. In 2007, a similar program was developed for female offenders at HoC. That program accommodates 12 to 15 women at one time and is a thirteen week long program.

22. With the considerable variety of program opportunities at HoC, it is apparent that most of the programs are serious enterprises and some, like the GED program and the welding program in particular, have most impressive success rates. At the same time, the support for these programs has been something of a patchwork quilt of other public agency help, grant funding, State and Federal funding of mandated activities and volunteer efforts. There has been no real attempt to "scale up" even the most obviously successful programs either because of lack of financial support for expansion or because only a small proportion of the HoC population would be eligible for that program. In spite of the success of the program area overall, and the clear strong support for inmate programs demonstrated by the top three administrators at HoC, these efforts still reach only a small number of the inmates at HoC. (It was not clear to the consultant that most inmates have an opportunity to see or hear about the HoC programs that they might apply for, but most of the programs have lengthy waiting lists, rendering that question irrelevant).

S. Inmate Grievance System

1. An inmate grievance system is an important correctional management tool for a few reasons. First, it provided inmates with an approved process for addressing and potentially correcting individual problems. Second, it serves as a safety valve so that inmates do not engage in self-help remedies or allow a perceived problem to persist until the inmate may become violent or take some other dangerous action. Least well recognized is that an effective grievance system can constitute an early warning system for management, if management chooses to make use of grievance data in that way. That is, a monthly summary of inmate grievances by subject matter, by area of the jail and by shift can highlight for management an area, a service or even a group of staff perceived by inmates to constitute a serious problem. It is far better to notice that there is a sharp increase in inmate complaints about food quality and portions and to deal with that situation, than to receive initial notice of inmate dissatisfaction by way of a serious disturbance.

2. At HoC, the grievance system is broken. It is not a system and it does not work. It might be that HoC would be better off with no grievance system whatsoever than what is currently in place because the current situation is more effective at creating cynicism and bitterness than at redressing wrongs.

3. Currently, if an inmate submits a grievance form, it is sent to the staff member who is complained about in the grievance or to the person in charge of the service or area that the grievance was about. When and if that person answers, the answer is sent back to the inmate. If the person to whom the grievance was sent does not answer, there is no follow up and the inmate will not receive an answer. If the answer from the person complained about does not make sense or is inconsistent with other facts in the situation, it does not matter because the answer is not reviewed for validity before it is sent on to the inmate originating the grievance. Thus, the vast majority of grievances are either denied or go unanswered.

4. The consultant reviewed a large number of grievances and found that from twenty-five to fifty percent went unanswered. In some other cases, staff responses were sent back to inmates although the responses made little sense or failed to address the question that the inmate had raised.

5. As with many areas of HoC, the real question is "Why has this been allowed to continue?" Does no manager ever review the grievances to determine what percentages are answered within acceptable timelines, whether a reasonable number of grievances are sustained and whether the process has integrity? Does no supervisor ever talk to an inmate who is angry about something and has submitted one or more unanswered grievances, and then call to see what has become of those grievances?

6. There is no summary of grievance information prepared for management review, even at the level of total number of grievances filed per month.

7. There is a Correctional Manager nominally in charge of the inmate grievance system, and that is one or two ranks higher than would seem to be appropriate.

T. Inmate Discipline

1. The inmate discipline system needs a comprehensive review and substantial revision.

2. Inmates who receive disciplinary infractions ("write-ups") are locked up in one of the three segregation cellblocks in the North building of HoC. All three areas are single-celled. "A2" and "B2" are similarly constructed linear cellblocks, each with twenty-nine single cells. Staffing for each of the cellblocks is one officer on all three shifts. The two officers assigned to A2 and B2 are in a good position to help each other in an emergency because one cellblock is directly above the other and they are connected by an open stairwell. The third segregation area is "O2" which has a capacity of twenty-four. However, O2 is not a traditional linear cell design. Rather it is two contiguous areas on either side of a small corridor. Each area has antechambers directly off the corridor and then several cells within those antechambers.

   The O2 segregation area is used for suicide watch, for female and juvenile segregation and for overflow adult male segregation from A2 and B2. In addition, O2 may also be used for inmates who are acutely psychiatrically disturbed but have not yet been sent to CJF and for inmates who were very difficult to manage on A2 or B2. O2 is in the basement of the North building, across from the maintenance area and relatively isolated from most of the other housing areas. As such, in the event of an incident, assistance is not as readily available as in most other areas.

3. The O2 position, as it is currently constituted, represents a serious safety danger to staff. When the officer working O2 needs to let an inmate out of his cell for a shower or an hour of daily exercise, there is no way to accomplish that except to go into the antechamber, lock that door (locking the staff member into the antechamber), unlock the cell door and let the inmate out into the antechamber with the staff member. If the inmate then attacks the staff member, it is entirely possible that the officer would not have an opportunity to key his or her radio and there is an also an excellent chance that other staff would not hear the incident. If the officer were overpowered, HoC would have an injured officer with no one aware there was a problem, as well as an inmate who now has keys that give the inmate access to the basement corridor that is often empty and the ability to unlock other inmates on O2.

   Changing O2 into a two-officer assignment would be expensive (requiring six additional correctional officer positions) and inefficient since O2 has the capacity of twenty-five and is often well below that. On the other hand, requiring that the officer working O2 have a second officer present before opening any cell door would also require modifications of staffing, at least of first and second shift, because the cell doors are opened not only for exercise and shower, but also to give the inmate his or her food tray, and then later to retrieve it. The result is that cell doors are opened frequently on O2 during first and second shift.

4. The cells on O2 are particularly poorly designed for the housing unit's current purposes. There is some logic to moving an inmate from A2 or B2 down to O2 if the inmate is acting out frequently and particularly troublesome. The traditional linear open cell front construction on A2 and B2 offers that difficult inmate the opportunity to talk easily with the inmates in adjoining cells and to keep the entire cellblock in something of an uproar by yelling, threatening, etc. The quite isolated, closed front cells on O2 prevent much of that behavior. However, that advantage is outweighed by placing the most volatile, and presumably the most dangerous inmates, into an area where a single staff member is isolated and is forced to work with the inmate one-on-one, without restraints on the inmate.

   The cells in O2 are not satisfactory for suicide watch. The closed cell fronts have a very small window in the door and visual access to the cells is sharply limited. On one of the consultant's visits to O2, a psychologically disturbed inmate was sleeping against the bottom of the door inside his cell. The inmate could not be seen from outside the cell, through the small window. The staff member correctly woke the inmate to get a verbal assurance the inmate was not in distress. However, the inmate could have been in the midst of fashioning a noose from clothing or bedding and the officer could not have seen that. There was no good way for that officer to manage the inmate safely without requiring the inmate to move away from the cell door and sleep on the bunk or next to it. The officer could not enforce that direction without waking the inmate every fifteen or thirty minutes, and sleep

deprivation is not the treatment of choice for most seriously disturbed individuals. Some of the suicide risks in this situation would be mitigated if there were camera coverage in a group of the O2 cells, but that is not the case.

5. In theory, an inmate is taken to one of the segregation units because of a disciplinary infraction, is locked up, and the disciplinary hearing on that infraction occurs no sooner than within twenty-four hours but no later than seventy-two hours. The "no sooner than twenty-four hours" is so that the inmate can prepare a defense for the disciplinary hearing if he or she chooses. In reality, it is not unusual for the disciplinary hearings to be delayed beyond three days. During the consultant's first week at HoC, both A2 and B2 were filled to capacity and a review of the inmate disciplinary situations on one of those units showed that more than half the inmates had been on the unit over seventy-two hours but had had no hearings. That is one of the reasons the segregation units are frequently at capacity, with nowhere to lock up additional inmates who receive infractions. Also, a high percentage of the inmates in disciplinary segregation are there for verbal disrespect of staff or failure to follow a staff order. In many cases, the sanction imposed for verbal disrespect or failure to follow a direct order is three days in segregation. It does not make good sense to lock up an inmate longer pending investigation than the sentence the inmate would receive if found guilty.

6. At the time of the consultant's visit, HoC was planning an experiment with a citation program for low-level disciplinary offenses. HoC had recognized the problem with inadequate capacity on the disciplinary units and that a large proportion of the disciplinary situations were quite minor, but still taking up segregation bed space. Evidently, there was a time in the past when HoC had used written citations for minor offenses as a standard procedure and no one was sure exactly why that had been abandoned. Since it was still permissible by policy, HoC is planning to reinstitute that practice. While the consultant did not review inmate disciplinary data thoroughly, the proposed change appeared to make excellent sense.

7. A small number of segregation inmates are classified as "keep-ins." An inmate may be given the label of "keep-in" for a variety of reasons, but the most common is that the inmate is a problem when he is released from the cell. While the rest of the segregation inmates are locked up 23-7 (that is, they are out of their cells one hour a day for some combination of showering and exercise), keep-ins are only released from their cells for an hour, twice a week. The norm for jails and prisons around the country is to provide one hour of out-of-cell time for segregation inmates seven days per week. A minority of institutions only provide one hour for five days a week, as is done at HoC for most of the segregation inmates. Less than five days a week is unacceptable and, if challenged in court, is unlikely to pass constitutional muster in the opinion of the consultant.

8. Inmates on the three segregation units are tracked primarily through a card system with one card per inmate and each card in the slot of a visible metal wall-hung rack at the desk of each segregation unit. Each rack has one slot for a card for each cell on the unit. Each card lists the inmate's name and number and has a hand written notation indicating the date the inmate was first put on segregation and another notation of the results of the disciplinary hearing and the day on which the inmate is to be released from segregation back into general population. On both occasions the consultant visited A2 and B2, there were some cards that provided no indication of when that inmate had first been placed in segregation. Usually, the officer assigned to the unit could find that information from checking a notebook containing each inmate's actual disciplinary charges. On one occasion, even that information was missing and it required searching backwards in the unit log to find an entry with the inmate's name in order to find the documentation about inmate's offense. It was clear that the officers assigned to the segregation units do not regard it as part of their responsibility to make sure the paperwork on individual inmates is in order or that they know which inmates are awaiting disciplinary hearings and how long they have been waiting. It was also clear that supervisors and managers do not check this kind of information on their rounds.

9. While the consultant did not observe disciplinary hearings, the practice appears to be seriously flawed. Hearings are almost always held by a Lieutenant and they are typically held in the desk area of the disciplinary unit or at the cell front of the inmate's segregation cell. That, in itself, is unreasonable. A disciplinary hearing should be held in an office or small conference room, with a reasonable expectation of privacy. It is possible that some of the information discussed in a disciplinary hearing may put a particular inmate in danger with one or more other inmates.

10. Another disturbing aspect of this situation is the nature of the disciplinary hearings themselves. If the inmate does not contest the charges, the procedure is pro forma and some number of days in lock up are assigned as the sanction. Hearings are not scheduled in advance and there did not appear to be a procedure by which an inmate would notify anyone that he or she wished to contest the charges. When a Lieutenant arrives at one of the segregation units to conduct hearings, and an inmate indicates he or she is going to contest the charge, and/or wants witnesses or a representative, the Lieutenant typically then wants the officer present who filed the charges. If that officer is on another shift or is on one or more days off, or even on annual leave, the officer will not be brought in on overtime. Instead, the inmate is informed that he or she will need to stay in segregation for one to several days until the officer is back on duty. Of course, the inmate then capitulates and pleads guilty. Why would an inmate remain in segregation for five to seven days in order to contest a finding that might result in a punishment of three to five days? This procedure would appear to be coercive with regard to convincing inmates not to exercise their rights to a disciplinary hearing.

11. There is no summary data maintained about disciplinary infractions. There is no monthly summary which would inform management that disciplinaries are generally on the upswing, that they are disproportionately coming from one area of HoC, from one shift, etc. There is no data on the percentage of hearings that are contested or the percentage of contested hearings in which inmates are found not guilty. Managers also do not perform even the kind of cursory review of the disciplinary process conducted by the consultant. The practice of holding disciplinary hearings at cell fronts combined with the chilling effect of delaying hearings that the inmate wishes to contest, call into question the integrity of the inmate disciplinary system. Like the inmate grievance system, the inmate disciplinary system does not appear to be a real system at all. Data does not exist that would allow reasonable review or oversight and there appears to be little if any ongoing management awareness of the disciplinary process. While Lieutenants are assigned to conduct hearings, there was no indication any manager was in charge of the disciplinary process.

U. Medical Services

1. The consultant does not have medical expertise and cannot evaluate treatment plans, the accuracy of diagnosis, etc. The consultant is familiar with issues related to access to treatment, medical screening, staffing and medical costs. Medical services was one of the areas that the consultant did not review as thoroughly as he would have liked, partly do to time constraints and partly because medical services are managed by CJF, downtown. Thus, the observations below should not be regarded as comprehensive on the subjects discussed.

2. The jail system does not have a Medical Administrator. Instead there is a Medical Director and a Director of Nursing. They are both housed at CJF. Mental Health Services falls under Medical Services and the entire operation is county rather than contract.

3. There is twenty-four hour nursing coverage at HoC. There are eight or nine nurses on first shift, seven or eight on second shift and two on third shift. These numbers represent a combination of LPNs and RNs. A psychiatric nurse works evenings, until 10:00 PM, extending the hours that some psychological services are available since the PSWs are off duty at 5:00 PM. At the time of the consultant's visit, HoC had two vacant nursing positions and two more were anticipated. Hiring nurses to work in correctional facilities is often difficult and a national nursing shortage has made the problem more acute. Milwaukee is not different and HoC has been struggling for some time to keep their nursing positions filled.

4. There is an eight-bed infirmary at HoC. At CCC, no medical services are provided and residents are responsible to arrange and pay for their own medical services in the community. While that arrangement at CCC works well for the county financially, it also raises serious questions about the

county's responsibility. The majority of CCC work release inmates were incarcerated before the work release program and do not have financial reserves. Most do not make much money and they are paying for work release out of their often minimum wage salaries. As a result, many work release inmates will not seek medical treatment in the community because they cannot pay for it. Others will not seek medical treatment because it may be difficult to arrange and the individual must justify time in the community that is not spent at work. If a resident were to die at CCC or while on work release because of an obvious medical condition that was not being treated, the county would be in a difficult position in a number of regards.

5. Inmates are not allowed to maintain their own prescription medications inside CCC. Instead, prescription medications are kept for the inmates by the correctional staff. Correctional officers on each floor distribute prescription medications twice a day. There is no protocol and different staff members have different procedures. The best method the consultant observed was a sign up system. Any inmate on that particular floor who was to receive medications, signed his name to a sheet on the desk. The correctional officer then called inmates by name to come up and receive their medication. That system prevented the whole group of inmates receiving medication coming up to the desk at one time, making it more difficult for the officer to carefully supervise the distribution of the medications. Each floor has a separate medications logbook and the officer records how many pills of what kind were distributed to each inmate, by date and time. As a safeguard, some officers make a duplicate entry into the floor log itself. The officer is also responsible for checking the inventory of each type of pill so that after John Doe receives, for example, a 5 mg. tablet of medication X, the officer then dumps out the remainder of the bottle of medication X and notes that there are 17 tablets left and checks that against the running inventory in the log. Since a resident may be taking 4 or 5 different types of medication, the entire process is lengthy and painstaking. The correctional officers the consultant spoke with do not like distributing medications, and with good reason. It is an accident waiting to happen. The officers have no training to know what various types of pills look like or what are appropriate dosages. If an officer inadvertently distributed the wrong medication to the wrong inmate, it could produce an immediate medical crisis or even death. The system also can be manipulated by inmates rather easily for the distribution of illicit drugs or even for a suicide attempt.

