Correctional Management Review

Milwaukee County Jail

Milwaukee, Wisconsin

October 2024

Creative Corrections findings and recommendations herein are based on information gathered during the site visit and are limited to the scope and time frame of the engagement. This report does not constitute legal advice.

Acronym Glossary

AA	Alcoholics Anonymous
CDC	Centers for Disease Control
CMR	Correctional Management Review
CQI	Continuous Quality Improvement
CRC	Community Reintegration Center
DHO	Discipline Hearing Officer
DOC	Department of Corrections
EO	Executive Order
EPA	Environmental Protection Agency
FIFO	First-In, First-Out
FMLA	Family Medical Leave Act
GED	General Educational Development
GFCI	Ground Fault Circuit Interrupter
HCD	Health Care Delivery
HSA	Health Services Administrator
IT	Information Technology
JCCC	Jefferson County Correctional Center
MCJ	Milwaukee County Jail
MOU	Memorandum of Understanding
MPS	Milwaukee Public Schools
MSCO	Milwaukee County Sheriff's Office
NCCHC	National Commission on Correctional Health Care
NDS	National Detention Standards
NFPA	National Fire Protection Association
NRI	National Resource Information Network
OSHA	Occupational Safety and Health Administration
OTC	Over-the-counter
PREA	Prison Rape Elimination Act
RCA	Root Cause Analysis
SCBA	Self-Contained Breathing Apparatus
SMEs	Subject Matter Experts
TTY	Text Telephone Device
WHO	World Health Organization
WI	Wisconsin

To the esteemed members of the Milwaukee County Board of Supervisors,

Creative Corrections extends its sincere gratitude for the opportunity to conduct a comprehensive evaluation of the Milwaukee County Jail (MCJ). Our team of subject matter experts approached this assessment with a deep commitment to identifying strengths and areas for improvement within the facility.

Before arriving on-site, the Creative Corrections audit team conducted a comprehensive review of conditions at the Milwaukee County Jail (MCJ). This pre-audit review focused on three key areas:

1. **Legal Compliance:** Determining whether MCJ practices align with relevant State of Wisconsin and federal laws, rules, regulations, Christensen Consent Decree, Court appointed Monitor for medical services, and correctional pretrial facility best practices.
2. **Interviews:** Interviews with Milwaukee County Sheriff's Department leadership, jail administrators, key staff at the Community Reintegration Center, Milwaukee County judicial system officials, including Court officials, the Office of the District Attorney, and the Public Defender.
3. **Mortality Reduction:** Identifying operational changes that could decrease the number of in-custody deaths, prioritizing the safety and well-being of occupants.

This thorough preliminary analysis provided a foundation for the on-site audit, enabling the team to focus on critical areas and develop targeted recommendations for improvement.

We meticulously examined MCJ operations, drawing upon our vast correctional experience and employing a multi-faceted approach. This included:

- **On-site observations:** Directly observing jail conditions and practices.
- **In-depth interviews:** Gathering valuable perspectives from both occupants and staff.
- **Policy and procedure review:** Analyzing existing documentation to assess compliance and identify potential gaps.
- **Rigorous assessment tools:** Utilizing a comprehensive framework that included:
    - Wisconsin Jail Standards (Chapter DOC 350)
    - Wisconsin Department of Corrections Inspection report November 2023
    - U.S. Department of Homeland Security-Immigration and Customs Enforcement 2019 National Detention Standards (NDS)
    - U.S. Department of Justice: National Institute of Corrections
    - National Commission Correctional Health Care Standards
    - National Commission Correctional Health Care Standards Suicide Prevention Resource Guide
    - Correctional best practices from our extensive experience performing Correctional Compliance Audits for the past fifteen years.
    - World Health Organization (WHO, 2007 Preventing Suicide in Jails and Prisons)
    - Wisconsin Board of Pharmacy
    - National Fire Protection Association
    - Occupational Safety and Health Administration
    - Center for Disease Control
    - Environmental Protection Agency
    - National Prison Rape Elimination Act (PREA) Public Law 108–79 108th Congress-2003 and PREA Standards
    - Executive Order 13166, EO 13166, Improving Access to Services for Persons with Limited English Proficiency
    - Miller, R., & Mason, S. E. (2012). Open-Ended and Open-Door Treatment
    - U.S. Department of Justice: Bureau of Justice Statistics
    - U.S. Department of Justice Office of Justice Programs National Institute of Justice, Women Offenders: Programming Needs and Promising Approaches

This extensive evaluation allowed us to develop a comprehensive understanding of the challenges and opportunities facing MCJ. We are confident that our findings and recommendations will provide valuable insights as County Officials consider strategies to improve the safety, well-being, and operational efficiency of the facility.

The Milwaukee County Jail (MCJ) faces a complex web of challenges that jeopardize the safety and well-being of its occupant population and staff. This report, based on a thorough review of the facility, reveals systemic issues ranging from dangerous suicide watch practices and a mental health challenge to critical staffing shortages and occupant overcrowding. While the jail is staffed by dedicated individuals, it operates within a system constrained by limited resources, court-imposed limitations, and a lack of essential oversight. This introduction will briefly highlight the key challenges facing the Milwaukee County Jail, facilitating a more detailed examination of specific issues and potential solutions.

This final report identifies areas for improvement at the Milwaukee County Jail (MCJ), highlighting systemic challenges that could impact the safety and well-being of occupants and staff. Here's a summary of the key findings:

1. Suicide Watch Procedures:

- **Unsafe Restraining of Occupants:** During our on-site audit, we observed an unsafe practice: suicidal occupants were being handcuffed to benches in the open booking area, sometimes for extended periods exceeding 8 hours. This unsafe restraining practice enabled the occupant to utilize an unworn leg restraint in an attempt to commit suicide. This incident occurred during our visit; an individual restrained to a bench managed to take a leg restraint attached to the floor and wrap it around his neck. He then locked the restraint and laid down on the bench to conceal his actions. Fortunately, an MCJ Officer walking by noticed his actions and intervened, calling for assistance to remove the leg iron.
- **Overuse of Suicide Watch:** Placing an average of 36 occupants on suicide watch weekly without consistent mental health assessments strains resources and potentially neglects those truly in need. The mandatory 24-hour suicide watch stay, even for individuals who are not clinically suicidal, exacerbates this issue. This concern was observed during our visit. While the Mental Health Supervisor explained the reporting procedures for suicide watch and reviewed the "whiteboard" indicating who was on suicide watch, the board showed no one on suicide watch in the booking area. However, upon entering the booking area, we discovered an individual was indeed on suicide watch, unbeknownst to the Mental Health staff. This discrepancy highlights a critical breakdown in communication and procedure.

2. Mental Health Challenges:

- **Jail Competency Evaluation Backlog:** 51 occupants are awaiting jail competency evaluations (average Wait time 3-5 months) for restoration, indicating a severe bottleneck in the mental health system. Delays worsen occupant conditions and create management challenges.
- **Medication Non-Compliance:** During our interview with the Mental Health Supervisor, she estimated that 10% of jail-competent occupants decompensate after returning from the state hospital due to medication refusal, highlighting the need for better post-release support and monitoring.
- **High Psychotropic Medication Use:** High numbers of pre-trial occupants on psychotropic medication suggest a significant mental health burden within the jail, requiring robust mental health services.

3. Staffing Shortages and Training:

- **Correctional Officer Shortage:** Despite recruiting efforts, MCJ faces a critical shortage of correctional officers, leading to the reliance of mandated overtime to fill gaps, impacting work-life balance for the jail staff.

- **Insufficient Training:** The current training model for correctional officers at MCJ presents the following concerns.
    - **Inadequate Preparation for Probationary Staff**: Probationary staff receive insufficient training in managing mental health occupants, suicide awareness, suicide prevention, and de-escalation techniques before attending the MCSO Training Academy. This lack of preparation leaves them ill-equipped to handle the complex and demanding realities of the correctional environment, potentially jeopardizing the safety and security of both staff and occupants.
    - **Insufficiently Tailored Training for Existing Staff**: Annual training for non-probationary staff needs to be more effectively tailored to the specific roles and challenges faced by correctional officers. This would foster a deeper understanding of the complexities inherent in working within a correctional setting. Real-life examples from within MCJ should be integrated into the training curriculum to illustrate these complexities and provide practical context.
    - **Positive Developmen**t: It is important to acknowledge that the training academy has recently updated its lesson plan for probationary staff to include an in-depth training module on suicide prevention and awareness. This is a commendable step in the right direction.

4. Overcrowding and Resource Disparity:

- **Overcrowding Crisis:** Overcrowding is a recurring issue at MCJ, particularly in specialized housing and mental health units. Despite regularly transferring individuals to the Community Reintegration Center (CRC) to maintain a population below the 960-person cap, the jail faces consistent challenges. These challenges include court-imposed limitations stemming from public defender shortages, a backlog in competency evaluations, a steady influx of new arrests, and restrictions on who can be transferred to the CRC.
- **CRC Transfer Restrictions:** Despite having 240 unoccupied beds, the CRC's stricter pre-trial occupant acceptance criteria severely hinder MCJ's ability to manage overcrowding.

5. Lack of Oversight and Accountability:

- **Absence of Internal Compliance:** While MCJ currently employs camera monitoring and supervisory rounds to oversee correctional officer activities and address concerns, there's an opportunity to enhance oversight through a more robust internal compliance program. Implementing a system of perpetual audits would allow for proactive identification and correction of problematic practices, strengthening accountability and improving overall operational effectiveness.
- **Specialized Unit Concerns:** The restrictive housing units lack adequate supervision, procedures, and review processes, raising concerns about their effectiveness and safety. This was observed during our visit. The staff were asked by our team where the supervisor was, and they reported “we don’t have one” a follow up question revealed that there was no chain of command to disseminate responsibilities and duties. The staff reported to the auditor “we just work out together what we need to do to get done”.
- **Additional Concerns:** Issues with key and tool control, jail sanitation, food service security, calculated use of force procedures, pre-trial occupant management, and staff supervision point to a need for comprehensive operational improvements.

This report highlights areas within the Milwaukee County Jail (MCJ) where operational enhancements can be implemented to further ensure the safety and well-being of both occupants and staff. The challenges identified present opportunities for growth and improvement. Addressing these areas will require a collaborative and comprehensive strategy involving resource allocation, policy adjustments, enhanced training initiatives, and a continued commitment to maintaining a safe and secure environment for all. These findings and more will be discussed in detail in the Results of Review section.

INTRODUCTION

This report presents the findings of the Correctional Management Review (CMR) of the Milwaukee County Jail (MCJ), commissioned by the Milwaukee County Board. The CMR, conducted by Creative Corrections Subject Matter Experts (SMEs) from October 21-25, 2024, involved comprehensive on-site assessments and stakeholder engagement, including:

- **Facility Observations:** Thorough review of physical conditions and operational practices.
- **Extensive Stakeholder Interviews:** Gathering diverse perspectives from:
  - **Judicial Representatives:** Chief Judge and representatives from the District Attorney's and Public Defender's offices.
  - **Law Enforcement and Corrections:** Milwaukee County Sheriff's Department and Community Reintegration Center personnel.
  - **MCJ Staff and Occupants:** Frontline staff, administrators, and individuals currently residing within the facility.
  - **Christensen Consent Decree Monitor:** Unable to interview due to retirement.
- **Document Review:** Analysis of records related to staffing, programs, confinement conditions, medical and mental health care, NCCHC Accreditation, and misconduct.

This review was initiated to address concerns regarding MCJ's management of suicide awareness and prevention, mental health and medical care provisions, occupant overcrowding, correctional officer retention and MCJ operations. These concerns were heightened by recent in-custody deaths and challenges in maintaining adequate staffing levels despite ongoing recruitment efforts.

Milwaukee County Jail

Opened in 1992, the Milwaukee County Jail (MCJ) is an eight-story facility located in downtown Milwaukee. Operated by the Milwaukee County Sheriff, MCJ houses both male and female occupants (separately) and has a maximum capacity of 990 individuals.

MCJ has primarily served as a pre-trial detention facility, accommodating individuals awaiting trial and those sentenced but awaiting transfer to other correctional agencies. Additionally, MCJ provides secure housing for various law enforcement agencies at the county, state, and federal levels.

Addressing Overcrowding:

In 1996, a class-action lawsuit (Christensen Decree) was filed against MCJ due to concerns regarding overcrowding and its impact on safety and conditions of confinement. A 2001 consent decree stemming from this lawsuit established critical measures to mitigate overcrowding, including:

- **Population Limit:** Capping the number of pre-trial occupants at 960.
- **Booking Time Limit:** Restricting the time individuals can book to a maximum of 30 hours before being assigned to a housing unit.
- **Court-Monitored Healthcare:** Mandating court oversight of healthcare services within the facility.

Facility Overview:

MCJ features a range of housing units to accommodate diverse needs and security classifications:

- 12 general population housing units
- 3 restrictive housing units
- 1 direct supervision mental health unit
- 1 indirect supervision mental health unit
- 1 direct supervision special medical unit

While MCJ functions as a standalone facility, it has historically collaborated with the larger Milwaukee County Correctional Center (Community Reintegration Center) to manage overall pre-trial occupant capacity.

Originally operating as a work farm for sentenced individuals, what was formerly called the House of Corrections has undergone a significant transformation. Now known as the Community Reintegration Center (CRC), this facility in Franklin, Wisconsin (approximately 30 minutes from MCJ) primarily houses pre-trial residents for Milwaukee County municipalities along with sentenced occupants.

With a reported capacity of 1,766, the CRC also accommodates some Wisconsin Department of Corrections (DOC) occupants under a Memorandum of Understanding. This shift in the CRC's mission reflects an evolving approach to corrections, emphasizing reintegration and community-based supervision. However, as of the date of this report, the CRC houses more MCJ pre-trial occupants than sentenced offenders.

Shift in Oversight:

MCJ and the CRC were historically under the Milwaukee County Sheriff's authority from 2009-2013, when a shift occurred in January 2013. Due to operational concerns, the Milwaukee County Executive transferred oversight of the CRC to an appointed superintendent, who now reports directly to the County Executive.

New Leadership and Classification:

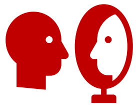
This change in leadership led to the implementation of a new classification system at the CRC. This system, while jointly created with the MCJ leadership and progressive in its intent, has inadvertently contributed to overcrowding at MCJ by restricting the transfer of pre-trial occupants who do not meet specific criteria. Specifically, it was reported to our team that the Superintendent added an additional criterion to include a bond of more than $65,000, which precludes additional occupants from being transferred to the CRC.

