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JUSTICE CONSULTING

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Greetings:

Thank you for allowing me the opportunity to assist the Louisville Metro Department of Corrections (LMDC) and help reduce harmful events by improving operations. Every jail was designed differently and therefore every jail operates differently. As you are aware, the design of the LMDC facility is poor, limiting lines of sight and sound between staff and inmates. As the saying goes though, "It is what it is." Our goal is to make the best of a difficult situation and there are many opportunities to improve upon the safety and security of the facility.

Of equal concern are the customs and practices in the LMDC. There are staff who are engaged and have the energy and ideas to make a meaningful difference for the future of the jail. Many of them appear overshadowed by more apathetic and unmotivated staff, who are sometimes their supervisors. Employee engagement can be a challenge in any jail environment, but many jails have adopted successful practices that raise the level of employee satisfaction and engagement, thereby reducing the number of harmful events. Jails rely upon the frontline staff. We need them to give care and attention to the inmates and operations of the jail that keep it a safe and secure place to live and work.

My perception is the current culture in the LMDC does not promote engagement and innovation as well as it should. Even more disturbing, there appears to be a tolerance for poor performance and misconduct, one of the most harmful behaviors that can exist. If destructive behaviors are tolerated, the LMDC will never be the jail that you want it to be.

There are many positive changes that can be made in a short amount of time. Simple physical improvements and a unified vision of the LMDC leadership team can begin having an impact almost immediately. However, the long-term challenge will be to change the culture throughout the organization and research shows that may take 18 months to 2 years. Regardless of how long, culture change will be the best investment you can make. Good employees working in a poor facility are more successful than poor employees working in a good facility.

While some planning effort has been made over the past 14 years, there is little evidence of execution. In 2008, the Louisville Metro Correction Committee put forth 37 recommendations titled "Metro Corrections: Vision 20/20". None of the membership included someone from the LMDC, although they were listed as a "resource team." The stated goal of the effort was, "To develop a comprehensive plan that addresses both existing and future needs and provides strategic direction as the community looks forward to the year 2020." While many of the recommendations were good, they were strongly focused on criminal justice and court reforms rather than jail practices or conditions.[1]

In 2014, the LMDC completed an audit process for accreditation by the American Correctional Association (ACA). While commendable, the ACA standards are strongly focused on administrative matters and reporting rather than operational practices.

In 2016, Director Bolton published "Post 20/20: A Look at How Far We Have Come." It was presented as an update on the progress of the 2008 recommendations.[2] Along with accomplishments on the criminal justice reform recommendations, Director Bolton noted the continuation of the Daily Shift Briefing, an organizational restructuring, a safety committee and

[1] https://louisvilleky.gov/corrections/document/vision20-20finalreportpdf
[2] https://louisvilleky.gov/corrections/document/post20-20february2016-revised2-2019pdf

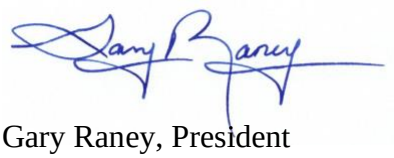
oddly enough, he touted a data-driven decision-making process called "LouisStat Performance Management" (likely after the New York police Compstat model) and the success of the "comprehensive and customizable" xJail system. While I do not know what was happening in 2016, today the LMDC is not tracking suicides, suicide attempts, uses of force and many other basic measures.

It is also interesting to note the LMDC Strategic Plan that was published in 2018. While many of the Department goals were commendable, none of the seven goals had any detail beyond the first step of identifying "what" to do.[3] It appears the lack of focus and execution has led the LMDC to where it is today.

In the following pages I have organized my observations, concerns and recommendations for your review and consideration. With only three days on site, I may have received inaccurate information or made a false assumption, but the LMDC command can clarify any of those issues.

The scope of work for the current assessment project included an informal report. I hope there is sufficient information in this document, but I stand ready to provide as much additional detail and advice as you need. I can also complete a formal report on these findings if needed.