6. At HoC, medication pass is done on the floors by LPNs. The medication cart is kept in the corridor and the inmates come to the dormitory door individually. The administration of the medications is supervised jointly by the nurse and the correctional officer on that dormitory. When an inmate comes to HoC from CJF, the inmate typically has medications with him that have been prescribed by the CJF medical staff. For the smaller number of inmates who come to HoC directly from the street, prescription medicine is taken from the inmate at intake but that medicine is then administered as prescribed until a staff physician can see the inmate and write a new

prescription. On release from HoC, an individual will be given his own medications back or, if he or she has been on HoC medications, then a three-day supply will be given to the individual as a bridge until arrangements can be made with a community health provider.

7. At the Franklin facility, medical services are provided either on an emergency basis or through a medical request form filled out by the inmate. For emergency situations, inmates are brought to medical when possible but when the inmate is not ambulatory because of the medical emergency, the nurses will grab "crash bags" and go to the dormitory or other location necessary. Emergency calls typically come from correctional officers on the scene of the problem and nurses said that occasionally a correctional officer will call an emergency when the initial non-emergency reaction to an officer's medical request was not what the officer wanted. This kind of situation did not sound frequent and the consultant's general impression, from both correctional staff and from nursing staff, was one of good cooperation and positive relationships between the uniformed staff and the medical staff. That is no small accomplishment as a number of jails and prisons have substantial conflict between those two groups and it inevitably affects the provision of medical services and creates morale issues. On another positive note, HoC security staff do not serve as gatekeepers of medical services, as is still the case in some correctional institutions.

8. Medical request slips are collected twice a day by the LPNs as they distribute medications to the dormitories and cellblocks. Then the request slips go to medical records, a contract function at HoC, and the medical records staff pull the chart for the inmate requesting medical services and the requests slip and chart is forwarded to the triage nurse. The requests slips are then triaged and inmates are scheduled for sick call at the clinic on a priority basis. The clinic sick call is staffed by RNs.

   Two nurses interviewed were not sure but thought that the time standard for seeing an inmate was three days from the time a request slip was submitted. That sounds quite restrictive and it may be that the time standard is actually three days from the time of submitting a request slip to the time it is triaged. In either case, there is an apparent timeliness problem. The consultant took the tray of request slips, with charts, that were waiting to be triaged and found that a number of them were 4 and 5 days old (that is, requests slips that were submitted on September 22 and September 23 had not yet been triaged on September 27). A related problem was that inmates still waiting to be seen as of September 27 had in some cases submitted requests slips more than 20 days earlier (September 7). In that length of time, some ailments will have cured themselves and others will have gotten substantially worse. A three-week wait to see an inmate in response to a request for medical services is unreasonable.

9. When medical requests slips are triaged, no information is sent to the inmate that submitted the request. That is a problem in two ways. When the inmate

hears nothing for a few days, the inmate will frequently submit another request for the same problem. It is not unusual to see several requests over the period of a week even though the first request was triaged promptly and the inmate was scheduled for sick call. The repetitive and unnecessary requests add volume to an already overtaxed system and the medical records staff and the triage nurse must spend time deciding which requests are duplicates and which are different complaints from the same inmate.

The second problem is that the lack of feedback convinces inmates that their requests have been ignored, and that contributes to a sense of cynicism and negativity about medical services among the inmate population.

10. The nursing staff interviewed were uninvolved with or unclear about information that should have been central to quality assurance standards. For example, the consultant asked an RN and two different supervising nurses what percentage of the population at HoC was taking psychotropic medications. One nurse did not know and two others estimated 90% of the population (a later inquiry by the consultant established that the correct figures are 17% for the male population and 40% for the female inmates). The nurses were unclear about time standards for triaging medical request slips and did not know whether the fourteen day standard for medical exams was met at HoC or not.

11. The consultant did not have time to review data on full medical exams nor to personally review the medical screening at intake. According to some nursing staff, that medical screening at intake is quick and involves a paper review of the inmate's chart but no interview and no physical check, even of vital signs. If that information is accurate, it would be a particular problem for those inmates coming to HoC from the street rather than from CJF or from state facilities. An inmate from the street, although reporting voluntarily, could be seriously ill, seriously injured, in the early stages of withdrawal or could otherwise be in a condition in which admission should be denied (and in most cases, the inmate sent to or referred to a hospital). Without some form of rudimentary medical screening in place, HoC could have an in-custody death and find that the individual should not have been admitted to HoC and, worse, that the death was preventable.

12. The consultant did a brief spot-check of the inventory and checkout system for syringes and sharps and for controlled medications. In both cases the procedures and systems were well designed and the spot-checks of both perpetual inventories and checkout and use logs were precisely accurate. That is an excellent state of affairs and is often not the case at institutions that the consultant reviews.

V. Mental Health

1. Mental health services at HoC are budgeted and managed from CJF, as part of medical services.

2. There are three full-time Psychiatric Social Workers (PSW) positions currently working. There are five positions authorized but at the time of the consultants visit one person was off on extended sick leave and another was off on family medical leave. Two of the three PSW's working had just been hired and the other had about two years experience. HoC also has one Case Manager who assigns requests for service among the available PSW's. The PSW's and Case Manager report to the nursing supervisor, located at CJF, and they do not regularly meet with managers or administrators at HoC.

3. Every inmate is supposed to have a mental health screening and assessment within the first fourteen days of incarceration. That includes mental health history, suicide history, medications, hospitalization, school and family history, substance abuse, homelessness and the like. Data was not available at HoC but staff believe that in most cases the fourteen day requirement is met. Staff do encounter cases occasionally where CJF has not met that deadline and inmates are transferred to HoC without a mental health assessment even though they have been at CJF more than fourteen days.

4. HoC has two psychiatrists on a part-time basis. Both psychiatrists are relatively new at HoC and both are seen as excellent by the other mental health staff. Both psychiatrists will see an inmate immediately for an urgent evaluation, based simply upon a phone referral from one of the PSW's. Both psychiatrists are interested in following serious and chronic cases, although there is no system in place at HoC to do that.

5. Relationships between mental health staff and nurses and other medical staff appear to be informal and very positive. The nursing staff at HoC have generally been excellent about referring to a PSW when they encounter an inmate who may be suicidal or who is actively psychotic. The PSW's also work closely with uniformed staff and if a correctional officer working a dormitory refers an inmate from that dorm, the PSW will typically see that inmate quickly. (However, there is no manual or protocol for requests for mental health services from line staff or supervisors, and there is a clear need to specify a procedure and include documentation). The PSW's set priorities for referrals and will give first priority to inmates who may be suicidal or inmates who may be floridly psychotic.

6. While staff relationships and communication within mental health seem good, the most serious issues have to do with available services. Neither medical staff nor mental health staff nor administrators at HoC were familiar with data on the percentage on the HoC population that is on psychoactive medications. However, everyone asked indicated (incorrectly, it turns out) that it was a very high percentage. That is an important figure and one that management should track. In some correctional facilities, psychoactive medications are dramatically over-prescribed; they should never be used primarily for security purposes.

The three Psychiatric Social Workers are busy with evaluations in response to referrals and follow up with inmates who have been evaluated. They do not attempt to work in or cover the dormitories. Since there are no counselors, there is no mental health coverage on the floors and the identification of inmates who may be decompensating or becoming suicidal is then left to the correctional officers working the dormitories. Staff training has not placed a heavy emphasis on these issues in in-service training so the question of whether or not a correctional officer will try to identify inmates that should be referred to the PSW will often turn on that officer's background, skills and level of involvement with the job. It would be preferable if there was some regular if intermittent mental health presence on the floors, at least checking with correctional officers to identify inmates who might be in need.

7. There are no treatment programs run by any of the mental health staff at HoC. Until recently, there was a dormitory dedicated to special needs inmates that was recently closed. The closure was controversial. A special needs program had been started on the S6 ("Sam 6") dorm. (As is often the case, at HoC "special needs inmates" is a euphemism for mental health inmates. The "special needs" term more properly refers to a broad range of inmates including those who may be physically handicapped, developmentally disabled, mentally ill, geriatric and more). The special needs unit accommodated less than forty inmates and had four correctional officers assigned. It appeared to some managers that the staffing pattern was unrealistically heavy and they became frustrated with the lack of a defined program and the appearance that a group of staff had found a soft "niche." The program was discontinued with the thought that it would be redesigned and restarted. Unfortunately, once the program was discontinued, no one took responsibility to redesign or restart anything. The program was not in operation while the consultant was visiting and he has no basis for assessing the efficiency or effectiveness of that program. However, it was a place that mental health inmates could be housed with knowledge that they would be closely observed. In a large jail system with no other mental health programs to speak of, that by itself was extremely important. Now there is nothing. Mental health inmates may be sent to the psychiatrist for medication or may be sent short term to one of the crisis cells in O2, or they may be transferred back to CJF. However, CJF has but one special needs unit itself and that unit is always full. As a result, CJF is constantly identifying the least serious mental health inmates on that unit and putting them into general population so that more seriously disturbed inmates can be admitted to the unit. At HoC and at CJF the result is that inmates who should be in a mental health unit (whatever it is called) or a transitional ("intermediate care") unit are instead in general population where they are often vulnerable and victimized and where there is an excellent chance that they may go unnoticed if their condition deteriorates.

W. K-9 Unit

1. HoC has had a well established K-9 Unit for some twenty years or more. The K-9 Unit is very large, with fourteen handlers with dogs and a Sergeant. (The canine Sergeant is also the department's training officer).

2. In general, there are two canines on duty on a 24/7 basis. One canine post is at the vehicle sallyport and the other canine has a post on the west side of the compound, outside the main buildings and in a position to help supervise inmate foot traffic between the Annex and the South building.

3. About half of the dogs are trained for drug interdiction but all of the dogs are trained for a broad range of patrol functions including crowd control, tracking, handler protection and building and area searches. In the event of a fight that is not over immediately or a small disturbance, the dogs will be taken into the buildings and to the dormitory or other site where the alarm was sounded. During day shift and the first part of the second shift, the dog at the vehicle sallyport or that dog's handler may be occupied with vehicle traffic and unable to respond immediately, so it is typically the dog and handler on the west side of the compound that respond to major fights or disturbances. When the dog arrives, if the inmates have not gotten back on their bunks or there are inmates who are refusing to follow orders, the dog will be brought up barking and used as a show of force. On second and third shift, the dogs may also be used for outside perimeter checks and for security checks across the road at the farm. The canines that have been trained to locate contraband drugs can be brought into the facility and used for dormitory shake downs or searches of other areas where there is inmate traffic, although that did not appear to happen often.

4. There is a two-hour training sessions for all of the dog handlers every two weeks. All fourteen handlers will not attend every session because some will be on vacation, days off, etc. In addition to the scheduled four hours per month of refresher canine training, each handler is also required to complete a one-week, forty-hour recertification canine training program that is offered externally.

5. The dogs live at home with their handlers. They come in at the beginning of a shift with the handler and then go home at the end of the shift with the same handler. Dogs are retired after seven years of service. Thus, with fourteen canines, HoC now budgets for two new dogs each year. That is probably an underestimate of the need because that schedule does not take into account any dog that must be taken out of service prematurely due to injury or illness.

6. The key questions about the canine unit center on effectiveness, productivity, costs and appropriateness. HoC spends a large amount of money buying highly trained but expensive dogs. HoC spends a substantial additional amount of money for ongoing training of the dogs and the handlers. No one

doubts that the dogs and the handlers are well trained. One manager observed wryly that at HoC the dogs receive more training than the staff. Questions about productivity of the canine unit were impossible to answer because no records have been kept. This is a joint failure of management in not establishing accountability, and the canine unit itself in not documenting nor evaluating its own activities. At any rate, when the consultant asked for a log or other documentation that would show the frequency of perimeter checks or the number of building searches or the number of times the drug trained dogs participated in shakedowns of dormitories or other areas, etc., there was no data available and no records from which data might be extracted. Even the consultant's question about why there were fourteen dogs and handlers when twelve dogs should be enough to cover two posts on a 24/7 basis, including sick leave, annual leave, training days, etc., produced no clear answer.

From observations and interviews, it appeared to the consultant that the dogs are not frequently used for perimeter checks (inside or outside), contraband shakedowns, building searches or security checks at the farm. Most of the time one of the two dogs on duty is at the vehicles sallyport and sometimes helping with vehicle inspections and the other dog is on the west side of the compound helping to monitor inmate traffic to and from the Annex. However, the dogs do respond to serious fights and small disturbances and some other situations where inmates in a dormitory may be ignoring staff direction. Many inmates are very much afraid of the dogs and they sometimes produce quick compliance from inmates. This the heart of what the canines do for HoC and this is what must be analyzed most carefully in determining the effectiveness of the canine unit at HoC. It is not that the dogs are used with some frequency to bite unruly inmates. In fact, the information the consultant received is that it has been perhaps ten years since one of the dogs was set upon an acutely disturbed and wild inmate who was threatening others. According to what the consultant heard, the use of force with the dog was appropriate in that situation. It is clear that the handlers believe the dogs are invaluable as a deterrent and as a show of force in situations that have the potential to get out of hand. It is also clear that the canines are part of the culture of the institution and that many staff find the presence of the dogs reassuring. Also, the value of the dogs as backup and as a larger scale control mechanism is magnified because of the lack of a realistic emergency response capacity at HoC and the lack of a functional tactical team.

7. Dogs are the exception rather than the rule at correctional facilities, although institutions that use dogs are not rare. They are more common at prisons than at jails and they are more common in the South and Southeastern part of the United States than in the rest of the country. Many institutions that do have dogs maintain only tracking dogs, while a small number of institutions use dogs only to patrol the area between double perimeter fences. HoC is quite unusual in that very few minimum-medium security facilities have dogs and perhaps even fewer county sentenced facilities.

8. There is another aspect of this situation that cannot be ignored. The HoC inmate population is three-fourths Black and Milwaukee County is only one-fourth Black. For many African-Americans, a show of force involving uniformed officers holding barking German Shepherds evokes memories of Bull Connor and Civil Rights marches in the South. While not all inmates will react that way, and not all Black inmates, that could hardly be a more negative racial stereotype. The question must be asked whether raising that stereotype is outweighed by the results the dogs obtain.

9. HoC is in a serious budget crisis and an accompanying staffing shortage. Each dog and its handler is very expensive. It is not clear why HoC needs fourteen dogs and handlers. If the primary need is for a dog to enter the building in response to larger or fights or minor disturbances, then one dog on a 24/7 basis, which would equate to six dogs and handlers, would be adequate. If those six dogs were drug trained as well as trained on more general patrol functions, the dogs could participate in frequent area shakedowns for contraband, which would improve overall security at HoC. It is not essential to have a dog working the vehicle sallyport. Many jails and prisons throughout the country do an excellent job with security at vehicle sallyports, and almost none of them use dogs. Since the dog handler assigned to the vehicle sallyport is usually working there alone, that officer and his or her dog are not free to respond to a fight or other problem in the building until they close down the vehicle sallyport. That can take some time. That is why it is the canine and handler from the west side of the compound that are expected to respond to a situation within the buildings when needed. If the vehicle sallyport position was changed to a non-canine post, that would allow reducing the required number of dogs and handlers to six.

X. Sanitation

1. Sanitation is one of the foundations of correctional facility management. It is not a minor or trivial matter in a jail or prison. Appearance (sanitation and maintenance) is one of the first and strongest impressions upon entering a correctional facility. For a visitor, an inmate or a staff member entering a facility for the first time, the cleanliness of the facility will often register in less than fifty feet. As such, sanitation is an important contributor to the "climate" of a correctional institution. It is well established that inmate behavior is, to a substantial degree, a product of the inmate's environment. There are many examples in corrections of inmates who were dangerous and extremely difficult to manage in a violent, poorly run institution, but who then morphed into adjusted and constructive offenders when transferred to a safe and well managed institution. Examples of the opposite transformation may be even more common. If a jail is dirty, poorly maintained, loud and profane, those characteristics will substantially define the climate of the jail. They constitute an implicit set of expectations about behavior within the facility. There are no indications that those expectations affect staff any less than inmates.