MCJ Facilities and Services:

MCJ offers a range of services and departments to support its population:

- **Food Service:** An on-site kitchen operated by Trinity Services Group; Inc. provides three daily meals via satellite feeding to occupant housing units.
- **Infrastructure:** MCJ includes a booking/intake area, administrative offices, housing pods, and multiple recreation areas.
- **Law Library:** occupants have access to legal publications through electronic tablets provided by MCJ.
- **Medical and Mental Health Care:** Wellpath, a contracted provider, delivers medical, psychiatric, and dental services within the jail. This includes acute and chronic illness treatment, crisis intervention, supportive counseling, mental health resources, and re-entry planning. For specialized needs, occupants can be referred to external medical and mental health care providers.

RESULTS OF THE REVIEW



SUICIDE PREVENTION AND AWARENESS

The MCJ staff, which for the purpose of this report include individuals contracted through Wellpath, are a dedicated group committed to serving their community, facing a challenging environment daily. As front-line workers in the criminal justice system, they navigate complex mental health, healthcare, and security needs within a demanding setting. They process thousands of occupants annually, conducting medical and mental health screenings and security classifications, often with limited background information.

Bench located in MCJ booking

While MCJ and Wellpath's mental health and suicide prevention policies comply with laws and regulations as required in DOC 350.17 Suicide Prevention, they lack specificity and clarity. This vagueness hinders consistent and effective implementation of critical procedures, particularly those related to suicide watch. This was evident during our visit to the booking area when the following observations and staff interviews occurred.

Booking Area: The practice of handcuffing individuals on suicide watch to benches in the MCJ booking area was deeply alarming and should be stopped. This unsafe procedure not only provides a means for self-harm, as evidenced by a suicide attempt that occurred during our visit (as noted on page 2) but also increases vulnerability to assault by other occupants. The reliance on this method reveals a critical lack of training and understanding regarding appropriate suicide watch protocols. MCJ must prioritize the safety and well-being of individuals in their custody by utilizing available cells for observation. Failure to address these issues could raise serious ethical concerns regarding the treatment of vulnerable individuals and jeopardize MCJ's commitment to providing a safe and humane environment for all those in its custody. (NDS 4.5 Significant Self-Harm and Suicide Prevention and Intervention “H” No Excessive Deprivation, DOC 350.23 Use of Restraints (#1).

Recommendations:

- **Specific Mental Health Staff Notification:** Clear designation of individuals responsible for suicide watch notifications within each specialty. Provide booking nursing staff and correctional supervisors with the mental health staff's work schedules for immediate notification.
- **Procedures for transferring occupants to suicide watch rooms:** Detailed protocols on when and how to move occupants from Booking to designated suicide watch areas as soon as practical.
- **Handcuffing:** Refrain from Handcuffing individuals on suicide watch to benches within booking. Place them in appropriate suicide watch cells and implement suicide watch protocols (see cost estimate for 2X3 Portable Containment Cell).

Suicide Watch (1:1): The practice of placing an occupant on a 1:1 suicide watch as required by the policy is being followed. However, observations of procedures for constant observation (1:1) of occupants on a suicide watch revealed significant safety concerns. The current method appears ineffective and essentially no different than standard 15-minute checks. (NDS, Significant Self-harm and Suicide Prevention and Intervention standard 4.5 F, NCCHC Suicide Prevention and Intervention G)

During the audit, an occupant on constant observation was placed in a cell with the lights off and a dirty, scratched window. The observing officer sat at a table 15 feet away, separated by a glass wall. From this position, it was impossible for the auditor to see into the cell, rendering the "constant" observation ineffective. (NCCHC Suicide Prevention and Intervention G)

This case exemplifies the inadequacy of current constant observation procedures. While documentation may indicate 1:1 observation, the reality falls short of providing the necessary level of monitoring for at-risk occupants. This discrepancy poses a serious safety risk and requires prompt attention to ensure the well-being of occupants on suicide watch.

Recommendations:

- Identify appropriate suicide watch cells that can be effectively and constantly monitored by staff with an unobstructed view of the occupant.
- Consider the purchase of ankle bracelets that provide constant vital sign monitoring and notify staff when changes occur in an occupant's vital signs. This new IT technology can enhance 1:1 constant observation but not replace the current practice. (See cost estimate)

Suicide Watch Cell Physical Plant:

- **Non-working interior lighting:** Many rooms had non-functional lights, hindering the staff's ability to observe occupants. (DOC 350.12 Sanitation and hygiene #1)
- **Light switches inside rooms:** This poses safety risks as occupants could tamper with electrical components to intentionally hurt themselves, and staff cannot easily control the lighting to observe the room.
- **Scratched glass:** Scratches and taped items on door windows obstructed visibility into the rooms, making observation difficult. This often necessitated using the food slot for interaction, compromising observation protocols. (DOC 350.12 Sanitation and hygiene #1)

These deficiencies hinder effective observation and compromise the safety of occupants in these critical areas.

Recommendations:

- **Repair or replace non-functional lighting:** Ensure all lights are operational to maintain adequate visibility into rooms.
- **Relocate light switches:** Move switches outside the rooms to prevent occupant tampering and allow staff to control lighting for observation purposes.
- **Replace scratched glass:** Ensure clear, unobstructed views into rooms by replacing damaged windows. (See attached associated cost estimates)

Operational Reviews: Both the Milwaukee County Sheriff's Office (MCSO) and Wellpath cite Wisconsin State Legislature DOC 350.17(13) in their respective Suicide Prevention Policies (MCSO Policy Manual 718; Wellpath HCD-100_B05). This statute mandates an operational review following a suicide or significant suicide attempt. (World Health Organization WHO, 2007, Preventing Suicide in Jails and Prisons).

While MCJ and Wellpath leadership meet weekly to discuss various operational issues such as staffing, medical care, and facility services, these meetings fail to address a critical area: the review of critical incidents, particularly those involving self-harm. Despite documented instances, including those observed during the audit and in previous incidents, neither MCJ nor Wellpath conducted these required operational reviews. This oversight represents a significant missed opportunity to identify systemic issues, improve staff response to critical incidents, enhance occupant safety, and potentially prevent future occurrences of self-harm.

Recommendation:

Implement operational reviews, which will provide vital opportunities for corrective action to include:

- **Understanding the occupant's clinical presentation:** Gaining deeper insights into the individual's mental health status and contributing factors.

- **Evaluating policy and procedure adherence:** Determining whether existing protocols were followed and identifying any deviations.
- **Improving staff response:** Critically analyzing staff actions to identify areas for improvement and enhance future responses.
- **Developing corrective actions and training:** Implementing measures to better equip staff to handle similar situations and effectively address occupants' mental health needs.

Wellpath Mandated 24-Hour Suicide Watch Policy: Wellpath's policy HCD-100-B05 mandates that individuals placed on suicide watch must remain in that status for a minimum of 24 hours, regardless of clinical presentation. This represents a significant systemic issue. This rigid policy undermines the clinical judgment of mental health professionals and could potentially harm occupants who were not considered suicidal. This section highlights a critical inefficiency in MCJ's suicide prevention procedures, which stems from a lack of communication and adherence to existing policies. While any staff member can place an occupant on suicide watch in the absence of a mental health professional, this practice is inefficient and potentially harmful to an occupant when mental health staff are available on-site. (DOC 350.17 Suicide prevention #6)

MCJ's current practice of placing individuals on suicide watch without consulting mental health professionals who are on duty is inefficient and potentially harmful. This approach triggers a cascade of clinical encounters and documentation that can consume 14 hours of staff time over 90 days for a single 24-hour watch. By bypassing mental health expertise, MCJ misses crucial opportunities. These include conducting comprehensive risk assessments to determine the necessity of a full suicide watch, exploring less restrictive interventions like crisis counseling, ensuring adherence to Wellpath's policy requiring mental health consultation, and improving communication between medical and mental health staff. This collaborative approach would conserve resources and ensure that individuals receive the appropriate level of care, potentially mitigating harm and streamlining documentation processes. (DOC 350.17 Suicide Prevention #4)

Missed Opportunities for Prevention:

By failing to consult with mental health professionals before initiating suicide watch, Wellpath medical staff misses opportunities to:

- **Conduct thorough assessments:** Mental health professionals can conduct comprehensive suicide risk assessments to determine the true level of risk and identify appropriate interventions.
- **Prevent unnecessary placements:** Many occupants placed on suicide watch by non-clinical staff may not require this level of intervention, leading to inefficient use of resources and potential harm to occupants.
- **Provide alternative interventions:** Mental health professionals can offer alternative interventions, such as crisis counseling or increased mental health observation, that may be more appropriate and less restrictive than a full suicide watch.

Recommendations:

- **Enforce existing policy:** Ensure adherence to Wellpath's policy HCD-100-B05, requiring consultation with mental health staff before placing an occupant on suicide watch when they are available.
- **Improve communication**: Facilitate better communication between medical and mental health staff to ensure timely and informed decision-making regarding suicide risk.
- **Clinician Autonomy:** Allow the Mental Health Clinician to place or remove an occupant from Suicide watch status based on sound clinical judgement and thorough clinical assessments criteria.
- **Streamline documentation requirements:** Evaluate the necessity of all documentation associated with suicide watch and explore ways to streamline the process without compromising care.

By optimizing the use of mental health resources and improving communication, MCJ can enhance suicide prevention efforts, reduce unnecessary placements, and free up valuable clinical time for other essential services.

Positive Impact of Mental Health Increased Staffing:

- **Enhanced Screening and Prevention:** Increased staffing allows for more comprehensive screening and identification of at-risk individuals upon intake and throughout their detention.
- **Improved Suicide Risk Assessments:** With more clinicians available, MCJ can conduct more thorough and timely suicide risk assessments, ensuring appropriate interventions are implemented.
- **Enhanced Crisis Intervention:** With more clinicians available, MCJ can respond more effectively to mental health crises, potentially de-escalating situations and preventing self-harm.

Limited Occupant Information on Suicide Awareness and Mental Health: Providing MCJ occupants with accessible programming information on mental health and suicide awareness is crucial for prevention and intervention. However, the audit revealed limited signage and notifications within housing units and the booking area. Existing materials were primarily in English, potentially excluding non-English speaking occupants. (Best Practice, Executive Order 13166, EO 13166, Improving Access to Services for Persons with Limited English Proficiency, August 11, 2000)

Recommendation:

To enhance awareness and promote an identified "Best Practice," MCJ should implement the following:

- **Multilingual Signage:** Prominently display concise, easy-to-understand multilingual signage in high-traffic areas (near phones, unit entrances, showers) providing information on:
  - Mental health services availability
  - Suicide warning signs
  - Reporting procedures for suicidal ideation or concerns
- **Information Leaflets:** Distribute multilingual leaflets containing similar information to incoming occupants during the booking process.
- **Occupant tablets:** incorporate suicide awareness and prevention psychoeducational programming to optimize occupant understanding of suicide awareness and prevention.

These materials should prioritize clarity and brevity, avoiding complex policy jargon to ensure effective communication and encourage help-seeking behavior. By increasing access to information through diverse mediums, MCJ can empower occupants to recognize warning signs, seek assistance, and potentially prevent suicide attempts. This practice is also endorsed by the National Commission on Correctional Health Care, which can be found in their Suicide Prevention Resource Guide.

The monitor in the booking area, currently used to display information about MCJ in English, presents an untapped opportunity to enhance communication and support occupant well-being. As incoming occupants are a captive audience in this area, utilizing the monitors to provide multilingual information on various topics could significantly benefit their transition into the facility.

Recommendation Consider expanding the monitor's content to include information on:

- **Mental health services:** Details about available mental health resources, how to access care, and what to expect.
- **Suicide prevention:** Warning signs of suicide, how to report concerns and available support systems.
- **Facility rules and expectations:** Clear and concise explanations of rules and regulations to help occupants adjust to their new environment.

- **Available programs and resources:** Information on educational opportunities, substance abuse programs, and other resources that can aid in rehabilitation and reintegration.

By providing this information in multiple languages, MCJ can:

- **Reduce anxiety and uncertainty:** Incoming occupants often experience fear and apprehension. Providing clear and accessible information can alleviate these anxieties and promote a smoother transition.
- **Increase awareness of available support:** Many occupants may be unaware of the available resources. The monitors can effectively communicate this information, encouraging help-seeking behavior.
- **Promote a sense of safety and support:** Multilingual information demonstrates inclusivity and a commitment to meeting the needs of all occupants, fostering a more positive and supportive environment.

This enhanced communication strategy can improve occupant well-being, reduce potential incidents, and support a more positive and productive experience within the facility.

Inadequate Staff and Contractor Mental Health Training:

This section reveals a critical gap in suicide prevention training at MCJ despite existing policies and state regulations. While both MCJ and Wellpath provide initial suicide prevention training, annual refresher training is not consistently provided to all staff. (NCCHC Suicide and Prevention A, Wisconsin DOC 350.17 Suicide prevention #11, NDS 4.5 Significant Self-Harm and Suicide Prevention and Intervention 2B)

Key Findings:

- **Lack of Annual Training:** Training records indicate that Wellpath contractors have not received the required annual suicide prevention training. (NCCHC Suicide and Prevention A, Wisconsin DOC 350.17 Suicide prevention #11, NDS 4.5 Significant Self-Harm and Suicide Prevention and Intervention 2B, MCJ Custodial manual 718.4)

- **Knowledge Gaps:** Interviews with Correctional Officers revealed limited knowledge of suicide risk factors, procedures for identifying and managing at-risk occupants, and notification protocols. During our visit, it was determined through interviews that staff take the required training at their desk in the housing unit while trying to supervise the occupants. The current training consists of 85 slides that are broad in scope and fall short of the intent to provide MCJ-specific training as outlined on page 2, "key findings" of this report.

- **Insufficient Training for New Correctional Officers**: Correctional Officers often begin working at MCJ before receiving formal training, potentially exposing them to suicide-related situations without adequate preparation.

Recommendations:

- **Prioritize and Mandate Annual Training:** Ensure all staff, including contractors, receive documented annual suicide prevention training in compliance with state regulations and facility policies.
- **Tailor Training to Specific Roles:** Develop training curricula that are relevant to the responsibilities of different staff members:
  - **For Correctional Officers:** Focus on recognizing behavioral indicators of suicide risk, appropriate actions to take, and MCJ's suicide watch protocols.
  - **For Clinical Staff:** Emphasize evidence-based practices for suicide risk assessment, intervention, and documentation, including diagnostic formulation, risk assessment, and treatment planning.

- **Implement Onboarding Training:** Provide mandatory suicide prevention training during the initial onboarding process for all new staff, before they begin interacting with occupants.