Again, thank you for the opportunity to help make the LMDC an outstanding jail,



Gary Raney, President

[3] https://louisvilleky.gov/corrections/document/lmdcspsept2018pdf

Observations, Recommendations and Solutions for the Louisville Metro Department of Corrections

1) The Facility

a) Observations

i) The facility is obsolete and poorly designed. Modern jail design includes good lines of sight and sound for correctional officers to see and hear inmate activities. Inmate observation in the LMDC requires officers to intentionally look into each cell and often enter dayrooms to make checks. The disjointed design of the LMDC inhibits the staff's ability to casually see and hear inmate activity. This is inefficient but more importantly, the difficulties of the physical space have contributed to poor practices by staff.

ii) Bars, bunks and fixtures in cells facilitate suicide attempts. I did not observe any cells that were suicide resistant.

iii) Dim cells make officer observations difficult.

iv) The jail is not ADA compliant.

v) Maintenance has been deferred, leaving a disordered environment. Inmate behaviors are influenced by their setting. The paint, fixtures and many other aspects of the jail have not been maintained well. Exposed wires, missing wall covers and the general disrepair of the jail detract from a positive culture for staff and inmates.

vi) Trash is commonly visible inside and outside the facility and inmates have been allowed to collect personal items that violate policy and create a disarray of food, clothing, blankets and other property.

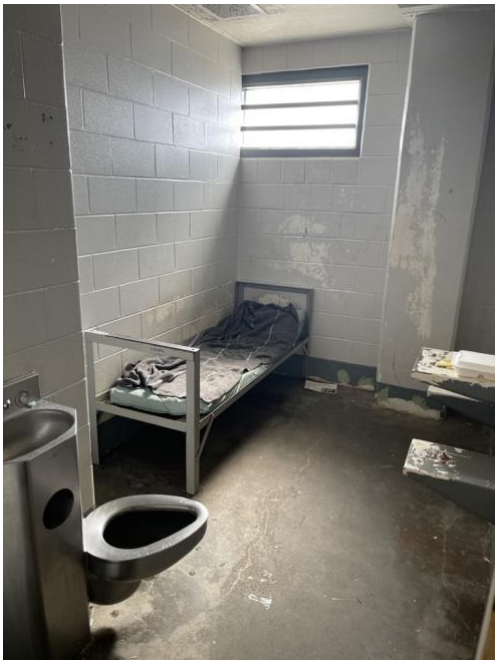
b) Recommendations

i) The camera systems in the jail should be expanded to include all hallways, ingress/egress points and as many cells as possible. Isolation cells are the most common places to commit suicide and out of 226 single cells in the jail, only 16 have cameras.

ii) Additional monitors for the cameras should be installed to allow more staff to observe high-risk inmates. One of the most notable examples of this is the "passive booking desk" where officers are always present but cannot video monitor the inmates in the holding cells.

iii) Convex and half-dome mirrors should be installed in hallways, especially at the intersections. This would allow staff to better observe inmate activities, especially worker aids.

iv) Cells that are frequently going to be used for suicide watch should be made into suicide resistant cells by replacing the bars, bunk, table/bench and toilet fixtures with fixtures that cannot be tied to. Note that even the sink/toilet fixture in the photo at right can be a tie-off point for a noose (strangulation does not require height).



v) There are no "two-person" cells in the LMDC. Given the number of isolation cells, it is puzzling that there are one-

person cells but no two or four-person cells and few six-person cells. If within Kentucky jail standards for space, or if standards can be waived, a second bunk could be installed in some of the single-person cells. While having the added value of capacity, the most important reason is to pair inmates and reduce the risk of suicide.

vi) Once a new classification process is in place, the housing plan should be reevaluated to ensure there is proper alignment of needs and available housing areas. The use of isolation cells should be reduced if possible as it is well-documented that isolation has negative outcomes.