2. There is no real excuse for a dirty correctional institution. Excluding perhaps a "supermax", one thing all correctional facilities have in common is the availability of labor. Most inmates dislike boredom and will gladly volunteer for work details that allow them to get out of their cells or off their dormitories. Age of the facility is also not a valid excuse. The consultant has been to very old prisons and jails that were spotless and to new facilities that were filthy.

3. HoC is an excellent example of the points discussed directly above. Sanitation in the South building and the Annex ranged from good to excellent, with most areas in the excellent category. That was true in dormitories, corridors, kitchens, bathrooms and other areas. Sanitation in the North building was poor and many areas were filthy. It makes no sense that there are dramatic differences in sanitation within the same facility, when the areas in question are supervised by the same staff (who rotate back and forth with great frequency) and when most of the dormitories are general population and housing very similar mixes of inmates. Obviously, the situation is a result of history and expectations. The North building has been dirty for a long time and so the same staff member who insists on a clean dormitory when assigned to the South building, may be assigned to the North building on the following shift and expects that dormitory will be dirty. The expectation, of course, is a self-fulfilling prophecy.

4. Sanitation at CCC was quite good. The building is very old, maintenance is poor and floor coverings, windows, doors and other components date from many years ago. The building also has very high traffic from the outside, since most of the population leaves and returns every day as part of the work release program. For all of these reasons, sanitation is a major challenge at CCC but the staff and inmate population meet that challenge well. CCC offers proof that the problems with the North building at Franklin are not due to the age of the facility.

5. When the consultant inquired about sanitation problems, the most common answer was that cleaning supplies are unavailable. That is not a satisfactory answer. The difference between adequate cleaning supplies and inadequate cleaning supplies is a tiny proportion of the institution's overall budget. It would be silly to cut back on cleaning supplies as a budget saving measure when those cleaning supplies are leveraged many times over by availability of free inmate labor. (If cleaning supplies are being wildly wasted or squandered, that is a supervision issue rather than a sanitation or budget issue).

6. A specific example may be helpful. During the second week of the consultant's on site work, he was in one of the North dining rooms observing the dinner and talking with staff supervising the meal and then later talking with groups of inmates. Some of the inmates begged the consultant to go back with them to their dormitory to see the conditions of the dorm and the bathroom. The inmates were not exaggerating. The conditions were nothing

less than disgusting. One toilet in the bathroom was stopped up and had not been working for at least a few days and perhaps much longer. The inmates had covered it with Saran wrap to minimize the smell. Paint was pealing off the ceilings and floors and there were paint chips in the sinks and on the floors. Inmates complained that the lead paint which was pealing everywhere constituted a health hazard and the consultant responded that the paint might be new enough to not be lead based, but that he did not know. The air vents in that bathroom were covered with heavy steel grates and the accumulation of dust, grime and dirt behind those grates greatly reduced the airflow and no one could be pleased about breathing air that was being "filtered" through the gunk behind the grates. The group of inmates told the consultant that they had repeatedly asked to be allowed to clean the bathrooms but had been told that there were no cleaning supplies. The inmates also pointed out an active leak in the ceiling in the bathroom which was located so that if you used one and perhaps two of the sinks in the bathroom, the leak might well be dripping on your head. The inmates said that the leak was urine or wastewater rather than just a water leak, and while a consultant has no expertise in the building trades, the leak appeared to be something other than clear water. It should be noted that the conditions observed were a combination of maintenance issues and sanitation issues. Still, it is unnecessary and offensive to require inmates to live in those conditions and it is equally unnecessary and offensive to require staff to spend a substantial proportion of their careers working in those conditions.

7. While that dormitory was the worst or one of the worst observed, other bathrooms in the North building had similar problems.

8. Kitchen sanitation issues are reviewed under "food service."

Y. Maintenance

1. The consultant did not have time to review the maintenance operation in detail.

2. Maintenance, like sanitation, has a great deal to do with expectations, standards and climate. That is, when an institution is well maintained and spotless, most staff and most inmates help keep it that way. When the opposite is true and a facility is dirty and poorly maintained, both staff and inmates expect that it will stay that way. Further, too many inmates and staff throw trash on the floors or in corners, put things in sinks and toilets that create additional maintenance problems and generally contribute to the poor state of affairs.

3. Maintenance is operated by HoC staff. That is an advantage as many county jails work with employees of a county maintenance department and those staff report to no one in the jail chain of command. While that works well in some locales, it is often a source of problems ranging from accountability to security.

4. The maintenance area is off-limits to inmates and takes a key to enter.

5. The maintenance area is large with a number of different sized storerooms and workrooms. At the urging of the new Assistant Superintendent, Joe McCarthy, there is a beginning effort underway to clean and organize the area and to develop a tool control system; those are important objectives. At the moment, however, the area is something of a disaster with tools and supplies everywhere and no organization. It appears that unused items, extra supplies, broken tools and a variety of other materials have been "squirreled away" in the maintenance area for many years. It will be a formidable challenge to clean up the area. At present, there is no working tool checkout system and no tool inventory system and only a beginning and rudimentary procedure for identifying and segregating tools that pose the highest security risks. For example, acetylene torch tips are stored with the gas cylinders in the large open maintenance rooms – rather than in either of the separately locked areas. Hacksaw blades are kept in one of the locked areas but are not inventoried and are not subject to an appropriate disposal protocol. Currently, tool control is not operational.

6. There are three storage rooms in the maintenance area that have limited access even for maintenance personnel and must be entered with a special key or by keypad. One of these rooms contains the bolt cutters and some other security-risk large tools. A second room will contain vehicle keys but that system is not complete or inventoried yet. A third room has smaller security-risk items. Identifying these separate locked areas and moving security tools into them is a good sign of positive change.

7. There are metal flammable cabinets within the maintenance area but they are unlocked and uninventoried. In some cases these flammable storage cabinets are so overloaded that additional flammable materials are stored on top of the cabinets.

8. HoC maintenance parallels sanitation in a number of ways. Maintenance is worst in the North building but appears good in the South building and the Annex. Maintenance at CCC is more mixed. Major systems are working and bathroom and kitchen items are fixed when they break and seem to be maintained and in operable condition. On the other hand, painting, doors, windows, light fixtures, floor coverings and the like do not look like they have had any attention since the building was an old and hard-used hospital. Some things in the building have a 1950's look but some may be pre-war (the Civil war?). It must be emphasized that age is less an issue than the very poor condition of much of CCC.

9. There is an argument that is does not make sense to put money into CCC since it is so old and dilapidated and since there are plans afoot to close it. There is some logic to that but it does not explain why repairs and improvements have not been made over the many years the building has been in use as a work release center. In particular, some kinds of repairs – paint,

for example – can make a huge improvement at minimal cost. Again, inmate labor is free.

10. A major reason CCC is in the condition it is has to do with maintenance responsibilities there. HoC maintenance is only responsible for moveable items, televisions, lockers, bunks – essentially the furnishings. All of the items described earlier, floors, windows, doors and everything else that is part of the building itself, are within the jurisdiction of the County Public Works Department. They appear to do little and CCC staff see the HoC maintenance folks as much more responsive, even going so far as to occasionally fix building items that aren't their responsibility but are important, as a favor to CCC staff.

11. The work order system for maintenance at HoC has been in place a for long time. There are numbered, multi-part maintenance requests forms available in many locations throughout the Franklin facility, and there are three maintenance mail boxes in different locations in the facility where filled out maintenance requests can be deposited. The maintenance requests are picked up each morning, five days a week, usually by the Assistant Superintendent for maintenance. Staff filling out a maintenance request can keep one of the carbon copies but they are also encouraged to make an entry of the request, along with date and time submitted, in the unit log. That is a smart procedure in case a maintenance request is lost or there is conflict about whether a problem was reported. The maintenance Assistant Superintendent "triages" the forms, sorting and assigning them by severity of the problem, trades or repair skills needed, materials available, etc. When a problem is repaired, the maintenance request form is used to document the job completion and one copy of that form is kept in maintenance and another copy is forwarded to HoC administration.

12. Maintenance requests may also be submitted by email, called in by radio or telephone or passed on to maintenance staff as they are walking through the corridors or working in an area. In any of these cases, the request for service should end up written onto a standard maintenance request form. The Assistant Superintendent's signature on a maintenance request form is the indication to the maintenance staff that the request form is valid and that they can proceed with repair work.

13. There are a number of obvious problems with the maintenance request process. First, like so much else at HoC, it is just what has been done for a long time rather than a clearly defined protocol or a written procedure. Second, it is too heavily dependent on one person and too personality driven with regard to things like which staff can be entrusted with challenging repair jobs. Third, there is no master log of requests with assignments, anticipated completion dates, progress notes, etc. In most large correctional facilities, at least that much of the maintenance request system is computerized. None of it is at HoC. Since staff cannot pull up a computer screen to see whether a request has already been submitted for a particular problem, multiple requests

for the same maintenance problem are common. For example, an officer starts a shift in a dormitory and notices that a security door will not close properly. It may be that the same broken door lock was reported three other times in the prior seven shifts but since the officer is working relief and has not been on that dormitory recently he or she will not know about the prior requests unless they were logged and unless the officer decides to read back through the log for the prior two or three days of entries. The lack of computer access to the system also means that staff cannot view the progress of a maintenance request. A request may have been reviewed promptly but the actual repair may be delayed awaiting the arrival of parts, which were also ordered promptly, or the delay is because the repair requires an outside contractor, who may have been scheduled but is not immediately available. In these kinds of cases, staff may get no feedback and, with no access to the maintenance "queue", the staff conclude that maintenance is unacceptably slow or is ignoring their requests. The Assistant Maintenance Superintendent tries to counter that by encouraging his staff to communicate frequently and informally with the uniformed staff, and particularly with supervisors and managers. He himself also sends frequent emails with progress reports for the same reason. These are admirable "work-arounds" but they can themselves take substantial time and they are somewhat inconsistent in reaching the staff reporting the problems. They are not a good substitute for wide spread computer access by all staff to the maintenance job queue.

14. With the installation of staff computer kiosks in a number of locations throughout the facility, there is a plan to very quickly put the maintenance request system on computer and to provide access so that any staff member can review the maintenance job cue. The maintenance Assistant Superintendent correctly worries that the change could have a chilling effect upon staff filling out maintenance requests. A staff member in a dormitory has time during a shift to fill out a paper request form and the forms are easily available there. If the staff member must go to a computer kiosk off the dormitory in order to submit a maintenance request, then that would have to be done during one of the officer's relief periods or during a meal break or right at the end of shift as the officer was leaving the dormitory. All of those possibilities are regarded as the officer's personal time. It is likely some officers would not use any of those available times to fill out a maintenance request at a kiosk if it is going to cost them part of, say, a meal break or a smoking break. The real problem is that there are no computers at the officer workstations on the dormitories. That is a much larger issue than anything related to maintenance requests and actually goes to the heart of the philosophy of direct supervision and the officer's role on the dormitory. Until there are computers on the dormitories, the maintenance request system will in all likelihood remain somewhat less than satisfying.

15. It should be noted that HoC purchased some relatively sophisticated software (by Eagle) which will not only automate maintenance requests but also track repairs and preventive maintenance on almost every piece of heavy equipment and every major item of infrastructure within the facility. At about

the time that that software was purchased, HoC also contracted with an outside company to assess the equipment within the facility, test bearings, record specifications and maintenance recommendations for new equipment, etc. That contract resulted in a massive amount of data that was intended to be input into the databases that were part of software purchased. HoC also paid for training of the maintenance staff on the new computer system at that same time. (Maintenance had been advocating for those steps from the time the South building came online. They were eventually able to make use of Y2K money for those items. Unfortunately, it never happened. Shortly after all of those steps were taken, there were serious staff cutbacks in maintenance, as there were elsewhere, and maintenance has never had the time or staff resources to input the data. Of course, over six or seven years, some of the data has become obsolete because intervening years' worth of maintenance and repair could not be recaptured and what may have been accomplished in training staff to the new system has by now been lost.

16. With regard to responsiveness of the maintenance department at HoC, the Assistant Maintenance Superintendent said that for items needing immediate repair, a clogged toilet or a broken shower, for example (and excluding repairs that need to wait on parts or on outside contractors), there is no backlog. That assessment is at odds with the perception of many inmates and some staff on the dormitories who pointed out those kinds of maintenance problems and said that they had existed for days or longer. There are many possible explanations for these apparent contradictions and the consultant did not have time to track a sample of individual problems and attempt to sort out the issues. Maintenance does rotate its staff through evening and weekend coverage and there is 24/7 response capability for emergency repairs. Even the evening and weekend staffing is very helpful in a large facility and somewhat unusual as many jails and prisons staff their maintenance operations only Monday through Friday during day shift.

    Overall, maintenance staffing includes two Assistant Superintendents, five tradesmen, one mechanic and twelve maintenance workers. Those are authorized positions and currently one of the two Assistant Superintendent positions is vacant due to retirement and four of the other positions are on suspension or on extended leave. Twenty maintenance positions seemed to the consultant to be extraordinary for the size of the facility, and that perception is only heightened when one considers the amount of work that is accomplished through contractors rather than in-house staff. Maintenance does make use of inmate workers when they find an inmate who has maintenance skills or who has worked in building trades. However, there is no screening mechanism to identify such inmates and it appears that only a small proportion of inmates who might have the required skills, are actually identified and used.

17. None of the discussion above explains the terrible conditions the consultant observed in several of the North building dormitory bathrooms. For the last five years, the Assistant Superintendent for maintenance has submitted a

budget item each year to renovate those bathrooms and each year that item has been removed from the budget "downtown." Actually, it is more likely that the items were removed from the budget by HoC management because typically HoC has given a total budget number or an amount that the new budget must be reduced from the prior year's budget, and it is then left to HoC to come up with the budget reductions any way they see fit.

It is not surprising that in a climate of cut-back budgeting and loss of staff positions, large maintenance projects will be lost even if they are essential to basic sanitation and health. This is another painful example of a much broader issue encompassing all of HoC. It is not possible to substantially increase the inmate population while substantially decreasing funding both in absolute and relative dollars, without risking some dire consequences. The maintenance strategy is to move inmates out of the dormitory needing serious repairs or renovations, complete the work as fast as possible and then repopulate the dormitory. That strategy works as long as there are two or more closed dormitories. Maintenance has sometimes taken an alternate strategy of moving inmates out of those dormitories that needed minor amounts of work, something of a "low hanging fruit" strategy. Another reason for the condition of some of the North building bathrooms is that the plumbing in particular in the North building is sixty years old and was not built for the intensity of use that is has received in recent years. Much of that plumbing is cast into the concrete walls and floors/ceilings and is difficult and expensive to reach or repair. However, it is now subject to catastrophic failure. In addition to the plumbing, the wiring and ventilation systems in the North building dormitories need replacement or extensive renovation.

None of the explanations, the recent population crisis, the failure to approve renovation budgets, the convenience of working on the newer dormitories or the extensive capitol outlays necessary to completely renovate the old dormitories – provided the consultant with any understanding of why the abominable conditions observed have been allowed to persist. Clearly, when things get that bad, it is important to place highest priority on those dormitories, move inmates to a closed dormitory, fix the paint, the leaking pipes, the broken toilets and showers, clean the air vents and fix the floors. That much could be done (or almost all of it) without a capitol budget even though the measures would be temporary and would not substitute for serious renovation. The consultant does not understand why HoC maintenance as well as the supervisors and managers responsible for those dormitories, are not insistent that those situations are top priority.