By addressing these training deficiencies, MCJ can enhance staff knowledge, improve suicide risk identification and intervention, and ensure compliance with state regulations and best practices.

MENTAL HEALTH SERVICES

Despite facing challenges, the mental health team at MCJ demonstrates significant dedication and engagement with occupants. They provide a dynamic program, evidenced by extensive contact hours and high occupant satisfaction with care. However, the heavy burden of documentation and clinical time associated with suicide watch protocols limits their capacity to expand group therapy and other valuable services.

Staffing Analysis and Recommendations:

While the current mental health staff are all licensed and qualified, a key gap was identified: the lack of an additional experienced mental health clinician (i.e., master level, doctoral level). This additional position is crucial to:

- Provide Clinical Supervision and Guidance: Offer support and supervision to frontline mental health staff, ensuring quality care and adherence to best practices.
- Enhance Documentation: Review clinical notes to ensure relevance, substance, and compliance with standards. (NCCHC Clinical Performance Enhancement)
- Disseminate Evidence-Based Practices: Provide training and information on current evidence-based interventions and best practices in mental health care.
- Offer Consultation Services: Serve as a resource for staff, offering consultation on complex cases and challenging situations.

Adding a mental health clinician would also allow the Mental Health Director to focus on essential administrative tasks, such as:

- Staff Training and Development: Overseeing and coordinating mental health training programs for staff.
- Policy and Procedure Review: Ensuring up-to-date policies and procedures align with best practices.
- Quality Improvement: Conducting regular audits and implementing quality improvement initiatives.

By addressing this staffing need, MCJ can enhance the quality of mental health services, improve staff support and development, and ensure the sustainability of a robust mental health program.

The lack of psychoeducational programming at MCJ is an identified concern. While mental health staff acknowledge its importance, they face challenges in dedicating time to programming due to competing demands, such as suicide watch and crisis intervention. Additionally, the transient nature of the jail population leads to high attrition rates in traditional programming groups.

To address these challenges and provide meaningful opportunities for occupants, consider the following:

- **Implement open-ended and open-door treatment groups:** This format allows occupants to participate regardless of their length of stay, maximizing exposure to therapeutic interventions (Miller, R., & Mason, S. E. (2012). Open-Ended and Open-Door Treatment Groups for Young People with Mental Illness. Social Work with Groups, 35(1), 50–67.

- **Utilize tablets for free psychoeducational programming:** Leverage existing technology to provide engaging and informative content on a variety of topics, including:

    - Medication compliance
    - Sleep hygiene
    - Substance abuse education
    - Mental health disorders
    - Accessing community mental health services
    - Suicide awareness and prevention
    - Sexual abuse prevention and reporting
    - Parenting skills
    - Diet and physical health

- **Offer incentives for participation:** Motivate occupants by providing certificates of completion for those who engage with tablet-based programs and successfully pass associated assessments.

By diversifying programming formats and utilizing available technology, MCJ can overcome existing barriers and provide valuable psychoeducational opportunities to a larger portion of the occupant population. This can contribute to improved mental health, increased knowledge and skills, and better preparedness for reintegration into the community.

The unsanitary conditions observed in the general population housing units, particularly the women's unit, pose a significant challenge to occupants' well-being and impede the effective delivery of mental health services.

Observations:

- **Extensive graffiti:** Graffiti covering every cell creates a negative and potentially distressing environment.
- **Unsanitary conditions:** Dirty toilets, unclean shower areas, and a generally dank atmosphere contribute to a sense of neglect and detract from the occupant's well-being.
- **Lack of dedicated programming spaces:** The absence of suitable spaces for programming hinders the delivery of multidisciplinary education and treatment.

One of many cells containing graffiti.

Recommendations:

- **Improve sanitation:** Implement a more rigorous cleaning schedule and ensure adequate cleaning supplies are available. Address any maintenance issues contributing to unsanitary conditions. (DOC 350.12 Sanitation and hygiene)
- **Remove graffiti:** Regularly remove graffiti to maintain a clean and respectful environment. Consider involving occupants in creating murals or artwork to promote a sense of ownership and pride in their living space. (DOC 350.12 Sanitation and hygiene)
- **Establish dedicated programming areas:** Identify and designate spaces within housing pods specifically for programming. Enhance these areas with:
    - **Murals and artwork:** Create a visually appealing and stimulating environment.
    - **Bright lighting:** Ensure adequate lighting to promote a positive and alert atmosphere.

By addressing these environmental concerns, MCJ can create a more conducive setting for mental health services and support the overall well-being of its occupants. A clean, well-maintained, and stimulating environment can positively impact mood, reduce stress, and foster a sense of dignity and respect. (DOC 350.12 Sanitation and hygiene and considered best practices).

During the on-site audit, it was observed that the two mental health housing units were staffed by probationary staff. This practice could potentially cause missed observations or incidents resulting in bad outcomes due to not having the required training academy modules for mental health and suicide prevention and awareness.

Recommendation for Enhanced Monitoring with Trained Correctional Officers:

Creating a specialized cadre of Correctional Officers trained in mental health awareness and crisis intervention could significantly benefit MCJ, particularly in managing the Special Needs population. This recommendation would be considered a "Best Practice" for the mental health program.

Benefits of a Mental Health Trained Cadre:

- **Enhanced Understanding and Interactions:** Correctional Officers with specialized training would be better equipped to understand and respond to the unique needs and challenges of occupants with mental health conditions.
- **Improved Rapport and Reduced Conflict:** Increased awareness and empathy can foster positive relationships between Correctional Officers and occupants, potentially reducing conflicts and promoting a calmer atmosphere.
- **Early Identification and Intervention:** Trained Correctional Officers could identify early warning signs of mental health crises or self-harm, enabling timely intervention and preventing escalation.
- **Valuable Observational Data:** These Correctional Officers could provide valuable behavioral observations to mental health staff, aiding in assessment, treatment planning, and early intervention.

Training Recommendations:

- **Quarterly Training:** Provide this specialized cadre with quarterly training on:
    - Common mental health concerns among the occupant population.
    - Recognizing and responding to signs of distress, agitation, and self-harm.
    - De-escalation techniques and communication strategies.
    - Understanding trauma-informed care principles.
    - Collaboration with mental health professionals.
- **Targeted Assignments:** Assign these trained Correctional Officers to posts and housing units specifically designated for the Special Needs population.

By investing in this specialized training and strategic deployment of Correctional Officers, MCJ can enhance the care and support provided to occupants with mental health needs, promote a safer environment, and potentially reduce incidents requiring crisis intervention.

Addressing the National Trend:

While national trends show an increase in jail suicides between 2001 and 2019 (Suicide in Local Jails and State and Federal Prisons, 2000–2019 – Statistical Tables, Bureau of Justice Statistics), MCJ has made significant strides in addressing this issue by enhancing its mental health staffing. This investment in mental health resources has led to improved outcomes in suicide prevention and intervention.

Sustaining Improvements:

To sustain these positive outcomes, it is crucial for MCJ to:

- **Maintain adequate staffing levels:** Ensure that staffing levels remain sufficient to meet the mental health needs of the occupant population.

- **Provide ongoing training and support:** Invest in continuous training and professional development for mental health staff to keep their skills and knowledge up to date.
- **Monitor and evaluate outcomes:** Regularly track key performance indicators related to suicide prevention and mental health care to assess program effectiveness and identify areas for improvement.

By continuing to prioritize mental health care and investing in its staff, MCJ can remain a leader in suicide prevention and provide a model for other pre-trial correctional facilities to follow.

Comparing MCJ to a similar facility in Jefferson County, Texas (JCCC) reveals valuable insights and highlights potential areas for improvement.

JCCC's Success in Suicide Prevention:

JCCC demonstrates exceptional performance in providing medical and mental health services to its occupants. Notably, JCCC has achieved and maintained NCCHC accreditation, a testament to its commitment to quality care. Furthermore, the facility's provision of 24/7 on-site mental health services has contributed to a remarkable achievement: zero suicides in the past 8 years.

Key Takeaways for MCJ:

- **24/7 Mental Health Staffing:** JCCC's success underscores the critical importance of providing round-the-clock access to mental health professionals. This ensures timely intervention and support for occupants in crisis, significantly reducing suicide risk.
- **NCCHC Accreditation:** MCJ has demonstrated NCCHC re-accreditation, which is an important comparison to JCCC, which highlights continuous quality improvement in correctional healthcare.
- **Comprehensive Mental Health Services:** JCCC's comprehensive approach to mental health care, including assessment, treatment, and crisis intervention, serves as a model for MCJ to emulate.

Recommendations for MCJ:

- **Explore the feasibility of 24/7 mental health coverage:** While resource constraints may be a factor, MCJ should explore options for increasing mental health staffing to provide more comprehensive coverage.
- **Continue to prioritize mental health program development:** MCJ should continue to invest in developing a robust mental health program that includes a wide range of services, including individual and group therapy, medication management, crisis intervention, anger management, AA, and NA.

- **Emergency Medication Policy:** JCCC Mental Health Clinicians have an emergency medication policy for the administering of emergency Psychotropic medication to urgently treat occupants who are displaying severe psychotic symptoms that cannot be treated through standard mental health treatment modalities.

By learning from JCCC's successes and implementing these recommendations, MCJ can further strengthen its suicide prevention efforts and improve the overall quality of care for its occupants. (Best Practice)

MEDICAL SERVICES

This section provides an overview of MCJ's health services department and its partnership with Wellpath, a contracted provider of healthcare services. The review of MCJ's health services department involved a comprehensive approach, including:

- Document Review: Examination of policies, occupant medical files, training materials, meeting minutes, compliance indicators, and quality improvement data.
- Facility Tour and Observations: A tour of the facility, as well as observation of intake screening and medication distribution processes.
- Meetings and Interviews: Participation in relevant meetings and interviews with health services staff.

Wellpath Partnership:

MCJ contracts with Wellpath to provide its occupants with medical, psychiatric, and dental services. Wellpath specializes in correctional healthcare and is equipped to manage a range of health needs, including:

- Special Needs: Providing care for occupants with disabilities or chronic conditions requiring specialized attention.
- Acute Illnesses: Managing acute medical conditions and providing necessary treatment.
- Emergency Care: Responding to medical emergencies and stabilizing occupants until they can be transported to a hospital if needed.
- Chronic Disease Management: Providing ongoing care for occupants with chronic conditions such as diabetes, hypertension, and asthma.

Access to Higher Acuity Care:

For specialized or higher acuity care needs, Wellpath has established a network of off-site providers and hospitals, ensuring occupants have access to necessary medical services beyond the scope of the jail's on-site capabilities.

Additional Services:
Beyond traditional medical care, Wellpath also provides:

- Crisis Intervention: Responding to mental health crises and providing immediate support.
- Supportive Counseling: Offering counseling services to occupants struggling with mental health challenges.
- Mental Health Resources: Connecting occupants with appropriate mental health resources.
- Re-entry Planning: Assisting occupants with planning for their release and connecting them with community-based healthcare providers.

This comprehensive approach to healthcare services demonstrates MCJ's commitment to meeting the diverse needs of its occupant population. The partnership with Wellpath leverages specialized expertise in correctional healthcare to provide quality care within the facility and facilitate access to external resources when needed.
In May 2001, a portion of the consent decree mandated court monitoring of health services. The National Commission on Correctional Health Care (NCCHC) was chosen as the external auditor. In addition to their triennial accreditation survey, the National Resource Information Network (NRI), a division of NCCHC, provides quarterly monitoring services to help improve and/or maintain healthcare delivery standards. On April 19, 2024, NCCHC granted accreditation to the facility, contingent upon receiving the requested compliance verification by August 19, 2024.

Two standards were identified as needing improvement and monitoring:

- Review the health record when notified that an occupant has been placed in segregation.
- When a restraint bed or chair is used, health care must be notified immediately to complete a medical record review and monitor the individual at specified intervals.

MCJ successfully modified its processes and demonstrated full compliance with NCCHC through comprehensive data analysis for these two standards. We spoke to Wellpath's Regional Health Services Administrator, and she credits the continued improvement in occupant healthcare services, particularly in terms of timeliness and reduced backlog, aside from dental services, to the contract with NCCHC and NRI. Data shows measurable improvement in the delivery of these services.

Areas of Strength:

Overall, the review found MCJ's healthcare services well-managed and high-quality. Systems are in place to ensure timely and effective care for occupants.

Areas for Improvement:

Despite the overall positive assessment, several areas require attention and staff education:

- **Tuberculosis Screening:** Established guidelines for tuberculosis screening were not consistently followed. Some occupants with HIV did not receive chest X-rays, and some long-term occupants missed their annual screenings. (Wellpath Policy HIV Monogram; IC-100 A-05 Tuberculosis Screening and Skin Testing for Patients)
- **Drug Screening for Pregnant occupants:** 100% of the charts reviewed (5) revealed all occupants who tested positive for pregnancy at intake did not receive a drug screen (Wellpath MCJ Policy HCD-100 F-05, page 4 sec 6.9.1)
- **Corrective Action Plans for Emergency Drills:** While emergency medical drills were conducted, there was no formal corrective action plan to address identified areas for improvement. (NCCHC P-D-07 #6)
- **Physician Review of Health Appraisals:** The responsible physician or medical director did not consistently document their review of health assessments with positive findings, as required by Wellpath policy. (Wellpath MCJ Policy HCD-100 E-04, page 3 sec 6.5, NCCHC P-E-04)
- **Commissary OTC Items:** The commissary list and signage did not accurately reflect available over-the-counter (OTC) medications and medical supplies. Additionally, the medical director and HSA were not involved in determining commissary items as required by policy. (Wellpath HCD-100 D-01 sec 6.25)
- **Housing Unit Walk throughs (Rounds):** The Medical Leadership do not perform weekly rounds within the occupant housing units to solve medical complaints informally. (Best Practice)

Recommendations:

- **Reinforce adherence to tuberculosis screening guidelines:** Ensure all staff involved in screening are properly trained and follow established protocols.
- **Mandate drug screening for all pregnant occupants:** Implement a policy requiring drug screening for all occupants who test positive for pregnancy at intake.
- **Develop Corrective Action Plans for drills:** Formalize a process for developing and implementing corrective action plans following emergency medical drills to address identified deficiencies.
- **Enforce physician review of health appraisals:** Ensure physicians consistently document their review of health assessments, particularly those with positive findings.
- **Update commissary list and signage:** Ensure the commissary list and signage accurately reflect available OTC items. Include the medical director and HSA in the process of determining appropriate commissary offerings.

- **Housing Unit Rounds:** The HSA and the Director of Nursing should perform weekly rounds in each occupant housing unit to observe pill lines and to minimize formal complaints by informally addressing occupant concerns.