2) Life Safety Practices

a) Observations

i) Safety practices that are fundamental to a well-run jail are often absent in the LMDC, including quality observations checks, enforcing life/safety inmate rules and recognizing high-risk behaviors. Many of these poor practices exist because of inconsistent supervision and enforcement of policies and inmate rules. This is a common challenge in jails and occurs when officers stop enforcing rules, making it hard for the successive officers to then enforce them. Combined with a lack of staff supervision, it quickly creates the situation where none of the officers are enforcing important rules.

ii) Observation checks are routinely late, poorly conducted and fraudulently logged. It is worth noting that the fraudulent entries are a Class D felony in Kentucky.[4]

[4] 519.060 Tampering with public records. (1) A person is guilty of tampering with public records when: (a) He knowingly makes a false entry in or falsely alters any public record; or (b) Knowing he lacks the authority to do so or

Additionally, the system for supervisor review of observation checks is meaningless and may even condone the misconduct by ignoring policy and rule violations. At the same time, redundant and inefficient systems have been created to try to establish accountability but have actually harmed the process. Staff view the importance of observation checks as a time issue rather than a safety issue. The universal concern of staff was that checks were clocked on time, but there was little attention to the quality of the observation check.

iii) Blanket tents are allowed around bunks. This not only prohibits the officer from conducting proper observation of the inmate, but it also provides the opportunity for suicide, assault, sexual contact and similar behaviors to go undetected.

iv) Staff allow lights, exterior windows and door windows to be covered, limiting their ability to see into cells. Again, this practice makes it difficult for the officer to conduct proper observations of the inmates.

intentionally destroys, mutilates, conceals, removes, or otherwise impairs the availability of any public records; or (c) Knowing he lacks the authority to retain it, he intentionally refuses to deliver up a public record in his possession upon proper request of a public servant lawfully entitled to receive such record for examination or other purposes. (2) Tampering with public records is a Class D felony.

v) Plastic sheeting is used as a visual barrier for staff and inmates, but it also inhibits staff's ability to observe inmates. Staff may need to cover the window of a misbehaving inmate or to keep inmates from looking into control rooms and staff offices, but the current practices limit important observation opportunities. Mirrored window coverings, mesh, magnetic cloth coverings and similar visual barriers can be equally effective while improving staff lines of sight.

vi) The LMDC inmate isolation practices are concerning. While the CGL report said there were insufficient isolation cells, it did not seem to take into account the national trend to reduce isolation due to its correlation with suicides and other harmful events. 12% of the beds in the LMDC are isolation cells, a number that is generally considered adequate. The unique situation in the LMDC is that there are single-person cells, then no two or four-person cells and few six-person cells.

vii) Staff may be misperceiving the danger of certain inmate behaviors. The lack of interaction between the staff and inmates is contributing to misperceptions of the dangerous behaviors that are occurring in the cells. The inordinate number of fights between inmates is a strong indication that a few inmates in the cells are using violence and intimidation to gain control of the cell. This allows them to establish themselves as the "tier boss", force payments of commissary and food and prostitute the weak inmates. There was little recognition by staff that this behavior may be occurring.

viii) Staff seem poorly trained or apathetic about other high-risk inmate behaviors. There is a lack of awareness and knowledge about managing mental illness, suicide warnings, victimization indicators and other concerns that should trigger a response

from staff. It is probable that the pandemic reduced training opportunities and the excessive overtime and lack of supervision has created staff apathy.

ix) Customs and practices regarding the use of force and restraints are dangerous and creating significant liability exposure, especially if there was a civil Monell claim. Poor policy, training and supervision are the trifecta of failures and to one degree or another, all appear to be concerns in the LMDC. In the recent death reviews, there was a clear instance of unreasonable force that drew no attention from any ranking officers. Additionally, there were poor restraint practices that led to unnecessary force. Supervisors overlooked these and there is no tracking or system to review these incidents.

x) In addition to uses of force, there is a seriously insufficient process for the reporting, review and investigation of other major events. All death investigations were insufficient and did not provide the opportunity for a broader view of what went right and what went wrong. Even the timeliness of some of them was insufficient. Administrative investigations should begin as soon as possible and Garrity interviews of staff should begin as soon as the criminal interviews are complete. While recent matters have focused the city's attention on deaths, unnecessary and unreasonable force should also be of concern. Every serious event should be seen as the opportunity to identify gaps and improve practices. There seems to be little, if any, recognition of this.