Z. Food Service

1. HoC contracts with Aramark to provide food service. Ron Malone had advocated for privatizing food service at HoC and the change was approved very narrowly by the Board of Supervisors. The county employs a full-time civilian employee, Nada Uzelac, who is the contract monitor overseeing Aramark.

2. Milwaukee County was evidently one of the first large Aramark jail contracts in the Wisconsin area (it is the consultant's understanding Aramark also has the food service contract for the Cook County Jails), and Aramark has seemed strongly motivated to make the contract successful. Aramark has its Regional Manager housed in the administrative area of HoC and that provides unusually good access and sometimes extra leverage when HoC has an issue with Aramark.

3. The Aramark contract is paid for entirely from the HoC budget but the contract includes food service at CJF. Thus, CJF does not manage or budget for food service just as HoC does not manage or budget mental health or health services operations at HoC because the latter two services are paid for by CJF and managed downtown. All three of these arrangements are unusual, and quite awkward for a number of reasons as discussed elsewhere in this report.

4. In general, inmate workers supervised by Aramark staff prepare all meals in the large main kitchen in the South building (at Franklin). Most meals are prepared in advance and "quick-chilled" and then rethermed before they are served at the various kitchens. With the exception of the three cellblock areas in the North building, all inmates move, by housing unit, to dining rooms in their own building, where they are served and eat. The same is true at CCC. Food is sent from the main kitchen at Franklin to CCC where the food is reheated in bulk in the small CCC kitchen and then large containers of food are placed in a serving line on the kitchen side. At Franklin and at CCC, the serving lines are designed to be "blind." That is, inmates working the kitchen side of the serving line assemble trays and hand them through a waist-level slot to inmates who file past on the dining room side of the serving line. However, there is no visibility from the kitchen side to the dining room side or vice versa unless an inmate bends down and looks through the waist-level slot. This is a common arrangement and is intended to stop inmates from giving extra helpings to friends, withholding food from inmates who may be part of a rival group, etc. Of course, if inmates are not supervised, they will do just that: they will bend down to see who is working on the serving line or who is coming through with trays in spite of the design of the area.

5. Inmates at CJF and inmates on the three cellblock areas of the North building at Franklin are fed in their cells. Trays designed to keep food hot are assembled by kitchen staff and the trays are then taken to the cell areas on carts.

6. In general, the main kitchen in the South building at Franklin was clean, well run, well organized and impressive. The consultant visited that kitchen area in the midst of the lunch feeding time and a second time when the dinner meal was being prepared. Feeding time is usually the most difficult for a kitchen because the volume of meals served is so high in a relatively short period of time that it is quite difficult to keep the kitchen clean and the various lines (the serving line, the tray cleaning and washing line, etc). well

organized. Some jail and prison kitchen operations simply let things accumulate on counters and on floors until the meal is completed and then do a major cleanup. The preferable method is to "clean as you go" and that is the way in which the HoC main kitchen operates. Even at the height of the lunch meal, the kitchen was very well maintained and the inmate workers were orderly, productive and well supervised.

7. The coolers and freezers in the kitchen were kept closed, temperature gages were working and within acceptable limits, and food items were almost all in appropriate containers, up off the floor, covered and labeled with the contents and the date on which the container was stored. There were a few items that were uncovered and/or unlabeled but they were the exception. All of the inmates working on food preparation or serving were wearing hairnets and gloves and, where appropriate, nets over beards and mustaches. That is another indicator of close and effective supervision of the kitchen. Where liquid items were stored in coolers, there was no evidence of "leakers" and there was similarly no obvious evidence of insect or rodent infestation in the coolers or freezers.

8. The kitchen at CCC was also kept very clean, particularly considering the dilapidated condition of the building, and the meal service at CCC was handled very nicely. However, the North kitchen at Franklin was the anomaly. Inmates in the North building dormitories had complained bitterly and almost unanimously about food sanitation (some complaints about food are extremely common in most jails and prisons but the number and intensity of complaints in the North building were quite different from the other HoC facilities). When the consultant observed the North kitchen in operation, it would have been easy to conclude that it was part of some different food service arrangement or contract. The kitchen was filthy, open containers of food were prevalent and there were indications that pilfering of food by inmate workers was a norm. Inmate workers were poorly supervised, sitting and visiting with each other while there was a great deal of work to be done.

9. The main kitchen includes a full bakery and the jail produces its own bread, rolls, etc. Yeast is kept in a locked metal cabinet and only staff are allowed to get yeast from that cabinet and add it during preparation of a baking mixture. The problem is that inmates in correctional facilities around the country frequently make various forms of "homebrew" (homemade alcoholic drinks) and yeast is the essential ingredient that can be reasonably well controlled. At HoC, yeast is in a cabinet with a small, common non-security key and the cabinet is in an open office. Inmates could pick the cabinet lock or otherwise open the cabinet and there would be no indication that yeast was missing since it is not inventoried. Similarly, it is easy to imagine a staff member under time pressure during meal preparation asking an inmate worker to pour a bag or two of yeast into a flour mixture. The high turnover among Aramark kitchen employees at HoC increases these kinds of risks.

10. The main kitchen has a well thought out security system for sharps and for knives. Sharps and knives are inventoried and the inventory recorded. Knives are shadow boarded and there is a checkout log maintained in the locked knife cabinet. All of this is as it should be. Unfortunately, the well designed system is being defeated because of complacency and lack of supervision. The checkout logs frequently show knives checked out but never checked back in. It is only necessary to review the checkout logs from a single week to find numerous examples of that. It is clear that the knives were actually returned because the same knife that was checked out and then, according to the log, never returned was then checked out again the next day or the next shift. Obviously, no one bothered to document that the knife had been returned.

    It must be underscored that this is a major security breach. In many correctional facilities, if a knife were unaccounted for at the end of the shift, there would be an immediate emergency lockdown of the entire facility and an area-by-area search. At HoC, if an inmate smuggled a knife out of the kitchen at the end of the shift, it is unlikely anyone would notice because the checkout log is not taken seriously and an "open entry," where a knife is not shown as returned, is very common.

    Another implication of the situation cannot be ignored. The contract kitchen staff either have not been well enough trained about the importance of matters such as knife security, or they have been adequately trained and are simply lax. Ultimately, however, security is the responsibility of the correctional officer staff and management at HoC. Since this security failure is obvious with even a sixty-second review of knife security in the kitchen, it is clear that correctional staff do not look at those issues. That would extend from the correctional officers assigned to the main kitchen, to supervisors and to managers.

AA. Intake and Classification

1. The consultant visited Intake on two occasions and observed and talked to staff for some period of time. However, the consultant did not have enough time to review Intake procedures.

2. HoC does no classification. That might not be a major problem for HoC if CJF did a serious job of classification because most inmates come to HoC from CJF and they should come already having been classified in most cases. HoC could then make use of that classification information on most new inmates.

3. Unfortunately, CJF does not use a modern objective classification system. There were discussions between HoC and CJF about classification systems and a request for an NIC Technical Assistance Project on classification was approved and completed earlier this year. That project produced an excellent final report which stressed the need for an objective jail classification system

and made a number of other specific, related recommendations. (See the TA report by Ray Sabatine, June, 2007). After the technical assistance project and the report, there was some initial agreement that CJF would take the lead in adopting an objective classification system and that HoC would then use the same system in order to provide continuity across the two facilities. Instead, nothing happened and it is not clear whether anyone at either facility is working on this question or whether anyone in the Sheriff's Office or HoC management regards a modern classification system as a priority.

4. Even if CJF did have a good classification system, HoC would still face a major challenge in this area. Enough inmates come in to HoC directly from court or from the streets that HoC would still need to have staff trained in classification procedures to deal with those inmates who did not come from CJF and those who were transferred from CJF before classification could be completed.

5. With no classification system in place at HoC, and no classification information available on most intakes, the simple rule is that almost all inmates will be assigned to wherever there is bed space, without regard to their history, behavior or committed offense. That practice makes it harder than necessary to manage the living units.

6. Without a classification system, there is of course no classification committee and no way to modify an inmate's status except for disciplinary segregation on one end of the continuum and a transfer to ES or work release on the either end of the continuum. The majority of HoC inmates are housed on the dormitories in large undifferentiated numbers.

BB. Internal Affairs

1. HoC has no Internal Affairs unit or full time staff. That is surprising for an organization with over 400 staff. (This function is referred to as Internal Affairs, or "IA," in this report. It should be noted that some agencies refer to this function as "Investigations" and there are a wide variety of other names that are in use but all of which refer to the person or group who investigates allegations against staff and investigates serious internal incidents. The scope of this function also varies to some degree from agency to agency).

2. Instead of an IA unit or staff, HoC uses part-time investigators, primarily retired law enforcement officers, who are hired on an hourly basis and a job by job basis.

3. In addition to internal investigations, the most frequent use of the part-time investigators is background investigations of applicants for correctional officer positions. Currently, the part-time investigators are assigned applicants who have successfully passed the county's written exam for the correctional officer position and conduct not only background investigation but also the final employment interviews.

4. This arrangement does not work well for HoC. There is no manager or mid-manager on staff in charge of investigations for the top administrators to consult with around a high profile or sensitive case. There is no one on staff with investigative skills or background to coordinate or supervise the part-time investigators. It can be argues that in some kinds of investigations, the independence of the part-time investigators and their lack of relationships with the HoC regular staff may prevent potential bias. In most investigative situations, however, that possible benefit will be far outweighed by the investigators' lack of familiarity with correctional practices and the lack of consistency across investigators.

5. The investigation into the August escape from the Franklin facility provides an excellent case in point. The incident was high profile and the top administration at HoC was under pressure to provide at least preliminary answers to questions from the media and county government. The investigation took a long time to complete and the final investigative report is so poorly done that it is embarrassing. The first sentence of the report states that the results of the investigation were unsuccessful in determining complicity by correctional staff. The next sentence says "however, the investigation and facts indicate correctional negligence…". The clear meaning of that first paragraph is that the objective of the report was to find staff complicity. That is inexcusable. The second sentence suggests that even though the report was unsuccessful in it's first objective, establishing staff complicity, it was at least able to determine negligence on the part of staff. Whatever happened to the quaint notion that investigations were simply to determine what actually occurred, rather than starting with a goal of "nailing" staff?

   The report fails to provide a summary of the fact situation. More importantly, the investigation fails to describe the methods used by the investigator, who was and was not interviewed, when the interviews took place and whether they were recorded, etc. Without a detailed statement of how the investigation was conducted, it is impossible to place the "results" in context or adequately evaluate their credibility.

   The report is poorly written. The conclusions and findings include statements such as, "this investigator can only surmise…". The rest of the conclusions and findings consist of a series of four questions each of which asks, "Has staff member (John Doe) violated the following rules or policies?" The investigator, and perhaps others at HoC, appear to be under the impression that the investigation is simply a tool to discipline staff.

   There is no indication in the investigation report that the investigator attempted to talk with the inmate who did escape. However, when a Captain at Dodge Correctional Institution did interview the escapee, the inmate was detailed and credible about how he had escaped and his story was to a large extent validated by the degree to which it conformed to what was already known about the escape situation. Importantly, the investigation report

simply missed almost every important aspect of the escape. Further, the investigation report made no attempt to highlight the policy, procedure or facility problems that were spotlighted by the escape, so that after waiting a long time to receive the investigative report, HoC management had no road map for beginning necessary corrective measures. The investigators lack of familiarity with correctional practices is apparent throughout the investigation report. A more detailed review of this report is beyond the scope of this technical assistance project.

6. Many law enforcement and correctional agencies outsource background investigations of potential recruits. That is an appropriate use of part-time and/or external investigators but the practice at HoC has not been good. The investigators have taken too long with background investigations, sometimes three or four months, and that has made an already unwieldy process impractical and ineffectual. There have been no standards or format for the background investigations. Finally, as mentioned above in the Personnel section of this report, the practice of using the background investigator to also conduct the final employment interview, rather than using an oral board of HoC staff, minimizes the added value of a final employment interview.

CC. Facilities

1. CCC has already been discussed extensively in this report. It is a very old, unappealing structure where "deferred maintenance" has evidently been the byword. It is difficult to keep clean and difficult to maintain and unless it is retrofitted with sprinklers, fire safety will continue to be a grave concern in any event. However, CCC's location in the center of downtown Milwaukee is a major asset.

2. The Franklin facility is more than serviceable. The South building and the Annex are well designed modern facilities. The North building has not been well maintained but is reasonably designed and also lends itself well to direct supervision.

3. The two adjacent cellblocks (A1 and A2) are not well designed. They have old, linear style units that present visibility problems for staff. Further, the officer's stations on these units are separated from the actual tier by a steel security door so that the officer at his or her station cannot see and does not easily hear any of the inmates. However, the cellblocks are better than many segregation units that are still in operation around the country and they are serviceable. There is no reason to expect that these cellblocks will need to hold very high security inmates and when an inmate is a very serious assault risk or a very serious suicide risk or wildly psychotic, that inmate should only be on one of the cellblocks for a short period of time before he or she is transferred to another facility. The basement cellblock (O2) does present real problems as a security housing area, as discussed in some detail earlier in this report.

4. There are questions about the ways in which the current facilities are being used. There is a general principle that except for segregation units, it generally most effective to use the best housing areas for the worst inmates and vice versa. The concept is that "honor dorm" inmates, for example, have a lot of free time and program opportunities and will have less objection to living units or rooms that are smaller or older or less attractive. On the other hand, the more difficult inmates will present fewer problems if they are in the least crowded areas and the areas which are more attractive and perhaps in better condition. At HoC, the opposite principle seems to be at play. The dormitories in the North building are in the worst condition and are the least attractive but they have established capacities of seventy inmates per dormitory. Also, although there is no classification system discernable at HoC, there is some tendency to put the more difficult inmates into the North building dormitories. Conversely, the South building dormitories and the Annex dormitories, which are newer, brighter, better ventilated and generally of better appearance and condition, have established capacities of sixty inmates per dormitory, and there is some tendency to put the easier to mange inmates into the South building dormitories. (The Annex is intentionally used as something approaching honor dormitory status, and that makes good sense given the layout and staffing at Franklin).

5. It was not clear to the consultant why the situation was not reversed, and staff that the consultant discussed this question with did not have a ready answer. That is, would it make sense to increase the South dormitories and Annex dormitories to seventy inmates and decrease the North dormitories to sixty inmates. At the same time, the more difficult inmates could be put into the South dormitories and the easier to manage inmates into the North building.

   The rationale for the current dormitory population capacities is that the buildings were designed and built for that specific capacity. The consultant did not measure square footage in the various dormitories nor did he count toilets, sinks and showers, and it may be that those are defining factors.

6. The best use of the facilities at Franklin is strongly compromised by the lack of a classification system. With so many dormitories, it would be relatively straightforward to have different kinds of inmates in different dormitories in a manner that facilitated inmate management. It would also be possible to develop behaviorally based "step" or "level" programs in which inmates earn progression to dormitories with successively higher levels of privileges and opportunities, by good behavior and/or program achievement.

IX. Recommendations: Introduction

A. These recommendations are just that: recommendations. They represent the best judgment of the consultant about what might, or should, or could be done to improve HoC. They are subject to all of the limitations discussed in an early section of this report and they are specifically not the recommendations of NIC.

B. The first section of recommendations are the broad or over-arching issues that may each involve a large number of specific actions. The next two sections of recommendations are Countywide Criminal Justice Issues and HoC issues, respectively. Within each of these sections, recommendations are organized following the same organization of topics in "Observations and Conclusions." That is, the discussion of Direct Supervision at HoC is found in section "VIII-L" of this report and the corresponding recommendations may be found in section "XII-L."