By addressing these areas for improvement, MCJ can further enhance the quality of its healthcare services and ensure compliance with relevant standards and policies.

Recommendations for Dispensing pill line Medication:

A review of the medication administration procedures was conducted, and our SME observed four pill lines. It was noted that the nurse administering some of the occupants' prescription medications had access to bulk stock medications to administer some of the occupant's medications. These doses were taken from bulk-stock medication bottles that were not appropriately prepared by a pharmacist or pharmacy staff. They also were not appropriately labeled with all the requirements of a prescription label.

Specifically, the bulk stock medications used during observed pill lines were Lisinopril 10 mg quantity of 100 tablets and Amoxicillin 500 mg quantity of 500 tablets. Both bottles had a bulk stock label, but they were not labeled with the occupant's name and specific instructions for administration (Wellpath policy D-02, page 3 "All medication rights"), (DOC 350.16 Control and administration of medications, NCCHC Pharmaceuticals operations).

Wisconsin's Board of Pharmacy regulations mandate that bulk medications should be dispensed by pharmacists, aligning with safety protocols for patient care. Wisconsin's Board of Pharmacy emphasize that these limitations protect patients by upholding safe, accurate medication handling processes. (Wisconsin Pharmacy Examining Board's, 7.06, https://docs.legis.wisconsin.gov/code/admin_code/phar/7)

Recommendation:

- Ensure all medication dispensed to the occupant population is dispensed properly with all the requirements of a prescription label.

Sharps Security

A review of the sharps and needle count logs in the pharmacy, dental clinic, medical booking area, and medication carts revealed inaccuracies in the inventories. (NCCHC Staff Safety P-B-09 #3, Best Practice, NDS 2.3 Tool Control)

Recommendation:

- Reinforce the correct procedures for each shift as required for sharps security and verify that two staff members signed them off.
- Reinforce Reporting discrepancies to health services supervisors to prevent potential risk of harm to staff and occupants due to unaccounted for sharps.

Dental Program

The current dental program has a backlog of 143 pending dental appointments, including 35 urgent referrals, 35 routine referrals, and 73 annual dental examinations.

Recommendation:

- MCJ should operate with one full-time Dentist and Dental Assistant. The current waiting list will not be resolved without additional dental work hours within the MCJ. In addition, the high number of new occupants being admitted into the MCJ would justify the need for a full-time Dentist. This will reduce dental emergencies and enhance the overall care of the occupant population. It should be noted that the occupant survey highlighted the need for a full-time Dentist as they verbalized the need to see the Dentist.

Medical Staff Communication

Healthcare staff do not always effectively communicate with occupants about their healthcare information. Wellpath had a contract with Language Line for interpretation services, and the use of this service must be documented. A review of five occupant files identified as having special needs due to language interpretation requirements and found that in all five files, staff did not consistently document the use of an interpreter during their interactions. Additionally, English consent forms and refusal forms were used with each client, even though both forms are available in Spanish. Furthermore, although MCJ had a TTY device for potential deaf occupants, it was only used for visitation purposes and was not medically certified.

Effective communication cannot be achieved without utilizing assistive tools, and poor communication can impact an occupant's health and safety. (NCCHC Information on Health Services Standard).

Recommendation for enhanced Medical Staff Communication:

- Provide training to the medical staff on the importance of interpretation services for occupants identified as having special needs due to language interpretation requirements.
- Provide a designated TTY device for potential deaf occupants to be available and medically certified in the medical department.

Continuous Quality Improvement (CQI)

The current CQI coordinator has been in her position for approximately 15 months and has had to develop this position. She has worked closely with NCCHC to develop studies supporting the healthcare needs of MCJ and findings from their audits. The CQI studies currently focus on task-based data points to confirm whether individual actions, program requirements, or timelines are being met or implemented. However, the program needs to expand towards more outcome-driven studies that evaluate effectiveness and impact on overall results. Data points for these studies are often derived from root cause analysis (RCA) to accurately identify the underlying sources of system breakdowns, enabling more targeted improvements. An example of this would be the current studies conducted for the suicide prevention program. While the current indicators being tracked suggest that the program is well-managed, multiple procedures within the suicide watch program need improvement. The CQI should have identified the trend that nursing staff in booking were placing occupants on suicide watch without consulting mental health staff. The trend would have identified a high number of occupants on suicide watch that potentially could have been prevented if mental health staff were notified. (NCCHC continuous Quality Improvement Program, Wellpath HCD 100 A-06 6.2)

Recommendation for CQI:

- Provide Training specific to CQI by a trained CQI medical provider.

Vaccine Program

The Milwaukee Health Department conducts vaccination clinics at MCJ following CDC guidelines. In 2024, they have already held seven clinics, administering 342 vaccines to 250 occupants. This program, funded by the health department, saved $36,030.03 in vaccine product costs.

Medical Staffing

The HSA has carefully selected each new team member, ensuring they are well-suited for the demanding nature of correctional healthcare. This thoughtful approach to hiring has strengthened program development and created a cohesive team environment. Although many program managers are new to their roles and still developing their programs, their dedication is evident. Best Practice

MCJ/Wellpath Partnership

MCJ has developed a strong partnership with Wellpath, built on clear, consistent communication and mutual respect between the director and the administrator. Communication is fostered through weekly administrative meetings and a shared understanding of the department's needs and challenges. They collaborate to develop practical solutions to meet the program's needs while upholding the business's mission. The HSA also conducts bi-weekly whiteboard meetings with program managers and supervisory staff to discuss intra-departmental needs and address high-acuity and high-interest occupants. Quarterly interdisciplinary CQI (Continuous Quality Improvement) meetings are well-attended, promoting cross-department collaboration and focusing on quality enhancement. Staff report that the HSA maintains strong visibility within the department, actively addressing both individual staff concerns and departmental needs, fostering a supportive and responsive work environment.

Occupants Survey (See Attachment B)

Occupants Survey outlines the methodology used to gather occupant feedback on medical and mental health services at MCJ.
Interview Methodology:

- Anonymous Interviews: Anonymous interviews were conducted with a representative sample of MCJ occupants to ensure candid feedback.
- Private Setting: Interviews were conducted in a private office space to maintain confidentiality and encourage open communication.
- Standardized Questions: Standardized questions were used to assess occupants' experiences with and perceptions of medical and mental health services.
- Diverse Sample: Both male and female occupants participated in the interviews.
- The sample included 5% of female and 3% of male occupants, ensuring representation across the population.
- Range of Lengths of Stay: Interviewees' stays ranged from 1 month to 2 years, providing diverse perspectives on the continuity and effectiveness of care.

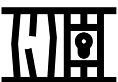
Here is the breakdown of the key takeaways:

- Access to Medical/Mental Health Providers: Upon arrival, all occupants received medical and mental health screenings and instructions on accessing medical and mental health care.
- Dental Screening: A significant number of occupants received a dental screening within 30 days of arrival. However, this was determined to be part of the booking questions asked by the nurse.

- Knowledge of Sign-up Process: Most occupants know how to sign up for medical and mental health services.
- Requests to be Seen by Providers: Most occupants requested to be seen by both medical and mental health providers and were satisfied with their care. A follow-up question not on the survey indicated they were seen within two weeks for minor complaints.
- Timeliness and Satisfaction with Care: Most occupants were seen in a timely manner and were satisfied with the care received from both medical and mental health providers.

Probable Insights:

- Occupants who reported their requests (pink and white slip) to be seen by a mental health and or medical provider are fulfilled, which suggests the services provided are effective and care rendered does not indicate a delay in access to care.



Security and Control

The facility has not developed specific procedures and guidelines or “post orders” for each correctional post. Post orders usually define the duties and responsibilities for correctional posts, emphasizing the custody, security, and supervision of occupants. Procedures associated with security and control are only referenced in policy. The policy does not address each post listed on the correctional staffing roster and does not describe specific duties required by staff staffing each individual post. Copies of post orders should be maintained at each post. Clear procedures should be incorporated into the post orders for all regular daily activities, including safety checks, headcounts, meals, sick calls, recreation, clothing exchange, mail distribution, and response to emergencies such as fires, natural disasters, and criminal acts. (Best Practice, NDS 2.9 Post Orders, MCJ Custodial manual 311.1)

Although not outlined in the policy, post orders should also contain a general section addressing topics such as suicide protocols, report writing, PREA, Self-Contained Breathing Apparatus (SCBA) procedures, shakedown protocols, and cell shakedowns. Post Orders provide staff with specific correctional post duties and responsibilities that support more general institution policies. (Best Practice)
Review of several correctional posts revealed: (MCJ Custodial manual 311.2)

- Post orders are not maintained on correctional posts.
- Duties and responsibilities for posts were not specifically defined in policy.
- Staff have not acknowledged the review of post-orders regarding the clarity of duties.
- Supervisors have not updated post orders to reflect actual duties.

Recommendation:

- Develop comprehensive correctional post orders and ensure they are placed at each post.
- Develop a comprehensive policy compliance, or perpetual audit system, to ensure policy compliance specific to post orders (staff signatures verifying they read the post orders).
-

Tool Control:

Our review of the MCJ's tool control procedures exhibits several security gaps. While tools are stored outside the secure perimeter and transported on mobile carts, these carts lack comprehensive inventories, making it difficult to track tools entering and leaving the facility. Furthermore, the current policy fails to classify tools according to their security risk and doesn't mandate that unit officers inventory tools entering or leaving their posts. The absence of tool shadow boards hinders quick identification of missing items.

While kitchen knives are tethered to tables, no inventory is maintained for knives stored in the cabinet, which was observed unsecured with a knife inside. These lapses in tool control create potential security risks and necessitate immediate attention to prevent misuse or theft. (MCJ Custodial Manual Policy 203.2, 203.2.3, NDS 2.14 Tool Control)

Recommendation:

- Develop and implement an enhanced tool control policy to ensure proper security measures are followed when handling tools within MCJ.
- Establishing an inspection system to ensure accountability.

Specialized Housing Unit

Specialized Housing Unit (4D) is a restricted unit that accommodates individuals with various classifications, such as protective custody cases, suicide watches, the general population, and administrative/disciplinary cases. Managing this type of unit is complex and challenging. Observations of this unit have revealed some practices that could potentially compromise its security.

The Specialized unit at MCJ reveals security and operational deficiencies. Cuffing a disruptive individual to a bench in a common area, instead of returning him to his cell, exposes staff to potential assault. This practice, coupled with the presence of unrestrained orderlies in the same area as restrained individuals, further compromises safety. Lax security practices were also observed, such as leaving a pod door unsecured while facilities staff conducted repairs. Additionally, the unit suffers from poor sanitation, lacks accountability for restraint equipment, and has no designated supervisor to oversee operations. These issues, combined with the housing of suicide watch occupants within the unit, create a volatile and potentially dangerous environment for both staff and occupants. (NDS 2.9 Special Management Unit, Best Practice, DOC 350.23 Use of restraints, DOC 350.25 Administrative confinement)

Recommendations:

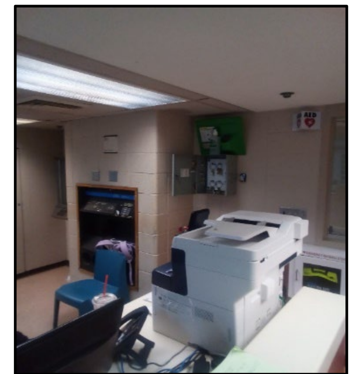
Unsanitary unit shower

- Refrain from cuffing occupants in the Specialized housing benches. Occupants should be restrained when moving outside their cell by an escorted Correctional Officer.
- All Pod doors should always be secured, as this is a restrictive housing pod.
- Restraints should be in a central location within the Specialized housing pod and inventoried each shift.
- A 1st line supervisor should be assigned to the Specialized housing during the day and evening shifts, Mon-Fri.
- Refrain at all possible housing suicide watch occupants in the specialized housing pod.
- Post Orders should be post-specific for each assigned Correctional Officer to ensure all work assignments are completed.
- Quarterly Specialized housing pod training should be performed due to the volatility of the pod.
- Deep cleaning should occur to reduce the poor sanitation within the pod.
- Jail Administration, HSA, Mental Health supervisors should make rounds weekly.

Key and Electronic Access Device Control

MCJ is in the process of implementing a Key Watcher system. Key and Electronic Access Control states, the control and accountability of facility keys and electronic access devices is a vital factor in maintaining a safe

and secure environment for occupants, staff, volunteers, contractors, and the public. During this review, our observations revealed the following issues:


Unsecure and Unattended Key

Key control procedures at MCJ present some security vulnerabilities. A lack of accountability is evident in the absence of key inventories for housing units and unsecured unit key boxes. Furthermore, key rings lack chits indicating the number of keys, making it difficult to quickly identify missing keys. The observation of keys left unsecured on an officer's desk rather than properly secured on their duty belt compounds these security vulnerabilities. These deficiencies in key control procedures pose a significant risk, potentially allowing unauthorized access to restricted areas and jeopardizing the safety and security of both staff and occupants. (Custodial Policy 208, NDS 2.3, Best Practice)

Recommendation:

- Implement the Key Watcher system.
- Create Chits for each security key ring that indicates the number of keys on the key ring
- Place instructions in the post orders to count your keys prior to the shift to ensure accurate key count.
- Educate staff on the procedures for broken keys and or missing keys.

Calculated Use of Force

Although Custodial Policy 537, Correctional Emergency Response Team (CERT) Activation Procedure This Policy outlines Calculated Use of Force, procedures, we found that the policy lacks specificity in calculated use of force protocols. For example, procedures such as confrontation avoidance (de-escalation), medical history reviews prior to calculated use of force, the use of a team trained in cell extraction, and continued use of restraints are not clarified. Additionally, the policy does not provide criteria or procedures to staff/supervisors when conducting occupant assessments for release from continued or extended use of restraints. MCJ's CERT policy and procedures have inconsistencies that jeopardize safety and accountability.

While the policy mandates medical checks and de-escalation efforts, it fails to require video recording of all de-escalation attempts, clearly defines the responsibilities of use of force team members, or ensure medical staff are consulted before using chemical agents. Not all staff observing calculated use-of-force incidents are required to document their observations, and debriefings lack participation from key personnel involved in the incident. Oversight is also lacking, with some supervisors not receiving the required annual training and team leaders, rather than supervisors, overseeing the calculated use of force team. An inspection of the armory revealed missing inventory records and outdated or inadequate protective equipment which could put the staff's well-being at risk and the jail at risk of litigation. (Custodial Policy 537.4 DOC 350.22 Use of force, Best Practice, NDS 2.8)

Recommendations:

- Develop a subcommittee with the Deputy Jail Administrator, HSA, Mental Health Supervisor, 2 Captains. 2 Use of Force Team Leaders and develop procedures that address proper use of force procedures that address the areas of concern.
- Update the Calculated Use of Force equipment for Correctional Staff in different sizes and store in the Armory.
- Once the New Procedures are developed provide training to ensure the entire team knows their responsibility.