b) Recommendations

i) Leadership throughout the jail should unite and identify priorities and clear expectations for staff, then consistently enforce those expectations. Behaviors that violate rules and endanger people should not be tolerated by officers or supervisors. The most significant safety practices should be clear lines of sight for all inmates accomplished by the removal of blanket tents, lighting obstructions and window coverings. Adaptations such as adjusting lighting levels at night and the installation

of reflective glass coatings may be required. See the culture section for further information on the Strategic Leadership Plan.

ii) Educate staff on observation checks and enforce that the quality of observations is equally important as timeliness. A near-term goal should be to require staff to enter every housing unit and interact with inmates at least 2 to 3 times per shift. Inmate counts and similar obligatory activities do not count toward this goal. Staff should be walking in during unpredictable times and engaging inmates in conversation while being intentional about thoroughly observing the housing areas and inmates.

iii) Create and implement an effective process for the investigation and review of major events. Continue to evaluate death cases and begin evaluating other high-risk cases like uses of force. Establish quality review processes that build a learning organization to constantly improve the Department.

iv) Evaluate training on high-risk behaviors during the Training Needs Assessment (discussed later).

v) Create one observation logging system (probably Guardian RFID) that is trackable and can improve accountability. The strategic location of contact points can assist with staff observations and inmate movement tracking.

3) Contraband

As you are fully aware, one of the most significant threats to the safety and security of the facility is the introduction of contraband. While the new body scanners will reduce the flow from new arrestees and those being transported, it will likely have little impact on the internal flow of contraband between inmates and staff.

a) Observations

i) Worker aids have constant unsupervised access throughout the jail. This is unheard of in other jails.

ii) Commissary employees have unsupervised access to inmates.

iii) Food ports do not lock, allowing worker aids to pass contraband at any time.

iv) Food, drink and other items are delivered by inmates without staff supervision. This not only allows for the introduction of contraband but also payoffs of extra items or the denial of items to certain inmates. In well-run jails, staff always supervise the delivery of food, clothing, blankets, etc.

v) A key entry point for contraband is likely the kitchen and warehouse areas. Again, there is little supervision of inmates in these areas.

vi) The delivery of items from worker aids to housing areas is very predictable. Food is delivered to floors, in the same order, to the same inmates, by the same worker aids every day. This makes it easy for an item of contraband to be hidden in the kitchen, laundry, etc. with assurance that it can be handed to the right inmate in a cell.

vii) There is a common belief in the LMDC that some contraband is attributable to corrupt staff. Currently, staff are supposed to have transparent bags/backpacks but the policy is widely ignored. Additionally, the practice does not deter contraband anyway.

viii) Strip searches are/were only conducted based on reasonable suspicion.

ix) There is no system to track inmate movement, especially worker aids.

x) Inmates are permitted to keep their personal shoes. This allows the introduction of contraband, including undetected steel shanks and they are valuable items for gambling, robbery, etc.

b) Recommendations

i) Strip searches should be conducted on all inmates moving into, or returning to, general population.

ii) Lock the food ports and/or prohibit worker aids from opening them without the presence of an officer.

iii) I am currently working with LMDC staff to identify chokepoints for contraband and disrupt them. For example, randomizing the food carts, the delivery schedule and the worker aids would eliminate the predictability of contraband delivery.

iv) Continue with the detection canine acquisition plans. In the meantime, research if other agencies have canines that are available for periodic checks.

v) The LMDC should conduct their own background check on any non-staff member who will be unsupervised in the jail. Specifically, Trinity (commissary vendor) and other outside contractors.

vi) Consider additional body scanners in the housing areas as funds become available.

vii) Staff should be more diligent about individual and cell searches.

viii) Establish practices, policies and investigations to swiftly identify, terminate and prosecute any staff member who is introducing contraband into the jail. Focus on the offenders so you do not further disenfranchise the good staff in the LMDC.

ix) Prohibit personal shoes unless by medical order.

x) Incorporate RFID tracking for inmate wristbands. This would allow for the automated tracking of recreation time, visits, court, worker aid movements, etc.