X. Recommendations: General

A. Milwaukee County should develop a comprehensive jail population management plan. The plan should encompass HoC and CJF but should take cognizance of the Day Reporting Center, the offenders on ES, bail issues, state inmates and the host of pre-trial and post-trial alternatives to incarceration that may be considered. While there is a need for a countywide criminal justice master plan, that is a lengthy undertaking. The jail population crisis in September made it clear that a broad and aggressive population management program for the two jails is an immediate need.

B. HoC needs to develop a plan to dramatically change the organization's culture. That will be a difficult and long-term undertaking.

C. HoC should develop a comprehensive security initiative with emphasis on "back to basics." After perhaps a year or eighteen months work with this intuitive, HoC should then commission an external security audit (NIC might support that effort as a follow-up to this technical assistance project).

D. HoC should make direct supervision the core concept defining how inmates are supervised and managed at HoC. This, too, should be the subject of a comprehensive plan which must include a heavy emphasis on staff training on direct supervision with different training provided to supervisors and managers than to front line staff.

E. A detailed staffing analysis should be conducted at HoC. That analysis should be conducted by someone with deep familiarity with jail staffing issues but independent of HoC and the County.

F. The County should develop a budget allocation protocol so that the costs of food service, medical and mental health services and inmate programs are reasonably allocated between HoC and CJF, and each organization should be responsible for managing it's own budget and services in those areas.

G. HoC needs to develop and maintain a comprehensive emergency preparedness system. That will not be quick, or cheap, or easy.

H. Almost all personnel functions at HoC need a thoroughgoing review and substantial change.

I. HoC should review the options available for closing or phasing out CCC, including a serious study of alternatives that would allow the current or a similar work release program. The assumption that offenders now on work release can be "ported over" to ES should be revisited. The resulting plan should not be based solely upon the decision to close CCC in order to reduce budget. HoC must avoid last minute decisions about work release inmates displaced by the closure of CCC and the risk that those decisions are not based upon adequate research, analysis or consideration of established correctional practices.

J. The highest priority recommendation is to immediately work to bring HoC to an acceptable level of fire safety. This is a specific rather than a broad and general recommendation but it is included in this section because of its urgency and its potential to be a life and death matter. If reasonable fire safety cannot be established at CCC, it should be immediately closed for that reason alone and having nothing to do with programmatic or budgetary considerations. There is no question that reasonable fire safety can be established at the Franklin facility and that, too, should be done immediately.

XI. Recommendations: Countywide Criminal Justice Issues

A. Criminal Justice Planning and Coordination

1. The new County Justice Criminal Coordinating Council should be supported as strongly as possible.

2. HoC leadership should take an active role on that coordinating council.

B. Jail System Structure

1. The new Criminal Justice Coordinating Council should develop a medium range and/or long-term jail plan for Milwaukee County. That plan will be in many ways dependent on the County's commitment to, and success with, jail population management.

2. If the County does not anticipate substantial reductions in jail populations through population management efforts, the county should in the short-term plan for additional jail facilities. The alternatives would include emergency releases or sending inmates out of the county on contract to private facilities. Neither of those approaches is recommended.

3. As part of the examination of the medium range or long range plans for the county jails, county decision makers should thoughtfully analyze the possibility of combining CJF and HoC as a single jail organization, either as part of the Sheriff's Office or as a County Department of Corrections.

C. Population Management

1. The County should, as quickly as practical, begin a comprehensive initiative to expand the current population management efforts of the Court broadly and aggressively. That initiative may involve the need for statutory changes and will likely involve the need for staff support. Most large counties that have worked aggressively on jail population management have had at least one full-time population management analyst. (Milwaukee County could contact Shelby County, Tennessee for some initial direction and guidance with such an effort. In 2000, the Shelby County Jail was deeply troubled and was over 3,000 inmates. As part of an effort to reform that jail, an aggressive and far reaching effort at jail population management reduced the population to approximately 1,800 inmates).

2. As part and parcel of a population management initiative, pre-trial and post adjudication diversion alternatives ("intermediate sanctions") should be reviewed as creatively as possible.

3. The County should establish a cap on the HoC population.

4. The County should establish guidelines and controls on the number of state inmates, and particularly the number POV offenders (inmates incarcerated on parole or probation violations) that can be accommodated at HoC.

5. One of the starting points for discussion of jail population management efforts should be to take a "snapshot" of the population of CJF, HoC, CCC and the Day Reporting Center at one moment in time. That snapshot, with data about the number of offenders in the county system, for how long, awaiting what next step, etc., may be the most helpful beginning picture for the Coordinating Council.

D. Information Systems

1. Milwaukee County should plan to move the various entities of the County System to a common software system, or to separate software systems that have the capability to allow access and data sharing across the organizational boundaries. If Milwaukee County wants to achieve a "turnaround" at HoC, a number of the major changes required (computers at the officer stations in dormitories, fire safety at CCC, a reasonable emergency preparedness system, rehabilitating the North building dormitories and bathrooms at Franklin, providing affective staff training) may not be possible if the pattern of position cut-backs and overall budget retrenchment at HoC continues.

2. It will be a distinct help to management at HoC if the current costs of prior incurred liabilities for retiree medical benefits and retirement benefits themselves are separated from HoC's operating budget. If that is not possible, it would be helpful if that was a separate item in the operating budget rather then some blended charge against positions.

E. County Budget and Other Resources

(No further recommendations)

XII. Recommendations: The House of Correction

A. Overview

1. HoC has been a troubled and in some ways dysfunctional organization for a long time. It does not need specific changes and adjustments, it needs a dramatic transformation. That is the first recommendation in the section on general recommendations. Changing the culture of the organization includes changing leadership, management, supervision, professionalism and morale as well as the philosophy of the work force and a host of other issues.

2. The consultant is not cavalier about the recommendations in this report. They are well beyond daunting. They outline years rather than months of hard work. Leaders who are willing to attempt a systematic turnaround at HoC had best pack a lunch and expect to deal with some failures because the nature of such organizational change tends to be slower and messier than planned, as well as "three steps forward, two steps backward" in style.

B. Mission

1. HoC should either embrace and adhere to its current mission statement or develop a new mission statement. Since the current statement is irrelevant to HoC's history and operations, it would probably be smarter to involve staff at various levels of the organization and across disciplines, and develop a new mission statement that has a high degree of staff ownership and "buy-in." The same process should be used to develop a vision statement for the organization and it would be most helpful if there were also a formally articulated set of organization beliefs and organization values.

2. Once developed, the mission statement and the statement of beliefs and/or the statement of values should be posted prominently in many locations throughout HoC.

3. Administrators, managers and supervisors should insist on integrity of actions, decisions and oral communication in relation to the agency's mission, values and beliefs. That is, major decisions and new directions should reflect the organizations mission and day to day actions, including verbal interactions, must not be allowed to violate the agency's beliefs and values.

4. The new HoC mission statement, vision statement and statements of beliefs and values should be emblematic of the new culture to be instilled at HoC.

C. Organizational Culture

(No additional recommendations.)

D. Leadership

1. The near term focus at HoC must be on internal leadership.

2. Leadership must be visible. The top administrators at HoC (if the organizational chart remains unchanged) should each spend a minimum of one and one-half hours touring the facility every day with the exception of days when the individual is out of the area on business or on leave. These tours should involve talking with staff and talking with inmates, individually and in small groups, as well as observing procedures, staff performance and making spot checks of everything from unit logs to tool control.

3. The leadership team that is to be responsible for the turnaround at HoC should be carefully identified. That group of five to ten individuals should meet no less frequently than three times per week, and preferably five times per week, at the beginning of the day. The Superintendent should be responsible for preparing an agenda in advance for those meetings. Action minutes of those meetings should be kept identifying topics, decisions, assignments and due dates. These meetings should be disciplined and should last between fifteen and forty minutes.

4. Leadership should be encouraged at every level of the organization. To do that, responsibilities throughout the organization should be clarified and authority should be given to individuals in the organization commensurate with their assigned responsibilities and the degree of leadership that is desired.

5. The HoC leadership team should take responsibility for turning labor management issues more positive and for developing consistent, reasonable and constructive working relations with represented groups within the work force.

6. HoC, as an organization, must become far more data oriented and analytic. In order to accomplish this, the leadership at HoC will have to model that behavior and expect that subordinate managers will collect data, analyze data and make decisions with reference to data. (A good starting point and reference may be to contact the Shelby County Jail, in Memphis, Tennessee and ask for both a print out and hard copy of what that jail refers to as "The Jail Report Card," which is compiled and published monthly. The monthly figures in that jail report card are the central element in a monthly management meeting and a monthly mid-management and supervisors meeting).

7. HoC should appoint a mid-manager or manager as the agency's public information officer and should provide that person with appropriate training. That individual should report directly to the Superintendent on public

information issues and work closely with the Superintendent in that regard. HoC should develop and annual plan for public information, including measurable goals and objectives, and should substantially increase its efforts to disseminate positive information about HoC.

E. Staff Professionalism and Morale

1. The organization's adopted, published and widely disseminated statement(s) of beliefs and values should be the cornerstone of staff professionalism. If HoC chooses not to develop a statement of beliefs and a statement of values, then a separate policy on staff professionalism will be necessary.

2. HoC should promote staff membership in, and participation, in professional organizations. At management levels, staff should be encouraged to visit other large jails, to attend NIC training and to attend professional meetings such as the American Jail Association's annual conference and the American Correctional Association summer conference.

3. Professional journals and literature should be available at multiple locations throughout the two primary facilities. External training opportunities should be widely communicated to staff. Staff should be made aware of web-based correctional training available without costs through NIC and on a fee basis from a number of other providers.

4. Evidence of professional involvement should be an important criterion for promotion and for special assignments.

5. If the County does not immediately develop a nepotism policy, HoC should. At a minimum, that policy should prohibit individuals from serving within the chain of command of an immediate family member or a person with whom they are involved in a romantic relationship; it should also prohibit immediate family members or persons involved in romantic relationships from working the same shift in the same facility. (That is, an individual and his or her spouse might work the same shift but only if one worked at Franklin and one worked that same shift at CCC). There should be a short transition period, perhaps sixty days, during which individuals whose work assignments place them in violation of such policy should be required to request a transfer for one of the individuals. After that transition period, the policy should require individuals to file a written notice with management at such time as new relationships are created by marriage or dating.

6. Gambling pools and similar unprofessional activities should be barred from the workplace and their future occurrence should be grounds for disciplinary action.

7. Supervisors and managers should be encouraged to model professional behavior. They should also be accountable for developing and maintaining professional behavior among subordinates.

8. Managers and supervisors should emphasize to all staff the importance of not talking about other staff to inmates or in front of inmates. The importance of staff dealing with staff away from inmates also needs emphasis. Staff should not argue with, override or otherwise undermine other staff, regardless of rank, within the hearing or sight of inmates unless the situation is an emergency or poses an eminent safety or security threat.

9. Staff inappropriate relationships with inmates should be dealt with, with a preventive focus in in-service and pre-service training but the topic should also be discussed at supervisory and management meetings. Supervisors and managers should be held accountable for early intervention in questionable situations. Here, too, NIC offers a wealth of state of the art material that is corrections-specific.

10. Staff recognition efforts should be continued and, where reasonable, expanded. They must remain serious and sincere.

11. The HoC HR Manager's idea of an employee satisfaction survey should be initiated now, and then re-administered on perhaps six month intervals in order to provide one of the metrics on change.

12. Exceptional performance should be recognized immediately and specifically by managers and supervisors throughout the organization. When any of the three top administrators encounter exceptional performance they should recognize it in some more public manner. A specific protocol may be developed for this purpose.

F. Management and Supervision

1. HoC should adopt the concept of supervisory accountability. That is, when something bad happens because a correctional officer has done something wrong, and when it turns out that many correctional officers were making the same error over a long period of time, the officer should be held accountable but the supervisor who failed to correct the pattern of errors over time should be held more accountable. In turn, the mid-manager over that supervisor and the manager the mid-manager reports to, may themselves be held more responsible respectively if they should have corrected the situation but did not. In short, each high rank should be held to a progressively higher standard. Also, accountability is not simply a matter of who participated but also a question of "knew or should have known."

2. Staffing should be adjusted to allow for consistent supervision. That is, assuming that a Correctional Manager will be the highest ranking staff member on a particular shift, staff at HoC should be organized into three regular teams, with each representing one of the three shifts, and one or two relief teams. Then to the greatest extent possible, a Correctional Manager along with a group of Lieutenants, Sergeants and correctional officers will work the same days, on the same shift, and will have the same days off. In this way,

supervisors and managers can work regularly with the same group of subordinates and the be responsible and accountable for those subordinates.

3. A practical system of performance appraisal should be adopted. Supervisors and managers should be trained on that system, so that they are familiar with key performance appraisal principles ("a performance appraisal is simply a summary of a year's worth of supervision," etc.) and so that they apply the system with reasonable consistency. In spite of transfers, promotions, etc. the annual performance appraisal should always be completed by the person who supervised the individual being evaluated during the largest portion of the preceding year.

4. The role of the Sergeant at HoC should be enhanced.

5. The role of Lieutenant at HoC should be changed substantially. Lieutenants should operate as mid-managers responsible for certain areas and/or functions of the facility and for supervising an identified group of Sergeants. Lieutenant responsibilities should not overlap each other. If it is necessary to have someone at the Lieutenant level responsible for developing master rosters and particularly for scheduling overtime, then that should be an assignment involving no more than one Lieutenant per shift and that Lieutenant should be supported by the necessary clerical staff.

6. Correctional Managers should serve, first and foremost, as Shift Commanders. In the current structure, it would appear that one Correctional Manager should be assigned to CCC, as is now the case, with five Correctional Managers heading security teams and the other Correctional Manager assigned to administration and responsible for coordinating areas ranging from maintenance to staff development to HR to budget and fiscal control. The Correctional Managers must be more involved in the overall management of the organization, in planning, in new initiatives and in setting overall direction. (Currently, too many of the Correctional Managers are managers in name only and actually function as third-line supervisors).

7. At each level of the organization, supervisors and managers should be responsible for working with their direct subordinates over the course of the year on career development issues.

8. Lieutenants and Correctional Managers should spend a significant amount of each shift moving through the facility and working with subordinates. They should be operational problem solvers. However, they also should closely observe staff performance, security procedures and be open to inmate issues.

9. Unless restricted by statute or existing labor agreements, days off should rotate. Staff already bid for shift, giving those with seniority a valuable advantage. However, the staff with the most seniority are also those staff least likely to have young children. Thus, many of the staff who do have young children are relegated to a shift that does not work well for their family

responsibilities. With that in mind, it is recommended that rotation be used for days off, so that all staff have equal access to weekend days off.

10. The HoC organization chart should be reviewed and revamped. In particular, too many key functions (inmate discipline, inmate grievance, etc.) are bundled into the security and operations area and that area represents too narrow a segment of the overall organization.

11. The two Assistant Superintendent positions should be realigned to provide more balance by substantially increasing the responsibilities of the Assistant Superintendent for Administration.

12. There should be a weekly rotating duty officer system among the three top administrators so that on a given week a particular administrator is available 24/7 by phone or pager.

13. HoC should explore whether a single Deputy Superintendent position would be more effective than the current two Assistant Superintendent positions.

G. Communication

1. Communication should be increased in all areas of the organization, in both directions and in many different ways.

2. Shift briefings should be more professional. They should always include a summary of key incidents or problems during the last shift or the last few days; announcements of changes in policy or procedure, upcoming events and the like; specific assignments of staff to posts (long-term assignments will eliminate most of this); and then, when time allows, questions or discussion from line staff.