Occupant Accountability/Counts

MCJ's Custodial Policy 501 on occupant count procedures is deficient in several areas. The policy fails to specify the frequency of formal counts, outline detailed counting procedures, or mandate the use of outcounts for occupants temporarily outside their assigned areas. This lack of clarity and procedural guidance was evident during the review, where an occupant's absence during count was not properly documented with an outcount. Additionally, the policy neglects to address emergency counts or census counts, further compromising the facility's ability to maintain accurate and reliable occupant counts. These shortcomings in the policy create an opportunity for security breaches and necessitate immediate revision to ensure accurate tracking of occupants at all times. (Custodial Policy 501.3, DOC 350.18 Security, NDS Population Counts 2.3, Best Practice)

Recommendations:

- Increase the frequency of official occupant counts within a twenty-four-hour period. Implement a count system requiring two staff members to count together as partners. Count slips should be signed and submitted to central control after each count.
- Develop an outcount system.

Overcrowding

- Since 2001, MCJ has been operating under a court-ordered consent decree that limits the number of occupants to a maximum of 960. However, MCJ works with 28 different agencies that bring occupants to the facility daily. There are various complexities that contribute to overcrowding issues, some of which are beyond the control of the jail administrators.

Recommendations:

- MCJ is overcrowding the specialized unit (4D) with inappropriate suicide watch occupants; develop the recommendations for notification of the mental health provider prior to placing an occupant on suicide watch.
- The status of an occupant in the Specialized Housing unit should be reviewed by supervisory staff in accordance with the required time schedules, and the results of those reviews shall be documented. This should assist in the decrease in the number of occupants in restrictive housing settings.
- CRC should consider reassessing its classification criteria and establish a memorandum of understanding with MCJ to make additional beds available.
- Institutional Adjustment should be considered for class one and two occupants. For example, if a Class 1-2 occupant has been in the MCJ for a year or more with no infractions, then a discussion should ensue to consider the occupant for transfer.
- Move the female occupants to the CRC Annex for programming, mental health group treatment, and work assignments. This would allow MCJ to complete its maintenance challenges. MCJ leadership have agreed to provide the security responsibilities within the annex to lessen the impact on CRC staff. (U.S. Department of Justice Office of Justice Programs National Institute of Justice, Women Offenders: Programming Needs and Promising Approaches page 7).

CRC Annex with 180 Available Beds

- CRC should consider reassessing its classification criteria for female occupants as they are less prone to violence towards correctional staff than men. Currently, the CRC uses the same classification for males. (U.S. Department of Justice National Institute of Correction, Women in Jail Classification issues: Institution conduct page 4)

Occupational Safety, Environmental Compliance, and Fire Protection

A review of MCJ's fire and safety programs was conducted to assess compliance with state and federal regulations. This involved a facility tour, staff interviews, and review of relevant documentation, including policies related to inspections, hazardous materials management, generator testing, and fire prevention. However, the evaluation was slightly delayed by the absence of the lieutenant in charge of fire and safety, who was on sick leave. A telephonic interview was conducted with the lieutenant to gather information and assist in the assessment of the program.

The safety program is not properly managed by a certified safety professional with certifications in NFPA, OSHA, EPA, and other relevant regulatory agencies. This individual should have specialized knowledge and expertise to identify, evaluate, and address the unique safety hazards associated with a pretrial correctional facility. Occupants were not trained in general safety practices to include fire exit locations, Right-to-Know, Slips, Trips, and Falls. OSHA requires occupants to be trained in safety procedures to ensure their safety and minimize potential injuries or fatalities. The need for a staff member assigned to the safety of staff and occupants regarding fire safety is important. The understanding of compliance of existing fire codes, automatic fire detection and alarm panels can be instrumental when a fire should occur. Training staff about the importance of fire drills, SCBA equipment and use, fire extinguishers and fire exits can mitigate fire related injuries or fatalities. (DOC 350.19 Fire safety, NDS 1.2, Best Practice)
Despite having written procedures, an inspection revealed that secondary containers, such as spray bottles, were not correctly labeled with content information or hazard identification. During an inspection of the living units, one-gallon bleach containers were unsecured and omitted from the chemical inventory accountability records. Although procedures are documented, the oversight and management of bleach were not executed. (DOC 350.12 Sanitation and hygiene, Best Practice, NDS 1.1)

Recommendation:

- Hire or appoint a qualified safety professional with certifications in occupational/environmental safety and fire safety from OSHA, NFPA, EPA, and other relevant regulatory bodies to oversee the MCJ safety program.
- Send the current Lieutenant to safety training and allow him to complete OSHA, NFPA, and EPA courses specific to pretrial correctional facilities.
- Provide resources, including online safety courses, to acquire certifications.

Maintenance Challenges and Collaboration Barriers:

An assessment of the jail's housekeeping and sanitation revealed unsatisfactory cleanliness levels throughout the facility. Occupant living units were particularly concerning, with graffiti-marked walls, stained surfaces, and peeling paint. Excessive personal property, cluttered cells, and brown paper bags served as makeshift trash receptacles. Unsanitary conditions extended beyond the cells, with stained shower areas and food splatter evident in laundry rooms, elevators, and common corridors. These findings indicate a need for significant improvement in the jail's cleaning protocols and overall hygiene standards. (DOC 350.12 Sanitation and hygiene)

MCJ's reliance on the county maintenance department for infrastructure upkeep presents significant challenges. Without dedicated maintenance personnel, timely repairs and preventative maintenance may be delayed. (DOC 350.12, NDS 1.2, Best Practice)

Further complicating matters, many repair projects require relocating occupants, and a proposed plan to temporarily house MCJ occupants at the CRC during renovations has been hindered by the CRC's reluctance to accept these transfers. This lack of inter-facility cooperation presents a significant obstacle to addressing MCJ's maintenance needs.

Food Service Administration:

CJ's food service operation, managed by Trinity Services Group, was observed to be well-organized with a focus on staff training and food safety. Both staff and occupant workers receive comprehensive training and medical clearances, and daily inspections are consistently conducted. However, a review of monthly inspection reports revealed a lack of documented action taken for unsatisfactory ratings, indicating a potential area for improvement in their documentation and follow-up procedures. A comprehensive annual inspection conducted by Steritech in Milwaukee, Wisconsin, on October 23, 2024, found MCJ complies with state food service regulations.

Unsecure Garbage Container

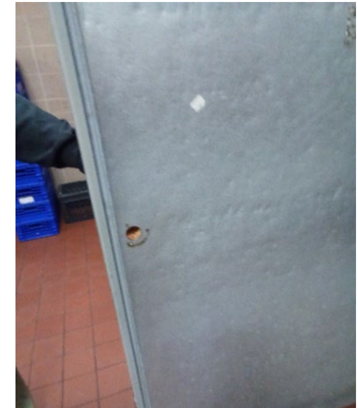
While occupant food service workers at MCJ adhered to most uniform requirements, including hairnets, beard guards, and aprons, they were observed wearing personal tennis shoes instead of the mandated non-slip safety shoes. This oversight poses a significant safety hazard, as slippery surfaces in food service areas increase the risk of slips, trips, and falls. Ensuring workers wear proper footwear is crucial to preventing injuries.

MCJ's food service demonstrates a commitment to providing nutritious and varied meals. Menus, including special diets, are reviewed annually and certified by a registered dietitian, with nutritional analyses provided for all options. The facility accommodates both medical and religious dietary needs, with proper documentation and procedures in place. While the current menus offer a variety of choices, updated versions are under review and awaiting final approval from a registered dietitian. Despite MCJ's efforts to provide nutritious and varied meals, food service staff need to communicate in writing to the occupants. Food menus are not posted in housing units, denying occupants the opportunity to preview meal options, manage dietary needs, and anticipate potential allergens. Trinity should comply with MCJ contract to notify correctional supervisors when there is a change to the menu so security can notify occupants of the change.

This lack of transparency can contribute to dissatisfaction, health concerns, and unnecessary tension within the facility. Making menus readily available in advance is a simple yet crucial step towards improving occupants' well-being and fostering a more positive environment. (Best Practice)

The facility operates a satellite feeding system that serves meals on thermally insulated trays. The meals are delivered via covered transport carts, accompanied by Trinity food service personnel. The carts are secure and supervised by staff. Occupants dine in the communal areas of their living units. The meals meet the required standards for temperature and portion size.

The sanitation level in the food service area is adequate. However, we do recognize that there are some areas that require further attention in terms of sanitation. Cleaning schedules were strategically posted throughout the area, and clean-as-you-go procedures were followed by both staff and occupant workers. It was observed that the ceiling tiles and A/C ventilation above the religious diet meal preparation areas were covered with dirt and dust. Garbage containers throughout the kitchen area were lined with plastic liners and kept clean. However, the containers were not covered with lids. Proper food storage temperatures were maintained to protect food from bacteria and prevent spoilage. The facility adheres to a First-In, First-Out (FIFO) stock rotation system and ensures a minimum 15-day food supply. Sanitation levels in the storage areas were found to be acceptable. The food supply storage racks were appropriately spaced from the walls to facilitate pest control inspections and prevent infestations and pest control services are routinely provided by Batzner Pest Control in Menomonee Falls, WI. Machine guards, light bulb covers, and GFCI electric outlets are in use and being continuously maintained.


No safety locks on walk-in coolers

However, doors to walk-in coolers two and three were not equipped with safety lock release mechanisms. Safety lock releases are necessary to prevent accidental entrapment, which can be life-threatening due to extremely cold temperatures. These mechanisms ensure that doors can be opened from the inside without requiring a key or special knowledge to exit. (DOC 350.11 Food service, Best Practice)

The facility uses a three-compartment dishwashing machine for trays, cups, utensils, pots, and pans. The equipment is prewashed in a four-compartment sink before being placed in the dish machine for further washing and sanitizing. This procedure eliminates the need for a three-compartment sink operation to wash large equipment such as pots and pans. (DOC 350.11 Foodservice, Best Practice)

Upon observation of the dish machine area and inspection of temperature logs, we found water temperatures are recorded daily. Test kits are provided for the dish machine operation, and the results are recorded. All cleaning and sanitizing agents are used in accordance with product specifications.

The food preparation equipment was clean, professionally installed, and equipped with an automatic emergency gas shut-off system and an Ansul fire suppression system that alerts the master control center when activated.

The food supply delivery process lacks adequate security measures to prevent escape risks. The security doors leading to both the food service area and the rear dock are often left unlocked while supplies are being unloaded from trucks, which is concerning due to the proximity to occupants in food service. Furthermore, the lack of a sallyport system does not deter individuals from trying to escape the facility. (DOC 350.18 Security, Best Practice)

Recommendations:

- Wearing certified non-slip safety shoes with specialized soles provides better traction and significantly reduces the likelihood of injuries to occupant workers.
- Food service monthly inspections (April 2024 - September 2024) found inspection reports to be well-written and concise, however comments were not entered in the "Action Taken for All "U" ratings" section of the report. This should be corrected by having the Food Service Supervisor complete the form in its entirety.
- Food menus should be made available in advance to the occupants by posting them in all the housing units or on the tablets.
- Install safety latches on food service cooler doors to prevent accidentally locking a person inside the cooler.

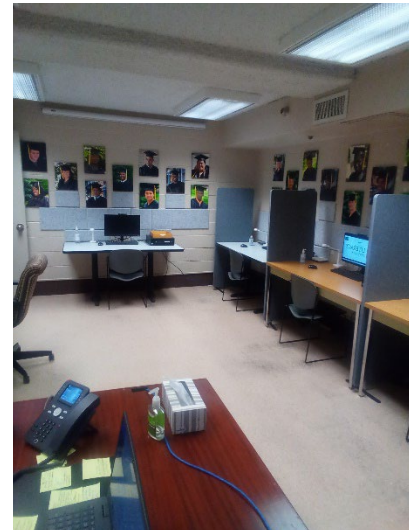
- Ceiling tiles and A/C ventilation above the religious diet meal preparation area should be cleaned or replaced.
- Install an expanded metal sallyport cage on the food service rear dock to prevent unauthorized access during deliveries or remove the occupants during the delivery then secure the garage door prior to the occupants returning.

Occupant Services and Programs:

The MCJ Custody Manual includes policies providing operational guidance for occupant management, due process, and programs. A review of policies, staff and occupant interviews, occupant handbook, and facility observations revealed that occupants have access to programming, the courts, their attorneys, legal materials, and medical and mental health care.

Programs and Services:

The MCJ Custody Manual - Chapter 10, outlines a written policy dedicated to Occupant programs. MCJ provides an array of programs and services, such as library and video visitation services, commissary, employment opportunities, recreational activities, religious engagements, and educational programs. MCJ employs 125 trained volunteers, including 20 virtual ones, to deliver programs focused on education, religion, self-improvement, life skills, parenting, and relationship building. MCJ facilitates Adult General Educational Development (GED) via Literacy Services of Wisconsin and offers High School Diploma classes through Milwaukee Public Schools (MPS). Occupants can engage in further online programming through their personal tablets. Postings within the housing units at MCJ were noted during our tour, providing occupants with information on the variety of programs offered and instructions on enrollment.



GED/Education Room

Visitation Program:

Remote off-site video visiting is available to occupants through the Getting Out App. Occupants can utilize the kiosk in the designated booths located on the top tier of their housing units. According to staff, occupants can also access video visiting through their jail-issued tablet. On-site visits are only available for occupants, attorneys, and professionals (e.g., clergy, probation officials).

Education Program:

Occupants participate in the Adult GED Program provided by Literacy Services of Wisconsin. The occupants in the GED classes communicate one-on-one with volunteer tutors from multiple states. Full-time teachers from Milwaukee Public Schools (MPS) provide classes four days a week.

Occupant Work Program:

MCJ houses both sentenced and pre-trial occupants in housing unit 3D. A review of work files and staff interviews revealed that sentenced occupants work in food services or general cleaning, while pre-trial occupants work in general cleaning or biohazard. Occupants assigned to these work details receive medical clearance, training, and orientation to safety practices.

The occupant workers can receive credit at the discretion of the Sheriff under the following conditions:

- The credit shall not exceed one day for every 24 hours worked.
- This credit is in addition to good time credit under Wisconsin Statute § 302.43.
- The occupant must not be in violation of any rules of MCJ.

Recreation and Commissary:

MCJ occupants have daily access to recreational activities outside of their cells. Those housed in the general population can use the indoor gym/recreation area located next to their housing unit. Unit staff follow a schedule to ensure that only one side of the unit is out at a time. The gym is equipped with basketballs and nets. Additionally, occupants were observed watching television and playing table games in their housing units.

Aramark provides commissary services to the MCJ population five days a week. A review of the commissary list revealed a variety of items available for purchase. Through the Aramark iCare Program, occupants' family members can order packages and meals securely through a website.

Discipline Program:

At MCJ, the role of Discipline Hearing Officer (DHO) is rotated among Captains. An examination of training records and interviews with staff disclosed that no formal training is given to those conducting hearings. Staff members report adhering to the protocols described in the MCJ Custody Manual, specifically Chapter 6, Section 600, which covers occupant discipline. An analysis of five disciplinary records confirmed that staff comply with the outlined procedures, guaranteeing that occupants are notified 24 hours before hearings, that hearings are held within three days following an infraction, and that occupants are apprised of their rights during the hearing, including the right to challenge the decision of the hearing officer.

MCJ Captains rotate the responsibility of DHO, however, a review of training documentation and staff interviews revealed there is no formal training provided for staff who conduct these hearings.

Classification Procedure:

MCJ classification officers use the Northpointe Decision Tree to classify new occupants. Classification staff review various factors such as the occupant's current charge, criminal history, age, sex, medical and mental health needs, institutional behavior, and special needs to determine the appropriate level of supervision, temporary holding, housing, and programming. New occupants are then assigned to intake housing units (3A, 3B, or 3C).

A review of five occupants' classification files showed that they were appropriately classified as medium security (4) and close custody (1) and housed accordingly based on their charges, behavior, mental and medical needs, separation needs, personal interviews, and observations. Occupants are re-classified when there are changes in factors such as new, dropped, or amended charges or when case status changes from pre-trial to sentenced, and at least every 90 days.

While efforts are made to house occupants appropriately, population constraints sometimes prevent them from being housed according to their security and classification levels. To address population concerns, MCJ occupants are screened by Community Reintegration Center (CRC) staff and moved there when MCJ is overcrowded and has limited beds. However, only MCJ occupants meeting the stringent classification criteria of the CRC will be accepted by the CRC. Staff interviews and observations revealed that MCJ houses different security levels in the same housing unit (4D) but in separate cells. Disciplinary segregation occupants were sometimes secured in cells in the general housing units. However, concerns were raised by staff about security and safety issues when occupants are outside of their cells.

- The MCJ classification staff indicated that, despite their best efforts, there are times when population constraints make it difficult to place occupants in suitable housing based on their security and classification levels.

Admission and Orientation:

The MCJ Custody Manual, specifically Chapter 5 on Occupant Management, Section 503, outlines policies addressing admission and orientation. The MCJ intake/booking area is a very busy hub featuring a workstation, 16 holding cells (1-7 for females and 8-16 for males), six cameras, two benches used for suicide watch, a fingerprint and photo station, offices for initial and secondary health screenings, and a search area equipped with a boss chair metal detector and a full-body scanner.

During admission, an occupant's property is searched, inventoried, and any funds are either deposited into a kiosk, immediately credited to the occupant's account, or secured in a locked cash box. Staff also ensure foreign currency is kept with the occupant's property. Searches of the occupant include the use of the boss chair, a pat-down, a walk-through metal detector, and a full-body scanner. Medical staff conduct initial and comprehensive secondary health screenings for all new occupants. An intake/booking officer takes fingerprints, photographs the occupant, and completes additional paperwork for the jail record/booking file.

An English-only orientation video is played continuously in the booking area. Occupants have access to the MCJ Occupant Handbook in both English and Spanish via tablets and kiosks within the housing units. However, a review of the handbook indicates that information on occupant visitation is outdated, as MCJ currently only permits attorney-client onsite visits. Despite the handbook's bilingual availability, several informational postings in the housing units are in English only. (NDS 6.1, Best Practice)

Staff interviews and observations revealed new occupants identified as suicidal are handcuffed to benches for observation. Even if the booking supervisor believes the occupant can be removed from watch, a 24-hour period for placement is mandated per established protocol.

Recommendation:

- The occupant handbook should be updated to include the new visiting procedures.
- An annual review of the occupant handbook should be completed to address changes.

Grievance Procedures:

MCJ has a written policy (MCJ Custody Manual - Chapter 6, Occupant Due Process, Section 608) that specifically addresses Occupant Grievances. These procedures are also detailed in the MCJ Occupant Handbook. Occupants can file grievances via the kiosk in their housing unit, although they are encouraged to first seek resolution with the unit officer. The Grievance Program Coordinator is responsible for logging, assigning, and reviewing responses, as well as maintaining the grievance log. An examination of the log showed that grievances were filed on various issues, including but not limited to medical service fees and time spent in segregation. A review of the closed grievance logs revealed one instance where an occupant accused an officer of misconduct, and that same officer responded to the occupant's grievance. The Grievance Coordinator explained that grievances are assigned to the supervisor responsible for the area where the occupant is filing the grievance.

Recommendation:

- The occupant accused an officer of *misconduct,* and that same officer responded to the occupant's grievance. This should not occur; a different officer should be assigned to respond to the grievance.

Correctional Staffing: (See Attachment A)

- Director - 1 (1 position filled)
- Deputy Director - 1 (1 position filled)
- Captain - 8 (8 positions filled)
- Lieutenant - 21 (21 positions filled)
- Sergeant - 21 (17 positions filled)
- Correctional Officer - 225 (190 positions filled)
- Deputy - 2 (2 positions filled)

Food and health services staff are contracted and do not affect MCJ's correctional staff complement.

Staff Training:

Staff development and training policy was reviewed, outlining procedures for all staff training at MCJ. During pre-service training, all correctional staff receive 64 hours of classroom instruction. Topics covered range from basic to complex, including CPR, report writing, radio etiquette, and taser instructions. However, there is no formal training provided for managing mental health occupants or identifying suicidal behaviors, suicide awareness, and prevention. Many new Correctional Officers working on assigned posts are probationary and have not yet completed the five-week (200-hour) mandated instruction at the training academy where these topics are covered. This became evident during staff interviews in which the probationary staff were unable to effectively address managing mental health occupants or identifying suicidal behaviors, suicide awareness, and prevention.

All staff receive 24 hours of annual refresher training. Training files are kept as electronic copies tracked on a spreadsheet accessible to management staff. The Jail Administrator's office oversees operations at MCJ and coordinates the staff development and training program. Due to shortages in correctional officer positions, additional in-service training is difficult to present as there are no relief positions available for staff to attend training.

Staff Surveys (See Attachment C)

Staff Survey outlines the methodology used to gather staff feedback with MCJ Mental Health and Medical, MCJ Administration and Supervision and MCJ Employee Engagement.

Interview Methodology:

- Anonymous Interviews: Anonymous interviews were conducted with a representative sample of MCJ staff to ensure candid feedback.
- Private Setting: Interviews were conducted in a private office space to maintain confidentiality and encourage open communication.
- Standardized Questions: Standardized questions were used to assess staffs' experiences with and perceptions MCJ mental health and medical, MCJ administration and supervision and MCJ employee engagement.
- Diverse Sample: Both male and female staff participated in the interviews.
- The sample included probationary and non-probationary staff ensuring representation across the facility.
- Range of Lengths of employment: Interviewees ranged from 1 month to 15+ months, providing diverse perspectives on the continuity and effectiveness of MCJ.

Breakdown of key takeaways:

- **Generally knowledgeable:** MCJ staff demonstrate a good understanding of how to access medical and mental health services for occupants.
- **Suicide prevention training needed:** There is a need for increased awareness and training on suicide prevention, particularly for probationary staff.
- **Knowledge gaps:** Some staff lack in-depth knowledge of suicide risk factors and symptoms.
- **Counseling awareness:** Some staff were unaware of the availability of counseling services after witnessing a suicide attempt. However, it should be noted a review of MCJ Leadership emails to staff and roll call talking points indicate staff have been educated on counseling services.
- **Responsive professionals:** Despite these areas for improvement, staff reported that both medical and mental health professionals are responsive to Occupant's needs.
- **Poor work/Life Balance:** Probationary staff work more than 60 hours a week which is impacting their home life. A follow up question indicated that non-probationary (80%) are routinely using FMLA causing the probationary staff to be mandated to work.
- **1st Line Supervisors Access:** 1st line Supervisors routinely make rounds to check on staff.
- **MCJ Administrative Staff:** Rarely make rounds in the housing pods.

Concerning Remarks from the Probationary Staff:

It is common for correctional staff to receive a letter from their supervisor mandating work on scheduled days off. A review of a correctional officer's three-week schedule revealed she was required to work an 8-hour post on one of her two scheduled days off each week. This practice of assigning work on days off is causing many new staff to resign.

Many correctional staff reported the abuse of FMLA within the correctional officer and supervisor ranks. Staff were using FMLA to avoid mandated overtime, undesirable assignments, and to supplement unscheduled vacation, causing scheduling issues for those without FMLA. Staff not requiring FMLA are often mandated to cover these posts. It has become common practice for correctional staff, coming off probation, to seek FMLA to avoid mandatory overtime.

Recommendations:

- Probationary staff should receive formal training for managing mental health occupants and identifying suicidal behaviors, suicide awareness, and prevention during their onboarding training.
- MCJ Human Resource support staff should investigate and determine if FMLA is appropriately approved for Correctional Officers. If Correctional Officers cannot work every post within the facility as stipulated in their onboarding process, then a fitness for duty should be considered.
- MCJ should prioritize giving staff two consecutive days off and eliminate mandatory work on scheduled days off. This will improve morale and work/life balance.
- Like many correctional systems struggling with staffing, MCJ evaluated the potential benefit of moving to a 12-hour shift schedule as opposed to an 8-hour shift schedule. There are some attractive attributes for a 12-hour schedule, including requiring only two shifts of staff to cover posts over a 24-hour period instead of three shifts of staff. From a staff perspective, the opportunity to work a schedule that requires having to report to work only 14 shifts per month with increased days off can be very attractive. This scheduling option was presented to staff for a vote. Reportedly, a majority of staff voted to retain 8-hour shifts. However, it should be noted that the majority of staff are currently working 12-hr shifts to prevent being mandated.

Conclusion

Despite uncovering several concerning safety and security risks at MCJ, Creative Corrections SMEs also acknowledge the facility's efforts to implement positive changes. This suggests that while significant challenges remain, MCJ is actively working towards improvement. A balanced approach that addresses both the deficiencies and the ongoing initiatives will be crucial for achieving a safe and secure environment for both staff and occupants.

The mental health department at MCJ stands out as a significant strength, consisting of a diverse and dedicated team of professionals who effectively serve the jail's dynamic population. The mental health department at MCJ plays a vital role, with a diverse and dedicated team of professionals who are making a positive impact on the jail's dynamic population. While clinical documentation could benefit from improvement, the team's commitment to occupant well-being is evident. Furthermore, the supportive stance of MCJ's administration, who are receptive to suggestions and eager to implement positive changes, creates a promising environment for enhancing mental health services and promoting staff wellness. External policy constraints do limit their ability to provide more clinical evidence-based therapeutics however, they have demonstrated a willingness to try and meet the needs of the occupant population.

MCJ and Wellpath must critically evaluate their suicide prevention and response policies, ensuring consistent implementation and addressing identified weaknesses. This includes improving communication between medical and mental health staff during booking screenings, re-examining the necessity of 24-hour suicide watch placements, and prioritizing improvements to the poor conditions of suicide watch cells. Furthermore, a comprehensive training program for all staff on recognizing and preventing suicidal behavior is essential to enhance the facility's overall suicide prevention efforts.

Despite some areas needing improvement, the collaboration between MCJ and Wellpath provides a solid foundation for delivering appropriate medical care to occupants. Wellpath's dedicated staff demonstrate a commitment to quality service. To further enhance healthcare at MCJ, Wellpath should prioritize improving communication with occupants about their health status, strengthening collaboration with mental health staff for suicide prevention, and expanding their CQI program to focus on outcome-driven measures. Additionally, enforcing strict pharmaceutical controls and recruiting an additional dental provider will address key areas identified in the review. By collaboratively addressing these recommendations, MCJ and Wellpath can continue to improve healthcare services and outcomes for occupants.

The current operational protocols for MCJ's Specialized Housing Unit (4D) suggest potential vulnerabilities. Housing occupants with diverse security and supervision needs, including those on suicide watch, disciplinary segregation, and mental health observation, within the same unit creates a volatile and potentially dangerous environment. This practice increases the likelihood of security breaches and exposes MCJ to significant liability. It is strongly recommended that MCJ reassess and reconfigure this unit to focus on a single classification need, ensuring the safety and security of both occupants and staff.

MCJ's lack of formal policies and written procedures for managing tools, equipment, and keys represents an opportunity to strengthen security practices. The observed instances of unsecured tools and keys accessible to occupants heighten the risk of escape or other critical incidents. To mitigate these risks, it is crucial for MCJ to develop comprehensive written procedures that include specific, chronological instructions for each correctional post. These post orders should be signed and dated by officers to ensure accountability and understanding. Additionally, implementing a daily stand-up count and increasing count frequency on weekends and holidays would further enhance security measures. These measures would not only improve overall security but also provide valuable support and guidance for new correctional officers.

MCJ's calculated use of force procedures warrants a thorough review, with particular attention to the current practice of allowing a team member, rather than a supervisor, to coordinate these events. To enhance oversight and accountability, it is recommended that a supervisor be responsible for coordinating and supervising all aspects of use of force incidents. Additionally, establishing a formal after-action review committee, composed

of qualified staff including health services and administrative representatives, would promote a comprehensive evaluation of such incidents. Prior to any planned use of force, health services should review the medical history of pre-trial detainees. Clear, written procedures for the use of progressive restraints should be developed, with a health services provider present during any use of force situation. Finally, MCJ should consider investing in updated protective equipment for its cell extraction team to ensure their safety and preparedness.

To enhance security and align with correctional best practices, MCJ should prioritize improvements to its occupant counting procedures. This includes designating a specific count each day as a stand-up count, increasing the frequency of formal counts, and establishing clear, written procedures for conducting counts. These procedures should require two staff members for each count, mandate signed count slips and outline specific requirements for verifying the presence of each occupant. Additionally, incorporating the use of out-counts during formal counts, as well as addressing emergency and census count procedures in policy and post orders, would further strengthen accountability.