3. The "all Sergeants meeting" should be continued and scheduled quarterly. Similarly, an all Lieutenants meeting should be held quarterly.

4. A meeting for all Correctional Managers with the top administrators should occur no less frequently than monthly, and bi-weekly would be preferable.

5. The Superintendent and Assistant Superintendents should attend the Sergeants' meetings and the Lieutenants' meetings and should each attend shift briefings with some frequency.

6. Every complaint, suggestion or other communication by telephone or in writing from the uniformed ranks, should be responded to by one of the top administrators in writing within forty-eight hours, or seventy-two hours if it is over a weekend. The response should be personal and specific.

7. A suggestion program should be initiated. If permissible by county statute, it should provide some meaningful incentive for a suggestion accepted. A staff

member submitting a suggestion should be notified within seventy-two hours whether the suggestion has been accepted, rejected (and reasons provided) or tabled for further study (with a timetable provided for an answer).

8. Regular meetings should be established between key non-security staff and the relevant security staff. The level of the security staff involved and the frequency of the meetings will not necessarily be the same for various non-security groups (PSW's, nurses and other medical staff, teachers, volunteers, etc.) but all of these groups need some regular communication with security staff and with administration.

9. HoC administration should develop a general method for rumor control.

H. Staff-Inmate Relationships

1. Supervision at HoC should focus on staff-inmate interactions. Communication with inmates should be regarded as a central element in staff professionalism. Supervisors and managers should encourage and reward positive communication with inmates and positive staff-inmate relationships. They must also model these qualities themselves when they interact with inmates.

2. Supervisors and managers must not tolerate staff who swear at, insult, talk down to or play verbal games with inmates. Organizationally, HoC must move to insure that staff have had well designed, practical and effective in-service training emphasizing communication skills, conflict resolution and crisis intervention. Along with that, supervisors and managers must hold staff accountable when they are verbally unprofessional or otherwise inappropriate with inmates.

3. Part of the cultural change required at HoC is recognition by all staff that providing service to inmates is a major part of the staff job. It can be argued that staff have the right to have any attitudes they wish, including attitudes that may be ugly. However, staff clearly have no right to act on those attitudes or express those attitudes on the job.

4. The plan to conduct staff satisfaction surveys should be extended to also include inmate satisfaction surveys. These should be done quarterly. As a practical matter, there are too many inmates at HoC to survey all inmates. Rather, some random sampling method should be used and a target of 5 to 10% of the total population would likely be manageable while still providing reliable data that could be generalized to the entire population. HoC does not need to develop such a survey, or even the procedures for sampling the inmate population and administering the instrument, as there are other jails that have already done that work. In particular, the consultant has had recent contact with the Sheriff's Office jail in Ada County (Boise), Idaho and they have such an instrument and an established procedure for administering it. An additional

advantage would be the opportunity to "bench mark" survey results against those from another jail.

I. Budget and Fiscal Control

1. HoC should have its own budget and finance manager or an administrative officer with budget and other fiscal matters as the largest portion of the position's duties. In either case, the position should be part of the HoC leadership team and report directly to the Superintendent.

2. Staff down to the Correctional Manager level, including comparable level civilian managers, should be involved in the development of the HoC budget, and also involved in budget administration. (In the future, these responsibilities should be extended to the Lieutenant level).

3. HoC managers should review the organization's actual income and expenditures against budgeted projections on a monthly basis.

4. HoC should plan to enhance revenue generation and manage against that revenue plan.

5. HoC should explore contract possibilities with the US Marshall's Office or ICE, provided such contracts would be revenue positive and provided population management efforts at HoC or countywide have been successful enough to free up additional bed capacity.

6. HoC should analyze the actual costs per day for municipal inmates and for state inmates and attempt to renegotiate those arrangements on a cost neutral basis.

7. HoC should explore its options with regard to either charging the state for VOP inmates or, in the alternative, refusing those inmates at HoC.

J. Personnel Issues

1. (No recommendations)

2. The HoC Personnel Manager

a. It is unrealistic to expect that one person, no matter how competent, can straighten out the mess that has developed over time with the HoC personnel function, while at the same time dealing with issues of crisis proportions such as overtime and forcing, abuse of leave, revamping the hiring process, etc. HoC or County HR should consider assigning a subordinate personnel analyst to the HoC Personnel Director for 12 to 24 months. When some of the crises have been managed and some of the backlog of inaccurate and missing data and inappropriate policies and procedures have been satisfactorily addressed, the level of

necessary on-going support may well be part-time and clerical or part-time from an analyst. Currently, the task is unmanageable for one person and is a recipe for burn-out.

3. Hiring

a. The HoC hiring process for the correctional officer position should be reinvented with a goal of being able to make an offer of employment within 10 days of the time the individual completes the application form. It may be necessary to conduct the background investigation in two parts, with all aspects that can be completed within several days constituting a preliminary background result, and the offer of employment contingent on a complete and final background investigation, which may require an extra week or 10 days. Since HoC wants to start new employees in small groups, rather than individually, so that they can go through the orientation class and the FTO program as a small group, delaying final the removal of the contingency on employment offer would typically not be lengthy enough to create problems.

b. HoC should transition to a hiring exam designed specifically for correctional officers and normed upon a correctional officer population.

c. HoC should similarly use a written psychological instrument that is designed for use and/or normed against correctional officers.

d. The employment exam for correctional officers should be given continuously, if possible, as soon as an applicant has completed the written application and age, driver's license and educational requirements have been provided by the applicant. If continuous testing cannot be arranged, then efforts should be made to offer the written exam and psychological written instrument weekly or bi-weekly, to small groups of applicants, rather than waiting months and administering the instruments to very large groups of applicants, as is currently the case.

e. The written exam should be scored on site.

f. The various steps in the selection and hiring process should be administered in a logical sequence that is designed to keep the process as short as possible while also saving the county money. For example, a records check should be at the front end of the process and a physical exam at the back end of the process.

g. The minimum age requirement for the Correctional Officer position at HoC should be changed from 18 years to 21 years of age.

h. The hiring process should be jointly coordinated by the County HR staff and the HoC Personnel Director. The portions of the process that are the responsibility of HoC (background investigation, final job interview, etc.) should be supervised by the HoC Personnel Director.

i. A traditional law enforcement or corrections oral board interview should be substituted for the current interview being conducted by the background investigator, with regard to correctional officer recruit selection.

j. For more detail on some of these recommendations and the recommendations in the following section on overtime and forcing please refer to my email of October 1, 2007, to the HoC Superintendent, with a copy to the County HR Director.

4. Overtime

a. HoC should give priority to protecting days off with regard to forcing. Where possible, minimum staffing needs should be met by forcing officers for four hours rather than eight hours and those four hours should be contiguous to regularly scheduled shifts. The current practice of forcing only within the same shift should be abandoned and forcing across shifts should be permissible and used before any forcing is done on scheduled days off.

b. Uniformed staff should be provided with incentive for volunteering for over-time. That could be a "get out of jail free" card which could excuse the officer from a forced shift of his or her choosing and that card could be given on an hour for hour basis or could be given for four hours in return for eight hours of volunteering. Other methods of encouraging staff to volunteer for overtime, and incentives, should be explored.

c. The practice of allowing staff to call in sick three days in advance, with a single phone call, should be discontinued.

d. The practice of restricting forcing to three days in advance should also be discontinued. The net result of this change and the change recommended directly above would be to eliminate any advantage for staff in calling in sick for more days than are actually necessary.

e. Abuse of sick leave and abuse of FMLA should be pursued aggressively at HoC with all necessary support from the county. The expectation that staff can abuse these kinds of leaves with impunity must be broken.

f. The county should explore whether it is obligated by law to honor medical directives for "intermittent FMLA." If legally permissible, the

county should consider requiring each separate use of intermittent FMLA to be separately justified. If that cannot be done, the county should invoke its prerogative to require additional medical evaluations with a physician of the county's choosing. Most public agencies have never heard of "intermittent FMLA" and the notion of staff taking time off regularly but intermittently on a schedule that they themselves establish, is most difficult to accommodate and has a strong negative influence on other employees and on the culture of the organization.

g. IOD claims should also be vigorously investigated by the county until the overall level IOD usage is comparable to other county agencies and/or to other correctional agencies nationally.

h. A positive attendance record should be an important criteria in promotion and in special assignments and the like. A pattern of abuse of sick leave, FMLA or IOD should be disqualifying for those opportunities.

i. The County should consider redesigning its policy on payout of sick leave at retirement. The cap on number of hours paid encourages staff to "burn off" any sick leave over that number of hours while still in active duty, or "lose" hours that most staff regard as their earned time. If the County paid a percentage of all remaining sick leave (perhaps 75% of current salary rate at retirement, for all sick leave hours) staff would have an incentive to retain as much sick leave as possible.

j. Light duty positions should be identified for as many IOD cases as possible.

k. HoC should explore brining retired correctional officers back on a part-time basis to alleviate the overtime crisis.

5. Recruitment

a. County HR should work closely with HoC staff on correctional officer recruitment.

b. HoC should consider offering the current workforce tangible incentives for recruiting successful candidates. In some agencies, staff have been given a cash incentive for recruiting a successful applicant. The payment is often conditioned upon the applicant's successful completion of the recruit academy but sometimes the payment is split with part of it paid at the point at which applicant accepts the offer of employment and the rest of it payable when the applicant successfully completes the probationary period. Another approach has been to provide days off as the tangible incentive for bringing in a successful applicant.

c. If HoC recruitment goes reasonably well, there may be no reason to need to consider tangible rewards. However, members of the current workforce should at least be encouraged to recruit for the agency.

d. In general, HoC should use narrowly targeted recruiting efforts rather than mass-media approaches and an attempt should be made to identify the way in which various applicants found out about the opportunity for the Correctional Officer position. In that way, data on the effectiveness of various recruitment methods can be collected continuously and it is then also possible to analyze which recruitment methods produced the most and least successful applicants.

6. Retention

a. HoC should initiate exit interviews, as planned.

b. Turnover should not be regarded as a crisis. The turnover rate for the past year and one-half has consistently been in the moderate range and there is every reason to believe that as some of the other serious and deep seated HoC problems are addressed and mitigated (staff morale, for example) the turnover rate will decrease significantly.

7. Staffing

(No further recommendations)

8. Promotions

a. The consultant did not review the promotional process at HoC. (The promotional process was alluded to briefly in the Organizational Culture section of this report).

b. Promotional procedures and promotional decisions are unusually sensitive in any law enforcement or correctional agency. Since there is continuing displeasure among some members of the workforce about the last large group of promotions at HoC, it is particularly important that the promotional process be reviewed for transparency, objectivity and fairness. HoC should consider an assessment center approach rather than the more traditional oral board interview for future promotions.

K. Staff Training

1. Staff training at HoC does not need to be reviewed as much as it needs to be reinvented. Staff development issues should be rethought without the constraints of past practices and expectations.

2. Consideration should be given to changing the title and rank from "Training Officer" and Sergeant to "Training Manager" and Lieutenant.

3. The Training Officer or Training Manager position should be used as a career development opportunity, with expected tenure of three to four years, but with a restriction by policy mandating a change prior to the end of the fifth year in any case.

4. Training records should be organized and automated, and then backed up off-site.

5. Training records should be automated in a way that would allow management to immediately review training completed by job classification ("what percentage of the Sergeants have received training on HAZMAT response and when did that training occur and for how many hours?"), by individual staff member, by course or by instructor.

6. A standardized training evaluation form should be developed that is at least substantially numerical and the numerical rating averages for any particular class should be entered into the training data base so that student evaluations can be contrasted for different instructors, for different courses, etc.

7. HoC should have a separate and realistic training budget. That budget should only cover training needs and should not include camouflaged items for other areas such as CERT or the K-9 Unit.

8. HoC should by policy require a minimum of forty hours of in-service training for all uniformed staff. That exceeds the twenty-four hour requirement for the State of Wisconsin but is consistent with national standards and will help with some of the large-scale remedial efforts that now confront staff development at HoC.

9. In-service training for Sergeants, Lieutenants and Correctional Managers should be developed and/or designed for superior officers and should be markedly different from training given to front line staff. There may be occasions when front line staff are receiving training that is essential for superior officers as well. In those situations, superior officers should attend the in-service training for front line staff but then additionally training provided for the superior officers.

10. The top administrators at HoC should audit in-service training for front line staff with some regularity. When a three day or five day in-service training program for front line staff is offered, a top administrator should attend the beginning of the course each time it is offered in order to provide an appropriate introduction and to underscore management's commitment to that particular training.

11. The leadership team at HoC should be deeply involved in decisions about training priorities and training content.

12. The urgent training needs at HoC will take two or three years to complete, at a minimum. By then, other urgent training needs will have emerged and will still be unmet. Rather than trying to do a small amount of training on a relatively large number of important topics, HoC should develop a high-quality, comprehensive, detailed, correction-specific and practical training program in one of these crucial areas, complete that training with the entire uniform workforce (with civilian employees included as appropriate), and then move on to the next training need. In short, it will be much more effective to do an excellent job with one training objective than to do a superficial or poor job with a number of objectives.

13. The most obvious training priorities for HoC are security procedures, direct supervision, conflict resolution and crisis intervention (including a strong foundation of communication skills), emergency preparedness and staff professionalism. The plan to send two staff members to NIC to be trained as instructors in direct supervision is an excellent idea to meet a high priority need.

14. The top priority for Sergeants, Lieutenants and Correctional Managers is a well designed, practical and corrections specific course on how to supervise and manage effectively. That course should not rely upon management game playing or paper and pencil assessments of management style, but should rather be skill-building in nature. It is clear that supervisors and managers will need to attend the line-level training on security procedures, so that they are fully familiar with the methods and expectations given to their subordinates. In addition, supervising and managing direct supervision issues will be a high priority for this group and more extensive training on an emergency preparedness system (as soon as HoC develops or adopts such a system) is an even high priority. Staff professionalism and ethics is a need at the superior officer level and that training should be different for supervisors and managers than for front line staff.

15. HoC should continue with its quite recent decision to send staff to NIC training as often as possible. Not only is this training without cost to HoC, it allows staff members from HoC to network with jail staff from other large jails around the country and to generally broaden their professional perspectives.

16. Once the very highest priority training objectives are underway for front line staff and for supervisors and managers, some attention should be given to designing or identifying leadership development activities for the Correctional Managers and the members of HoC's leadership team. Those activities may sometimes consist of formal training but at other times will include other kinds of professional exposure and job enrichment.

17. The FTO program should be enhanced with better defined evaluation responsibilities for the FTO's and an identified list of procedures and tasks that the FTO's will be responsible for showing to their recruits and then observing the recruits performing those tasks. The selection of FTO's should receive careful attention and only staff with good professionalism, a positive attitude and a reasonable record of attendance should be considered for the FTO programs.

L. Direct Supervision

1. Correctional officers working dormitories, cellblocks or other inmate supervision positions should be assigned for a minimum of a ninety-day rotation and one hundred and twenty days would be preferable. In general, correctional officers should be rotated from dormitory positions to non-dormitory positions.

2. All uniformed staff and the members of the leadership team should complete an intensive in-service training program covering how direct supervision is intended to operate.

3. The officer station in every dormitory at HoC should be retrofitted with a computer.

4. The threat of group punishment and actual group punishment in dormitories should be sharply reduced as should the use of segregation. These changes should be natural results of the application of solid direct supervision methods.

M. Security

1. By agreement, specific security recommendations have been presented separately, confidentially and informally to Superintendent Ron Malone and – as was true of the observations and conclusions regarding security at HoC – are outside the scope of this technical assistance project. The same reasons apply.