To further enhance safety at MCJ, it is recommended that the facility explore opportunities to strengthen its safety program. This could involve seeking guidance from a certified safety professional with expertise in relevant areas such as NFPA, OSHA, and EPA regulations. Such an individual could offer valuable insights into the unique safety challenges present in a correctional setting. A comprehensive safety program should encompass elements such as thorough risk assessments, fire safety and occupational health expertise, incident investigation and prevention strategies, emergency preparedness planning, safety training and education for staff, data analysis and reporting, and compliance management. By proactively addressing these aspects of safety, MCJ can foster a safer environment for both staff and occupants.

To further enhance security and occupant satisfaction, MCJ could consider a few refinements to its food service operations. A review of the food delivery process and the development of written security protocols could help streamline operations and ensure secure deliveries. Implementing a sallyport system for the loading dock would further restrict unauthorized access and enhance overall security. Addressing the sanitation concerns noted in the food service area would also contribute to a healthier environment for both staff and occupants. Additionally, posting menus in housing units and periodically surveying occupants about their dining preferences could provide valuable feedback and improve satisfaction. While survey responses may vary, gathering input from the occupant population can offer insights into their needs and preferences, ultimately contributing to smoother operations.

MCJ shines in its commitment to providing a diverse and enriching experience for its occupants. Recognizing the importance of comprehensive programming, MCJ offers an impressive array of services designed to support personal growth, educational advancement, and meaningful engagement. Occupants can access valuable resources such as library services, video visitation, and commissary, while also benefiting from opportunities for employment, recreation, religious practice, and education. The facility's dedication to learning is evident in its support for GED programs through Literacy Services of Wisconsin and its partnership with Milwaukee Public Schools to offer High School Diploma classes. Furthermore, occupants can expand their learning horizons through online programming accessible on personal tablets. These initiatives demonstrate MCJ's dedication to fostering a positive and productive environment where occupants can develop valuable skills and pursue personal growth.

Maintaining adequate staffing levels is essential for the smooth and safe operation of any correctional facility. MCJ faces a challenge in this area, as shortages in correctional officer positions can strain resources and impact overall effectiveness. These shortages can lead to increased overtime, potentially affecting staff morale, wellness, and ultimately, the security of the institution. To address this, MCJ has demonstrated initiative in addressing correctional officer staffing challenges by implementing creative recruitment strategies. These efforts include region-wide advertising campaigns and attractive incentives. With strong support from Milwaukee County in providing competitive compensation and benefits packages, MCJ is successfully attracting and retaining qualified correctional officers. This proactive approach to recruitment is helping to

increase the numbers in staff to ensure adequate staffing levels and enhance the overall safety and security of the facility. By investing in its workforce, MCJ can ensure adequate staffing levels, reduce overtime, and promote a healthy work environment for its dedicated staff.

To effectively address overcrowding at MCJ, a collaborative approach with the Community Reintegration Center (CRC) is urgently needed. We implore Milwaukee County to actively support MCJ in forging a mutually beneficial Memorandum of Understanding (MOU) with the CRC. This MOU would grant MCJ operational control of the CRC's vacant annex building, providing immediate access to 180 much-needed beds for pre-trial occupants. This collaborative solution offers significant advantages for both parties. It provides crucial relief for MCJ's overcrowding crisis, while also offering the CRC a means to utilize their vacant facility with minimal liability and providing meaningful programming to occupants who need it. We strongly believe that this partnership presents a unique opportunity to address a critical need within the Milwaukee County correctional system and urge both parties to prioritize its implementation.

The challenges identified during this review of the Milwaukee County Jail are not isolated incidents but rather reflect broader trends observed in correctional facilities across the United States. Creative Corrections' extensive experience conducting audits and reviews enables us to offer valuable insights and recommendations for improvement. This comprehensive assessment aims to provide the Milwaukee County Sheriff and her staff with a roadmap to navigate operational challenges and enhance the overall effectiveness of MCJ. Our observations and recommendations are offered in a spirit of collaboration, with the goal of supporting MCJ in mitigating these challenges and promoting a safe and secure environment for both staff and occupants. We express our sincere gratitude to the Sheriff and the entire MCJ staff for their cooperation and assistance during this review.

Cost Assessment for MCJ projects and Equipment

Items	Cost	Installation Cost	Total cost
Cell Door Glass with installation hardware	5- $600	Maintenance staff install	$3,000
Cell Light Fire rated	10- $252	Maintenance staff install	$2,520
** 4Sight Labs ruggedized biosensors continuously monitor	1- $8,702	Included with training	$8,702
Relocate electrical switch to external wall outside cells.	10- $200	Maintenance staff install	$2,000
*** 2X3 Portable Containment Cell	3- $4,500	Maintenance staff put together	$13,500

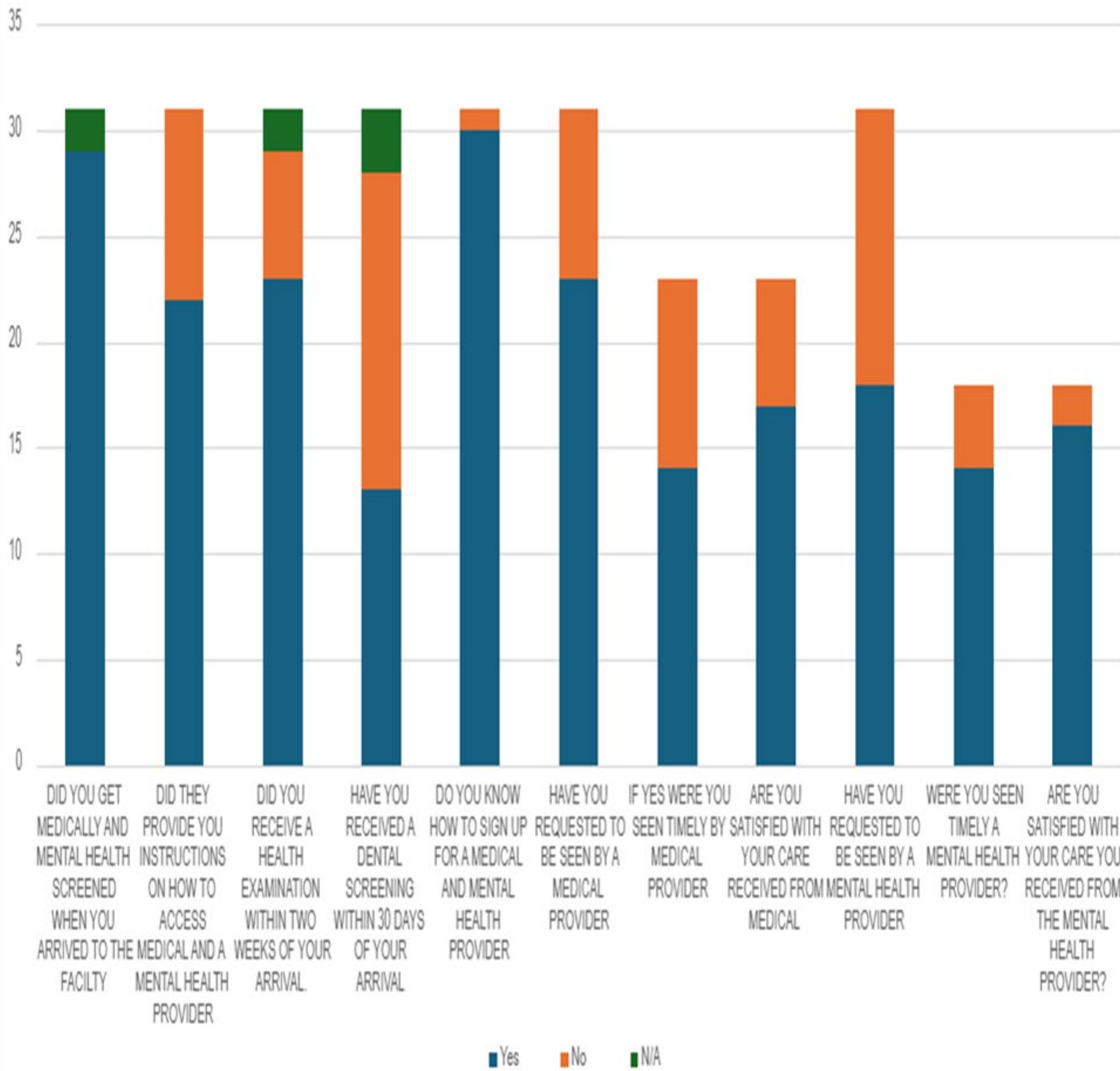
** MCJ should pilot the 4Sight Labs ruggedized biosensors to continuously monitor an Occupant with significant suicide ideation and attempts. https://www.fox5vegas.com/2024/10/19/technology-helping-prevent-jail-suicides-clark-county-detention-center/

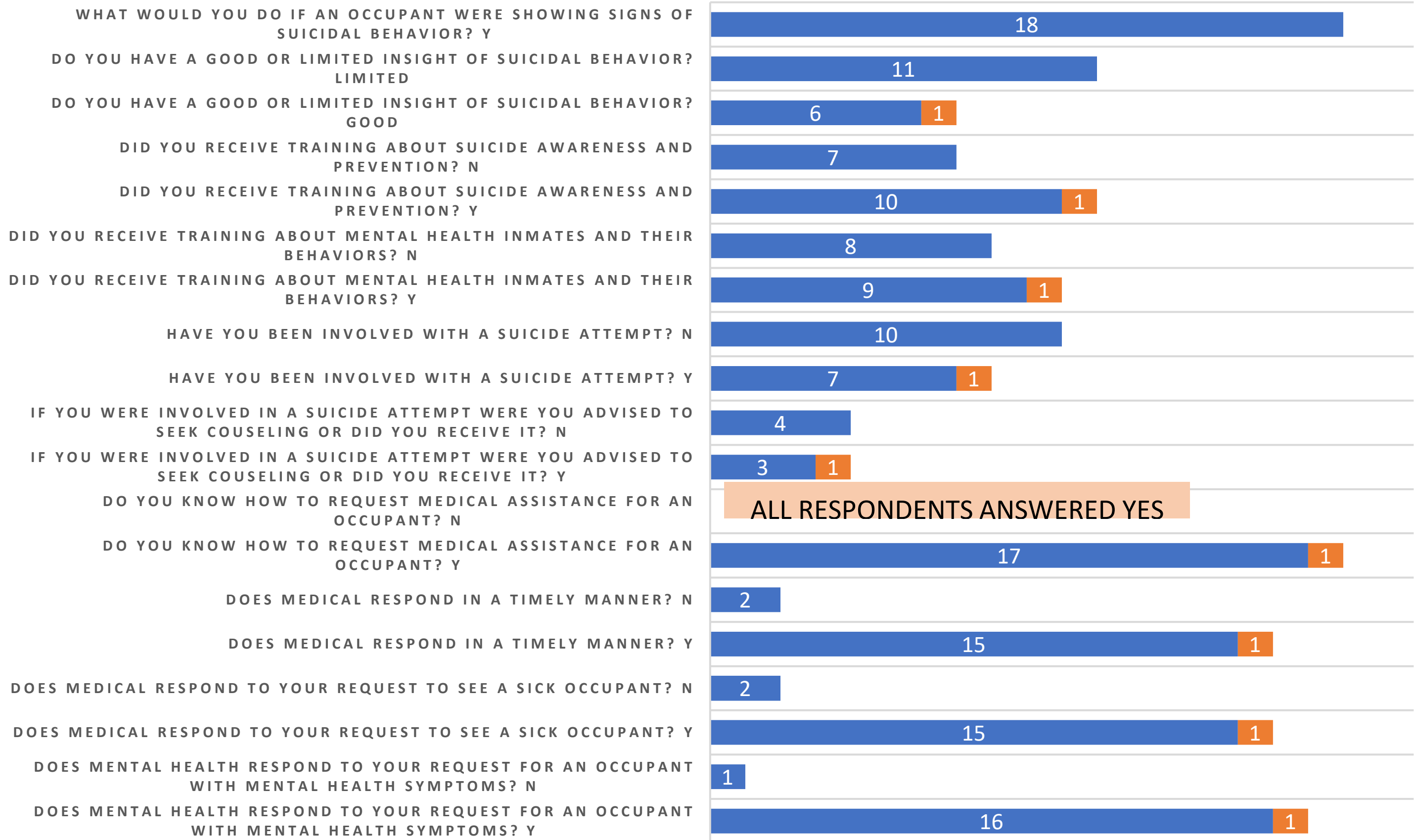
*** MCJ should remove the bench used in booking for suicide watch and replace it with the Portable Containment Cell to enhance the safety of the Occupant and eliminate the need for handcuffing.