2. Security procedures should be at the center of one of the broad HoC initiatives designed to transform the agency. Once that security initiative ("back to basics," or something similar) has been in place for perhaps a year or eighteen months, it will make excellent sense to then commission a thoroughgoing external security audit of HoC. To attempt such an audit initially would be a waste of time and money and the results would be so voluminous and negative that the effort would be counter-productive.

N. The Escape

1. HoC does not have a history or expectation of conducting critical incident reviews nor does it have a specific protocol for that kind of effort. HoC should adopt a policy requiring a critical incident review following a major

incident such as the escape that occurred, a disturbance, a suicide, etc. A specific procedure, or protocol, should be developed. The results of critical incident reviews should be disseminated widely through the organization as a learning tool. Specific exemptions because of ongoing litigation or continuing personal actions should be drawn as narrowly as possible. Sometimes critical incident reviews should be applied to "near misses" even though the incident in question did not develop into a disaster.

2. HoC should review the escape with regard to all of the security breaches and other performance and procedural issues that is raises. These issues should then be examined agency-wide to see if they are prevalent. Where necessary, they should be corrected immediately. (The same approach should be applied to the situation involving the CCC inmate now charged with a drug related murder).

3. The aftermath of the escape as well as the aftermath of the charging of the CCC inmate with murder, suggest that HoC needs to develop a public information plan that includes consideration of dealing with the media, the community and other governmental entities during and after an HoC crisis.

O. Fire Safety

1. The CCC fire alarm system should be tested immediately. If broken, it should be fixed immediately. If there is to be any delay in ensuring that CCC has a working fire alarm system, drastic measures should be considered. Perhaps a portable alarm and/or battery-operated detectors can be installed for the short run. Perhaps the residential part of the building must be closed until an alarm system is functional.

2. Fire hoses and fire extinguishers should be inspected (and hoses tested under load), current inspection tags appropriately affixed and fire cabinets repaired where necessary.

3. Fire evacuation routes should be posted by the officer's stations and by the stairwells at either end of the residential floors at CCC.

4. At CCC and at the Franklin facility, fire drills should be initiated immediately. Since staff and inmates are unfamiliar with fire drills in those facilities, and since drills and exercises should always be designed to teach staff and inmates success rather than failure, it may be a good idea to start with drills that are announced in advance and only after staff and inmates have had appropriate briefings on routes and procedures. However, even preannounced drills should be full evacuation exercises.

   Both facilities should quickly proceed to the point where fire drills are unannounced and a surprise to inmates and staff alike. However, every fire drill should be timed to the point of full evacuation and then timed to the point at which the complete evacuation is confirmed by count at the relocation point or by search of the evacuated area. Every fire drill should be observed

by at least two non-participants (and typically more) who are trained as fire drill observers and have adequate expertise to identify strengths and weaknesses as the drill progresses.

Each fire drill should result in a written report identifying the area of the drill, the time of day, the evacuation times and the identity of the observers. Each such report should have a thoughtful section on strengths, weaknesses and suggestions for improvements.

Every living area of each facility should by policy be required to complete a full evacuation fire drill at least once each quarter and each shift in each living area should be required to have an evacuation drill at least twice each year. That standard should apply to the three cellblocks and the hospital infirmary, even if it is necessary to bring in some extra staff on overtime to enable an evacuation drill of these areas while maintaining good security.

5. Flammable materials throughout HoC should be kept in appropriate locked metal cabinets. Each cabinet should include an inventory. Cabinets should not be left open or unlocked when not in use and flammables should not be stored on top of cabinets.

6. An independent individual or individuals with fire inspection expertise should be commissioned to do a detailed fire inspection at both CCC and at the Franklin facility.

7. HoC should have a staff member responsible for fire safety, whether full-time or part-time.

P. Emergency Preparedness and CERT

1. HoC needs to develop a comprehensive emergency preparedness system that begins with emergency policies and includes emergency preparations, risk assessment, emergency organizational structure issues, emergency procedures and response capacities, interagency emergency agreements, specialized emergency functions, institutional emergency manuals, aftermath procedures, training for front line staff on the entire system and a separate, more intense level of training for supervisors and managers on he emergency system. The emergency system must also include drills and exercises to test the system and further develop familiarization. If HoC does not want to develop its own comprehensive emergency system "from scratch," it should examine existing emergency preparedness systems to see if it can more easily adopt a system that has already been field tested for large correctional facilities.

2. Putting a comprehensive emergency system in place at HoC is such a large and lengthy task that it may make good sense to consider developing a "bare bones" approach to emergency preparation and emergency response, which could be developed and enacted quickly so that the organization would have some minimal emergency response capacity as an interim measure.

3. In developing an emergency plan, the document that has been identified to the consultant as the current emergency plan should be in large part ignored as it is not an appropriate foundation.

4. HoC needs to either train, develop and maintain a cadre of 8 to 12 hostage negotiators (also referred to frequently as "crisis negotiators") or, in the alternative, to make detailed arrangements with the Sheriff's Office or Milwaukee PD to use their negotiators in the event of a hostage incident at HoC. If HoC chooses to rely on outside negotiators, the agreements should include provisions that specify that the negotiators will become familiar with HoC facilities and will participate in emergency drills and exercises at HoC.

5. HoC is too large and too geographically distant from downtown Milwaukee to rely on the Sheriff's Office or Milwaukee PD for a disturbance control team. HoC should immediately revive its CERT team. In doing so, HoC should reevaluate the size and composition of the CERT team and establish minimum initial training standards and minimum in-service training standards for CERT. All of these decisions should be made realistically and practically, so that the CERT team can be supported over the long term.

6. In addition to disturbance control, HoC also needs a weapons team. Here, as with hostage negotiators, HoC has a choice of developing it's own team or relying on an outside team. If HoC chooses to have it's own tactical capacity then some subset of the larger CERT team should be trained as a weapons team with lethal force capacity and for missions such as hostage rescue. The larger team would typically be called a Disturbance Control Team or a Correctional Emergency Response Team (CERT) and should consist of 30 to 40 members (perhaps 3 teams of 12 members each plus 3 team leaders and a commander at the Lieutenant or Correctional Manager level). The tactical team would typically be called SORT or SWAT and may consist of 12 members with a supervisor or manager as team leader. Both the larger disturbance control team and the smaller tactical team should include assistant team leaders, a video operator trained in the use of camcorders and a person with paramedic background or some other medical training beyond first aide.

7. HoC should appoint an armory officer. That position will initially be full time until the armory is cleaned, organized, inventoried and documented. Once the armory is straightened out, that position should become part-time but will still occupy a significant portion of an individual's workweek.

8. Once cleaned and organized, the armory should be inventoried in detail. Broken equipment should be fixed or discarded and surplus and excess equipment should be sold, traded to agencies or otherwise discarded. Following that, the armory should be inventoried on a monthly basis against checkout logs.

9. Armory access must be available on a 24/7 basis and without delay. An armory key under glass in Central Control for major emergencies is one

relatively common method of guaranteeing quick access while insuring the armory key does not circulate or get misplaced.

10. HoC should develop a checkout system for armory equipment that is tied to the armory inventory. The armory log should be used to record every entry and exit from the armory, including names of persons entering, time, date and purpose.

11. HoC needs a great deal more capacity with intermediate force and needs more intermediate force options than are currently available. HoC should maintain a minimum of four 37 mm or 40 mm launchers and a reasonable number of several varieties of chemical agent projectiles for those launchers. Additionally, HoC should also have available rubber or wooden multiple baton rounds and/or bean bag rounds for those launchers. HoC will also need inert gas rounds for training and inert smoke rounds for operational purposes or training. In addition to projectiles for the launchers, HoC should maintain a reasonable supply of hand-thrown gas grenades of two to four different types in the armory. HoC should also purchase at least two pepperball systems and train first and second line supervisors and the members of the emergency teams with that system.

Q. Use of Force

1. HoC should develop and adopt a new Use of Force policy. It should be far more inclusive and far more helpful and directive for staff than the current document.

2. The Use of Force policy should include a requirement that all use of force incidents be reviewed and the policy should specify the provisions for such review and the criteria for progressing from the review to an IA investigation.

3. Aerosol OC should be carried by all Sergeants and all Correctional Managers as well as all Lieutenants. These staff must of course be trained in the use of OC before they are issued the chemical agents to carry. HoC should consider issuing OC spray to all uniformed staff members.

4. A separate form should be developed for Use of Force reports. The Use of Force policy should mandate that every staff member using force or observing the use of force in an incident shall independently complete a Use of Force report.

5. As a matter of procedure rather than policy, HoC should standardize the manner in which cell extractions are accomplished.

6. The Use of Force policy should include both sublethal force and lethal force issues rather than maintaining two separate policies as is now the case.

7. The new Use of Force policy should reject the concept of a "rigid" use of force continuum and should make a fundamental distinction between reactive uses of force and planned uses of force.

R. Inmate Programs

1. HoC should develop a medium range plan to expand employment opportunities, educational and vocational training opportunities and other programmatic efforts so that the majority of inmates housed at HoC participate in some meaningful activity rather than being warehoused.

2. If population management efforts are successful on a countywide jail basis or more specifically at HoC, consideration should be given to converting two to four dormitories into semi-permanent program space. An alternative would be to bring one or more portable buildings into the Franklin compound to provide additional classroom space and group meeting space. That alternative raises a number of security issues and other operational challenges however, and is expensive. There may be better answers but if HoC is to expand program and work opportunities for the inmate population, HoC will have to find more space for those programs.

3. HoC will need more financial resources in the program and employment area if more inmate opportunities are to be created. HoC inmate programs are already in a precarious position with regard to the proportion of the program effort that is supported by volunteers, other agencies, grants and Federal and State contracts. Some core of inmate programs likely need to be established on tax levy funds. If program and employment opportunities cannot be expanded at HoC, consideration should be given to changing the statutory mission of the organization so that there is a realistic chance for the agency to accomplish it's statutory mission.

4. In expanding inmate programs, HoC should pay particular attention to the development of programs that are appropriate for inmates serving short sentences.

5. HoC should explore alternative or additional women's vocation programs that would employ more individuals with better chance of post-incarceration employment then the print shop currently offers.

6. HoC should explore the possibility of private industry programs that could operate within HoC on a revenue positive basis while providing good wages to inmate workers and excellent potential for post incarceration employment. There are many such "free venture" programs in prisons and jails across the country that would provide models for HoC.

7. HoC should explore the possibility of organizing community work crews operating from HoC or CCC. Single gender work crews would be driven into the community in a large van by a correctional officer or civilian work

supervisor and could perform a wide variety of tasks ranging from road and park clean-up to clean-up, maintenance and minor construction projects for state and local public agencies and for non-profits. Services could be billed at a very low rate that would still pay for the salary of the staff supervisor and transportation costs, and perhaps some overhead, in order to keep the operation approximately revenue neutral. Inmates working in such a program should be dressed in highly visible HoC coveralls or jumpsuits so that community members recognize the source of the service being provided.

8. The plan (or lack of plan) to close CCC and to transition all work release inmates to ES and to transition all ES inmates from voice recognition monitoring to GPS monitoring, should be reconsidered, assumptions should be carefully examined and detailed plans should be developed based on best practices and historical experience in other correctional agencies.

   In particular, there must be recognition that ES provides a much lower level of supervision and support for inmate than does residential work release. That fact is quite independent of the kind of ES monitoring that is used or the specifics of the residential work release program.

   There is a danger that HoC will abandon its work release program as a cost saving measure without adequately investigating or planning a workable alternative. There is also a clear possibility that the county will push to close CCC because of the exceptionally poor security practices there and the recent high profile homicide arrest. The result could be to "throw out the baby with the bathwater."

9. HoC should determine what proportion of the work release inmates would be poor candidates for ES because of their lack of stable housing arrangements or inability to make enough money to support rent and living expenses in addition to the fees for the ES program. HoC should similarly determine the proportion of the work release inmates that would be poor candidates for ES because of their need for a higher level of supervision and structure or their inappropriateness for 24/7 community placement because of their criminal histories.

10. Financial eligibility requirements for both work release and ES should be examined and procedures should be developed so that indigent inmates incarcerated at HoC but otherwise qualified for work release or ES, could begin those programs without payment of substantial fees in advance. The practice of sending inmates back to HoC to "work off" debt to HoC at a set amount per day of incarceration, should also be reviewed with the goal of identifying alternative solutions. While almost no one believes that the criminal justice system can be made completely blind to money and to differences in socioeconomic class, incarcerating individuals who would otherwise be free in the community if they had financial means, when there is no nexus between the individual's financial status and public safety, brings us perilously close to the old English concept of debtor's prisons.

11. HoC should work closely with the courts to develop mutually acceptable criteria for when and how quickly the courts will be notified that an offender is out of compliance with the work release program or the ES program. Some discretion must be afforded to HoC staff to distinguish between acceptable and unacceptable reasons for failing to comply with program guidelines but the degree of discretion should be limited and there should be an established objective number of violations that mandates court notification. Serious violations should be reported immediately, without waiting for the accumulative effect of additional violations and HoC and the court should work with well established timeliness criteria for court notification.

12. The decision to eliminate the contract with Wisconsin Correctional Services (WCS) and replace those services with a single staff position devoted to job finding, should be revisited. The WCS Employment Services currently available to offenders at CCC or as a prelude to qualifying for CCC, are quite broad and serve a relatively large number of offenders. It appears unrealistic that those services can be replicated by a single staff position when WCS has long standing and deep experience as well as existing relationships with a relatively large network of potential employers. (For example, what will happen to inmates who could qualify for work release or ES if they were able to find employment but are incarcerated at HoC and cannot work with the staff member in charge of job placement because he or she is on annual leave?) The Job Placement Specialist position appears to be designed more to support the decision to close CCC and eliminate the work release program than to meet the employment needs of HoC offenders.

S. Inmate Grievance System

1. HoC needs to develop an effective inmate grievance system. The current inmate grievance procedures at HoC may not be an adequate base to build upon and it may be necessary to begin anew. If that is the case, there are many state and local correctional agencies that have well-established grievance systems which would provide excellent models of grievance policies, forms, timeliness standards, appeal procedures and the like.

2. No grievance system will be effective unless it is taken seriously by staff and monitored regularly by the organization's top leadership.

3. Timeliness standards must be developed and then adhered to if the grievance system is to have any credibility among inmates. Reports on the percentage of grievances responded to within established time requirements should be compiled on a monthly basis and forwarded to management for their review.

4. The practice of sending grievances to the staff member complained about or the staff member in charge of the service or program grieved, and then sending the answer back to the inmate without any level of review and whether or not the response is sensible or relevant, should be immediately discontinued.

5. Every grievance received should be logged in and its progress should be documented.

6. A Sergeant or Lieutenant should be in charge of the grievance system and it will initially be a full-time duty. With the size of the inmate population at HoC, it may not be possible to later reduce the assignment to part-time, but time will tell. The person in charge will almost certainly need a full-time civilian employee whose duties will be primarily clerical.

7. A monthly summary of grievances should be compiled that reflects, in addition to timeliness information, the total number of grievances for the month, the number of grievances by subject matter grieved, the distribution of grievances by housing areas of HoC, the percentage of grievances determined to be well-founded, the percentage of grievances taken to the second and third levels of the grievance system, and the percentages of dispositions at those appellate levels, etc. The grievance data for the current month should be contrasted with the running average of grievances over the past three months and with the data from the same month of the prior year.

T. Inmate Discipline

1. HoC should conduct a comprehensive review of the inmate disciplinary system.

2. A Lieutenant should be identified as in charge of the inmate disciplinary system. HoC should consider giving that Lieutenant "programmatic" responsibility for the three cellblock areas as well.