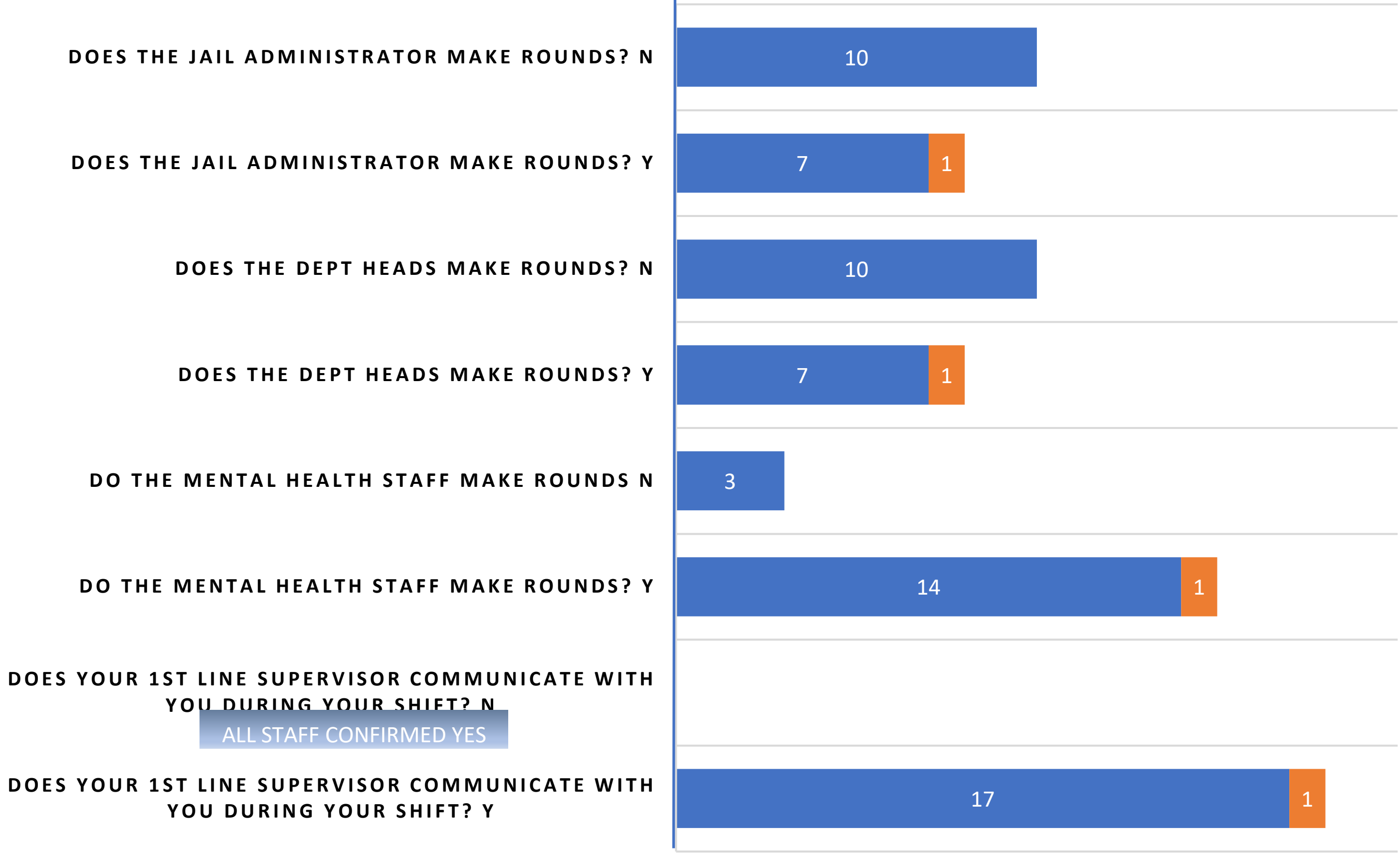
Staffing Analysis

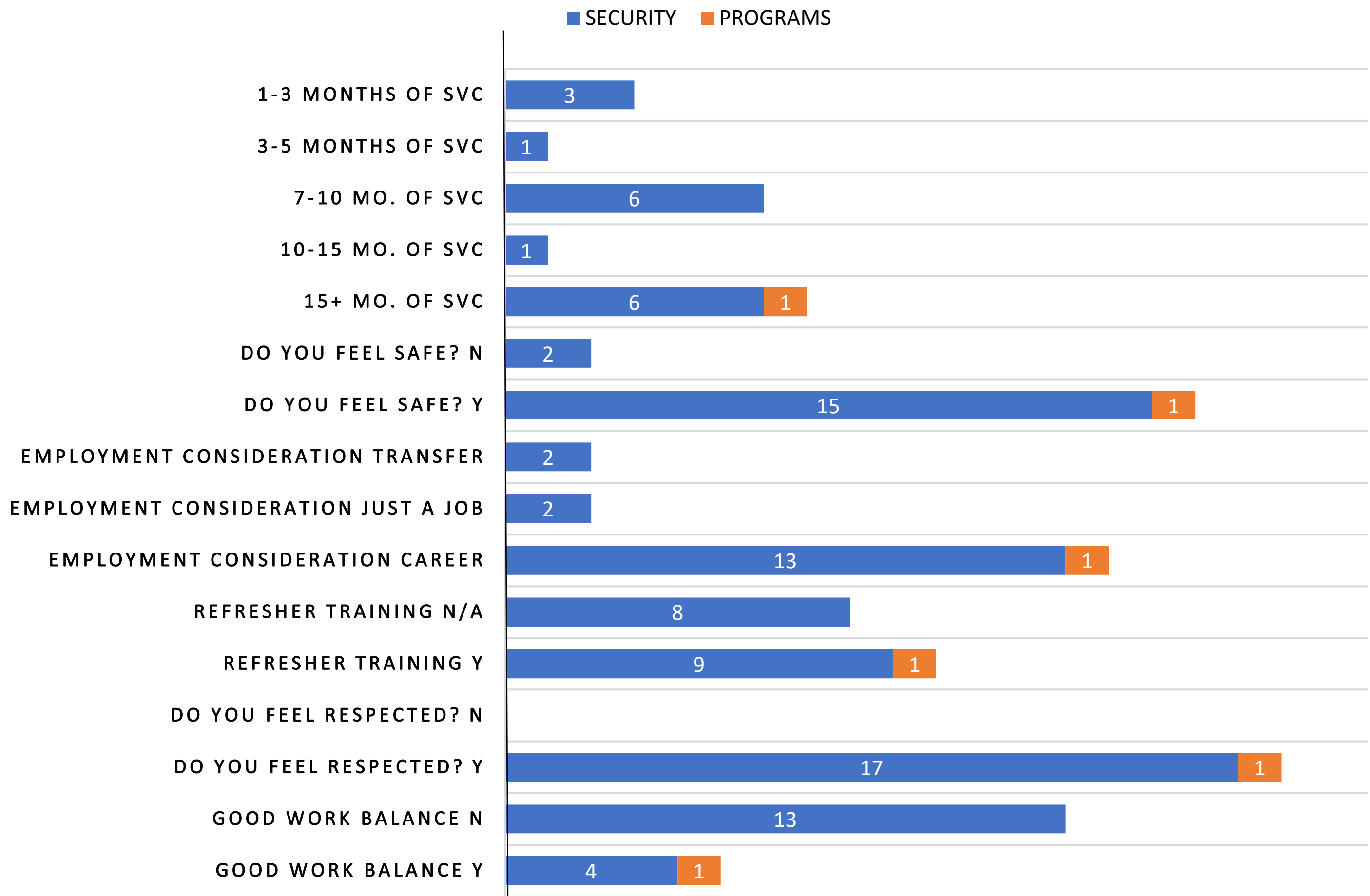
Position	Post	Shift 1	Shift 2	Shift 3	Relief	Staffing
Jail Administrator	5 Day Post	1			1	1.00
Deputy Director	5 Day Post	1			1	1.00
Assignment LT's	5 Day Post	4			1	4.00
Assignment Capt	5 Day Post	2			1	2.00
Sargent	5 Day Post	2			1	2.00
Captains	7 Day Post	2	2	2	1.66	9.95
Lieutenants	7 Day Post	4	4	3	1.66	18.25
Sargent	7 Day Post	6	4	4	1.66	23.23
Rounding						1.49
Subtotal		**22**	**10**	**9**		**62.92**
Position	**Post**	**Shift 1**	**Shift 2**	**Shift 3**	**Relief**	**Staffing**
Housing Unit Officers	5 Day Post	2			1	2.00
Occupant Worker	5 Day Post	6			1	6.00
Records/Identification	5 Day Post	2			1	2.00
DNA	5 Day Post	1			1	1.00
Mail Distribution	5 Day Post	1			1	1.00
Court Staging	5 Day Post	4			1	4.00
FTO	5 Day Post	4			1	4.00
CCF-S MVMT/Perimeter	5 Day Post	2			1	2.00
Transportation	5 Day Post	1			1	1.00
Law Library	5 Day Post	2			1	2.00
Facilities 1	5 Day Post	1			1	1.00
Occupant Communications	5 Day Post	1			1	1.00
Special Projects	5 Day Post	3			1	3.00
Property Supervisor	5 Day Post	1			1	1.00
Health Services Unit	6 Day Post	2			1.41	2.82
Med Movement	6 Day Post	2			1.41	2.82
Barber	1 Day Post	1			0.20	0.20
Master Control	7 Day Post	2	2	2	1.65	9.90
Housing Unit Officers	7 Day Post	29	29	11	1.65	113.80
Movement Relief	7 Day Post	1	1	2	1.65	6.60
Special Needs	7 Day Post	2	2	1	1.65	8.25
Special Medical Unit	7 Day Post	1	1	1	1.65	4.95
Clinic Assist Officer	7 Day Post	1	1		1.65	3.30
CIU Single	7 Day Post	2	2		1.65	6.60
CIU Double	7 Day Post	2	2		1.65	6.60
Classification	7 Day Post	2	2		1.65	6.60
Search	7 Day Post	2	2	2	1.65	9.90
Booking Security	7 Day Post	1	1	1	1.65	4.95
AFIS	7 Day Post	1	1	1	1.65	4.95
Photo ID	7 Day Post	2	2	2	1.65	9.90
Release	7 Day Post	1	1	1	1.65	4.95
Change Over (Male/Female)	7 Day Post	2	2	2	1.65	9.90
Jail Records	7 Day Post	2	2	2	1.65	9.90
CIU/Cstg Movement	7 Day Post	1	1		1.65	3.30
Pre-Book	7 Day Post	1	1	1	1.65	4.95
Stores Clerk	7 Day Post	2	2	2	1.65	9.90
Stores Clerk 3	5 Day Post	1			1.00	1.00
Rounding						0.51
Subtotal				**Subtotal**		**277.51**
Supervisor Staffing						62.92
Line Staffing						277.51
Total Staffing						**340.43**

Relief Factor	
5 Day Post -	1
6 Day Post -	1.41
7 Day Post -	1.66
7 Day Post -	1.65


Occupant Questionaire Results
35
30
25
20
15
10
5
0
DID YOU GET MEDICALLY AND MENTAL HEALTH SCREENED WHEN YOU ARRIVED TO THE FACILTY
DID THEY PROVIDE YOU INSTRUCTIONS ON HOW TO ACCESS MEDICAL AND A MENTAL HEALTH PROVIDER
DID YOU RECEIVE A HEALTH EXAMINATION WITHIN TWO WEEKS OF YOUR ARRIVAL.
HAVE YOU RECEIVED A DENTAL SCREENING WITHIN 30 DAYS OF YOUR ARRIVAL
DO YOU KNOW HOW TO SIGN UP FOR A MEDICAL AND MENTAL HEALTH PROVIDER
HAVE YOU REQUESTED TO BE SEEN BY A MEDICAL PROVIDER
IF YES WERE YOU SEEN TIMELY BY MEDICAL PROVIDER
ARE YOU SATISFIED WITH YOUR CARE RECEIVED FROM MEDICAL
HAVE YOU REQUESTED TO BE SEEN BY A MENTAL HEALTH PROVIDER
WERE YOU SEEN TIMELY A MENTAL HEALTH PROVIDER?
ARE YOU SATISFIED WITH YOUR CARE YOU RECEIVED FROM THE MENTAL HEALTH PROVIDER?
Yes
No
N/A


MCJ MENTAL HEALTH AND MEDICAL
SECURITY
PROGRAMS
WHAT WOULD YOU DO IF AN OCCUPANT WERE SHOWING SIGNS OF SUICIDAL BEHAVIOR? Y
18
DO YOU HAVE A GOOD OR LIMITED INSIGHT OF SUICIDAL BEHAVIOR? LIMITED
11
DO YOU HAVE A GOOD OR LIMITED INSIGHT OF SUICIDAL BEHAVIOR? GOOD
6
1
DID YOU RECEIVE TRAINING ABOUT SUICIDE AWARENESS AND PREVENTION? N
7
DID YOU RECEIVE TRAINING ABOUT SUICIDE AWARENESS AND PREVENTION? Y
10
1
DID YOU RECEIVE TRAINING ABOUT MENTAL HEALTH INMATES AND THEIR BEHAVIORS? N
8
DID YOU RECEIVE TRAINING ABOUT MENTAL HEALTH INMATES AND THEIR BEHAVIORS? Y
9
1
HAVE YOU BEEN INVOLVED WITH A SUICIDE ATTEMPT? N
10
HAVE YOU BEEN INVOLVED WITH A SUICIDE ATTEMPT? Y
7
1
IF YOU WERE INVOLVED IN A SUICIDE ATTEMPT WERE YOU ADVISED TO SEEK COUSELING OR DID YOU RECEIVE IT? N
4
IF YOU WERE INVOLVED IN A SUICIDE ATTEMPT WERE YOU ADVISED TO SEEK COUSELING OR DID YOU RECEIVE IT? Y
3
1
DO YOU KNOW HOW TO REQUEST MEDICAL ASSISTANCE FOR AN OCCUPANT? N
ALL RESPONDENTS ANSWERED YES
DO YOU KNOW HOW TO REQUEST MEDICAL ASSISTANCE FOR AN OCCUPANT? Y
17
1
DOES MEDICAL RESPOND IN A TIMELY MANNER? N
2
DOES MEDICAL RESPOND IN A TIMELY MANNER? Y
15
1
DOES MEDICAL RESPOND TO YOUR REQUEST TO SEE A SICK OCCUPANT? N
2
DOES MEDICAL RESPOND TO YOUR REQUEST TO SEE A SICK OCCUPANT? Y
15
1
DOES MENTAL HEALTH RESPOND TO YOUR REQUEST FOR AN OCCUPANT WITH MENTAL HEALTH SYMPTOMS? N
1
DOES MENTAL HEALTH RESPOND TO YOUR REQUEST FOR AN OCCUPANT WITH MENTAL HEALTH SYMPTOMS? Y
16
1


MCJ ADMINISTRATION & SUPERVISION
SECURITY
PROGRAMS
DOES THE JAIL ADMINISTRATOR MAKE ROUNDS? N
10
DOES THE JAIL ADMINISTRATOR MAKE ROUNDS? Y
7
1
DOES THE DEPT HEADS MAKE ROUNDS? N
10
DOES THE DEPT HEADS MAKE ROUNDS? Y
7
1
DO THE MENTAL HEALTH STAFF MAKE ROUNDS N
3
DO THE MENTAL HEALTH STAFF MAKE ROUNDS? Y
14
1
DOES YOUR 1ST LINE SUPERVISOR COMMUNICATE WITH YOU DURING YOUR SHIFT? N
ALL STAFF CONFIRMED YES
DOES YOUR 1ST LINE SUPERVISOR COMMUNICATE WITH YOU DURING YOUR SHIFT? Y
17
1


MCJ EMPLOYEE ENGAGEMENT
SECURITY
PROGRAMS
1-3 MONTHS OF SVC
3-5 MONTHS OF SVC
7-10 MO. OF SVC
10-15 MO. OF SVC
15+ MO. OF SVC
DO YOU FEEL SAFE? N
DO YOU FEEL SAFE? Y
EMPLOYMENT CONSIDERATION TRANSFER
EMPLOYMENT CONSIDERATION JUST A JOB
EMPLOYMENT CONSIDERATION CAREER
REFRESHER TRAINING N/A
REFRESHER TRAINING Y
DO YOU FEEL RESPECTED? N
DO YOU FEEL RESPECTED? Y
GOOD WORK BALANCE N
GOOD WORK BALANCE Y
3
1
6
1
6
1
2
15
1
2
2
13
1
8
9
1
17
1
13
4
1