3. The Lieutenant in charge of inmate discipline should not be a hearing officer. Instead, a small cadre of supervisors and/or mid-managers should be trained as disciplinary hearing officers.

4. Staff working the cellblock posts should be trained to review the paperwork justifying placement of an inmate into one of the segregation areas. If the paperwork accompanying an inmate is incomplete, staff working the cellblock areas should refuse to admit the inmate until the paperwork is corrected and complete.

5. The current plan to move to a written warning system for minor infractions such as verbal disrespect or disobeying a staff order, should be initiated and tested. If that approach does not prove workable, HoC should try other alternatives to reduce the overall amount of segregation time and the use of segregation for relatively minor infractions.

6. The O2 cellblock should be staffed with two correctional officers, rather than one, on all three shifts. It would be possible to staff that post with one officer on the graveyard shift, providing there was a policy requirement that the officer call another officer and have that second person present before any cell

door is opened. If the cell doors in O2 were retrofitted with handcuff ports (which would also serve as food ports) then the requirement for two officers might be eliminated because doors would not have to be opened for meals and inmates could be placed in restraints before coming out of their cells for any reason.

O2 will likely remain a difficult area for both staff and inmates because of its relative isolation. HoC should review the kinds of inmates sent to O2 and work to keep the population in that cellblock as small as possible.

7. HoC should carefully review the O2 area with regard to suicide prevention. Considerations should be given to retrofitting several of the O2 cells with closed circuit cameras feeding monitors at the O2 officer stations and or master control. Camera observation should be regarded as a supplement to, and never a substitute for, personal observation.

8. The practice of conducting disciplinary hearings at cell fronts should be discontinued immediately.

9. The practice of delaying inmate disciplinary hearings when an inmate chooses to contest his or her guilt, should be discontinued immediately.

10. The practice of identifying some segregation inmates as "keep-ins" and allowing those inmates out of their cells for an hour two times per week, should be discontinued immediately. Inmates who represent an ongoing assault threat to staff or cannot be treated in the same manner as other segregation inmates for some other reason, should be clearly identified with a magnetic marker or other highly visible sign next to the inmates cell door as well as clear identification on the board listing all inmates in that segregation unit (so that even a relief officer does not inadvertently overlook the inmates special status). Special procedures should be designed and adopted for these inmates, such as a requirement that two or three or four staff members be present prior to opening the cell door or escorting the inmate for exercise or a shower. That kind of special procedure should always be a response to the inmate's threat level and never a punishment for something the inmate has done. All segregation inmates should be kept locked up on a 23/7 basis, with one hour out of cell time for shower and exercise, a minimum of 5 days per week (seven days per week would be more typical).

11. The prohibition against holding disciplinary hearings during the first twenty-four hours after an inmate is placed in segregation should be eliminated. Every inmate should be given a copy of the charges against him or her and given an opportunity to study and consider those charges, and then the inmate should be asked whether he or she needs assistance, wishes to contest the charges, wishes to call witnesses or wishes to question the officer writing the infraction. If the inmate has had adequate opportunity to review the disciplinary write-up and charges, then the disciplinary hearing can be

scheduled as quickly as is practical. Disciplinary hearings should not be unduly delayed in any case.

12. The Lieutenant in charge of the inmate disciplinary system should prepare a monthly summary report indicating the number of disciplinary write-ups, the offenses involved, the number of contested hearings and their disposition, the percentage of disciplinary hearings held within timeliness standards and the current population and composition of that population on each of the three cellblock units. The summary data should be contrasted with the running average of the three prior months and with the data from the same month of the prior year. These data provide an additional metric on the effectiveness of change efforts at HoC. While some level of disciplinary action is inevitable in a large correctional facility, it also true that a very well run correctional institution will typically have very few inmates on disciplinary segregation, and the opposite also holds.

U. Medical Services

1. Top management at HoC should work much more closely with the medical administration. HoC management should have access to the medical budget and regularly review medical expenses at HoC. HoC top managers should meet regularly, at least monthly, with the Medical Director, the Director of Nursing and the person with overall responsibilities for mental health services as well as the people in charge of those services at HoC.

2. If medical and mental health services continue to be provided under an umbrella agreement with the Sheriff's Office, there should be a designated lead supervising nurse, lead physician, lead psychiatrist and lead psychiatric social worker at HoC.

3. The current situation with prescription medications at CCC should be discontinued immediately. Correctional officers should not dispense medications. Either CCC inmates should keep and self administer all of their own prescription medications, without CCC staff involvement, or CCC should have a nurse dispense prescription medications twice a day.

4. HoC should reexamine the question of providing medical and/or mental health services to CCC inmates. When it appears that a CCC inmate may have a serious medical or mental health problem, either by staff observation or self report, and when the inmate cannot or will not secure medical assistance in the community, there should be some provision for sick call at CCC with emphasis on triage and referral.

5. Two changes are in order with regard to inmate requests for medical services. First, timeliness standards should be established clearly for triaging medical request slips once collected, and also for scheduling someone for general sick call once the request slip has been triaged. A quality assurance protocol should be used on an intermittent but regular basis to measure compliance with the

timeliness standards. The second change is that as soon as a medical request slip is triaged, feedback should be given to the inmate who has submitted the request as quickly as practical, with specific information about the disposition of the inmate's request. That will reinforce the credibility of the medical request procedures and also decrease workload and confusion caused by multiple medical request slips from the same inmate concerning the same problem.

6. The medical screening process for intake (new HoC inmates) should be expanded from paper screening to include a brief face-to-face interview with a member of the nursing staff and the taking of vital signs. HoC appears to have a staffing pattern for nurses that would allow this change. HoC should adopt policy that provides nurses working intake with the discretion and responsibility to refuse admission, pending a hospital clearance, to any inmate who appears to be in medical distress, seriously injured without appropriate medical care for those injuries, floridly psychotic or acutely suicidal.

V. Mental Health

1. A specific procedure or protocol should be developed for requests for mental health services from line staff or supervisors, including appropriate documentation.

2. One dormitory at HoC should be used for the more serious mental health cases. Some kind of intermediate care (or "transitional") mental health program should be in place in that dormitory. Staff volunteering to work in that dormitory should be exempted from the mandatory rotation schedule and should be allowed to keep that assignment on a permanent or semi-permanent basis if they are effective and develop expertise in the area.
The program should not be referred to as "special needs" because a second HoC dormitory should be dedicated to what are more properly referred to as "special needs" inmates. (That dormitory should be reserved for geriatric inmates, inmates with serious physical handicaps and developmentally disabled inmates). The intermediate care mental heath dormitory should include a well thought-out mental health treatment program, designed with consultation with the psychiatric social workers, psychiatrists and psychiatric nurse at HoC. Again, other large jails can be contacted to find a variety of intermediate care mental health programs that are currently in use.

3. Even if HoC is able to substantially improve its in-service training emphasis on psychiatric and suicidal issues for uniformed staff, there is still a need for some mental health presence on the HoC living units. It is recommended that the PSW's divide the dormitories and cellblocks into approximately equal numbers and that each PSW visit each of the dormitories for which he or she is then responsible, on a twice weekly basis. These visits can be relatively quick. The PSW should not be responsible for talking to or observing all of the inmates in the dormitory. Rather, the PSW should check with the correctional officer in the dormitory and see if there are inmates the officer is concerned about

because of potential psychiatric or suicidal issues, but where this situation is not clear enough that the officer has referred the inmate to mental health. In those cases, the PSW can talk with the inmate on the spot, or can schedule a time to return to the dormitory or for the inmate to meet with the PSW at his or her office. This procedure will be substantially enhanced once correctional officers have stable, longer term assignments within the same dormitory.

4. All of the issues surrounding the management of suicidal inmates at HoC should be subject to a thoroughgoing review. The psychiatric staff at HoC are not comfortable with the manner in which potentially suicidal inmates are handled, and neither was the consultant. Fortunately, there has not been a high incidence of suicide at HoC. Without discounting the very serious concerns of HoC staff about suicide, and their very serious efforts at suicide prevention, there are at least two factors which may help explain why suicides have not been more frequent at HoC. First, group living arrangements seem to help with suicide prevention and the open bay dormitories at HoC do not foster or facilitate suicidal behavior in the way in which single cells do. Second, a large proportion of jail suicides are committed during the first seventy-two hours of incarceration and first time offenders are also disproportionately involved in "successful" suicides. At HoC, most offenders come from CJF where they have been incarcerated more than seventy-two hours and a fair number of first offenders have been released on cash bail or personal recognizance or otherwise diverted from continuing incarceration. Still, these factors do not substitute for adequate suicide prevention at HoC.

W. K-9 Unit

1. The consultant's recommendation is that the K-9 Unit be disbanded. This recommendation is made with awareness of the long history of K-9's at HoC and of the deep commitment of the dog handlers to this program, and their professionalism. The program is very expensive both in terms of staff resources and budget. However, the program has not been well managed and the available evidence suggests that the utility of the program, which can only be gauged anecdotally in the absence of records or other data, is substantially outweighed by the resources needed to maintain the program.

2. If the recommendation above is rejected, perhaps due to the long history of K-9's at HoC or because of the current lack of any other emergency response capacity in the area of disturbance control, or for some other reason, then HoC should consider reducing the number of K-9's and dog handlers to six, which would provide one K-9 Unit on duty on a 24/7 basis. If that decision is taken, the K-9 post on the west side of the compound should be maintained and K-9 use at the vehicle sallyport eliminated. The sallyport K-9 dog handler is often not free to respond immediately to situations inside the building and the K-9 response to a developing problem is the only indisputable advantage the K-9's offer HoC.

3. There should not be concern that eliminating the K-9's will decrease perimeter security because the K-9's have been doing very little perimeter patrol, and on some shifts none at all. However, if that remains a concern either the installation of electronics on or between the two perimeter fences or the establishment of a mobile patrol position, would provide far more enhancement of perimeter security than the K-9's currently offer.

4. If the K-9's are retained, standards should be established for the activities of the dog and handler on each shift. For example, on graveyard shift it could be specified that the K-9 Unit would complete an minimum of two inside perimeter checks and two external perimeter checks as well as one tour of the fish hatchery and the farm. On day shift, the specification might be that the K-9's would complete drug searches of a minimum of ten dormitories per week. (These are hypothetical examples and not specific recommendations).

X. Sanitation

1. The entire Franklin facility should be brought to a high level of cleanliness and maintained in that fashion. The North building and the North kitchen will need a great deal of attention to accomplish that. All public areas and staff offices should be maintained at the same standard.

Y. Maintenance

1. The current effort to organize and clean the maintenance area should be supported and quickly completed.

2. The current effort to inventory tools and other maintenance items and supplies should be given high priority.

3. A tool control system with appropriate checkout procedures should be developed and used as quickly as possible. HoC should check with several other jails or prisons and get the details of their tool control systems before finalizing such a system at HoC. (There is no need to reinvent the wheel in this area).

4. The entire maintenance area should be inventoried on a monthly or quarterly basis and class A tools should be inventoried either at the beginning and end of each shift or once per day at a set time.

5. Disposable items that present a security threat, such as hacksaw blades, should be disposed of following a specific procedure.

6. As covered under Fire Safety, metal flammables cabinets should be inventoried and kept closed and locked and should contain a running inventory log. Flammables should not be stored outside those cabinets.

7. Acetylene torch tips should be stored separately from the gas cylinders and the rest of the torch, under lock and key with other class A tools.

8. Maintenance contractors should be subject to the same or more stringent inventory and tool control measures as are used by HoC maintenance staff.

9. If CCC is kept operational, a maintenance and rehabilitation survey should be conducted throughout the building to identify, cost and prioritize necessary repair and rehabilitation projects there.

10. If CCC remains open, some cosmetic items, such as repainting, would go a long way toward improving the living environment within the building.

11. The maintenance requests and work order system should be automated immediately. That part of the Eagle software which was purchased several years ago should be put into operation without waiting for data entry on all of the HoC equipment and infrastructure. The work order queue and the status of individual maintenance requests should be accessible by computer by any staff member at HoC.

12. HoC should rehabilitate the North building dormitory bathrooms as a matter of very high priority. Other maintenance issues in the North building dormitories need systematic attention.

Z. Food Service

1. The North building kitchen should be thoroughly cleaned and repaired as necessary and maintained in the same condition that the consultant observed in the South building kitchen at Franklin.

2. Serving lines during meals should be closely supervised by staff.

3. Yeast should be stored more securely and subject to a checkout system tied to a perpetual inventory.

4. Security staff should regularly observe and review security issues (for example, yeast and knife control) in the kitchens.

AA. Intake and Classification

1. A decision should be reached, preferably by management staff at CJF and management staff at HoC working together, with regard to whether something will be done jointly with classification in the two jails.

2. If the recommendations of the prior technical assistance report on classification are not adopted, the reasons for not following that general direction should be specified in writing.

3. It is again recommended that a modern objective jail classification system would be a major improvement both for CJF and HoC.

4. HoC should train a small cadre of staff as classification officers or classification specialists, following the adoption of a specific objective classification system.

5. A classification committee should be established. That committee should review serious disciplinary incidents to determine whether some involved inmates should be reclassified upward as a result of the incident that led to segregation. Similarly, the classification committee should meet and consider reclassifying some inmates downward based on length of time in the institution or based on a recommendation from staff.

6. An inmate's classification should be a primary determinant in assigning that inmate to a living unit.

BB. Internal Affairs

1. HoC needs it's own internal affairs and investigation capability. HoC should appoint a Sergeant or Lieutenant as the head of IA. That person should be sent to training on investigative techniques and, if possible to training specific to the IA function. The IA director or coordinator should either have HoC correctional officers working for him or her (perhaps two full-time officers), or the IA coordinator or director should supervise and manage the part-time hourly investigators. The former alternative is superior.

2. Standards should be established, along with a common report format, for background investigations.

3. Background investigators should not be involved in the final employment interview for job applicants.

CC. Facilities

1. HoC should consider whether it would be feasible to increase the capacity of the dormitories in the South building and the Annex, while decreasing the capacity of the dormitories in the North building.

2. HoC should consider differentiating the inmate population among the available areas and dormitories in a manner that enhances inmate management and supervision.

3. HoC should consider a "step" or "level" program in which different dormitories would have different levels of privileges and inmates would be able to earn their way from the entry level to higher step or level dormitories through good behavior and/or program achievement.

XIII. Epilogue

There were both positive and negative events in the wake of the consultant's second week at HoC. However, some of these had no relationship with this technical assistance project.

On the positive side, the top managers of HoC met the week after the consultant's last day on site. That meeting was intended to sort through the information that consultant conveyed informally during his closeout meeting and to develop a plan to deal with the high priority areas. On the negative side, Joe McCarthy, the relatively new Assistant Superintendent, announced his resignation from HoC effective mid-November. That is particularly unfortunate because he was from outside HoC, with "fresh eyes" and good familiarity with large jail practices elsewhere in the country.

During that same week following the completion of the consultant's work at HoC, the Milwaukee Police Department announced the arrest of an offender housed at CCC for a drug-related murder. The case was very high profile. It appears that the police were initially suspicious about this offender immediately following the murder but dropped him as a suspect because of his alibi: He said that he was in residence at CCC on the night of the murder and the CCC records verified his alibi. After further investigation, the offender confessed to the murder and explained that he typically did not go back to CCC after he finished work, as required by the work release rules. Instead, he had an associate sign him into CCC. He had done this regularly for a relatively long period of time and had spent his evenings after work with a group of drug users, around or participating in drug sales.

The escape that occurred in August, before the consultant arrived in Milwaukee, and this arrest of an HoC inmate for murder that occurred just after the consultant completed his on site work, provide symbolic and dramatic bookends for this technical assistance project and they underscore the breadth and depth of the basic security issues at HoC.