4) Objective Inmate Classification

Classification and housing plans are one of the most significant processes to improve the safety and security of the jail and reduce the level of violence. The current classification and housing process is a cell assignment tool, but good classification processes are about managing inmate

behavior. Processes that have evolved into behavior modification tools now use the term "Strategic Inmate Management" to better reflect the purpose of a classification system and housing plan. Incentives and disincentives should correlate to positive and negative inmate behaviors, creating more compliance with rules and prosocial behaviors. It is critical that the LMDC update their classification and housing process to reflect these concepts.

a) Observations

   i) The classification tool is obsolete.

   ii) There are no routine classification reviews. These are fundamental to an effective system as a way to motivate positive inmate behaviors and usually occur every 60 days while someone is in custody.

   iii) The housing plan appears haphazard and not designed to incentivize prosocial behaviors.

   iv) There are no ongoing interactions or interviews between classification staff and inmates. This is likely due to the unusual circumstance of the jail using counselors as classification officers. While that may improve interactions at intake, it prohibits them from further interaction with inmates because they do not work in the housing areas. Classification should be an ongoing process, but it only occurs at intake in the LMDC.

   v) The concept of a classification committee currently in place is very good one but overutilized and too subjective. More than 30 years of research on classification systems has objectified the process and created reliable outcomes while reducing staff time. A classification committee should be used to review only the most problematic inmates, usually those with serious mental illness.

b) Recommendations

   i) Establish a validated objective inmate classification process, with a routine review process, likely every 60 days. Classification reviews will require training by

classification staff and an administrative decision about how to balance the current counselors with sworn staff who interact with inmates on the floor. All involved staff should have updated classification training.

ii) Establish inmate behavior management systems and integrate them into the classification system. For example, more prosocial housing areas should have more recreation time, better televisions, access to more commissary items, etc.

5) Culture and Leadership

There appears to be overall collegiality among staff. They commonly greet each other and voice support for each other. Some feel victimized by their perceptions of poor pay, a lack of support and the effect of understaffing. There is a tolerance of poor performance and strong indications of weak supervision. Some supervisors have become apathetic about their obligation to uphold policy and create consistency among staff. This inequity of supervision causes a fundamental deterioration of standards and creates safety and security risks.

There were few instances of staff having positive relationships with inmates, most likely caused by the infrequency of inmate-staff interactions. Staff rarely enter the housing units without cause and often do not engage in casual conversation with inmates. "Direct supervision" is the ideal situation for jails and occurs when staff are directly supervising and interacting with inmates 24/7. The observations and interaction created in a direct supervision environment often drop harmful events by over 90%. Unfortunately, the LMDC building design and lack of staffing make such a goal highly difficult, but not altogether impossible.

a) Observations

i) LMDC leadership and supervision have lacked professional unity, common vision and commitment to quality. There was no evidence of a collective vision for the future or strategic thinking with shared goals, priorities or quality assurance processes that should be in place.

ii) Communication vertically, horizontally and with stakeholders, like healthcare staff, is a significant issue.

iii) Supervision is not creating accountability. Sergeants and lieutenants ignore, and may condone, misconduct like falsified logs, unreasonable uses of force, etc.

iv) Supervision practices do not consistently direct staff time to the right needs. Some staff are very busy while others are not. While the LMDC is currently understaffed, there are practices that could be implemented to improve staff efficiency.

v) The staff have good ideas that would improve safety, security and efficiency but feel there is no feedback loop to share them.

b) Recommendations

i) Establish a Leadership Strategic Plan.

ii) Unify management to create common expectations of supervision and leadership. The new executive leadership in the jail is a perfect opportunity to set new expectations.

iii) Engage employees and consider engaging inmates in changing expectations and new leadership practices.

6) Management

While good supervision is mostly cultural, policy and training are also fundamental to a successful organization. Our impression is that management has tended to create a new policy and/or process each time a new problem arises rather than considering causal factors and using a problem-solving mentality. In short, the existing practices appear to be based on day-to-day decisions rather than informed and data-driven plans that change outcomes.

a) Observations

i) The 1,247-page policy manual is verbose, poorly organized and not easily accessible. Additionally, considering its volume, many sections provide little direction. What should be the most important guiding document in the jail has little value to line staff.

ii) Multi-layer processes, like observation check logging, have added additional tasks without adding quality. There are at least three different processes for documenting observation checks. This is inefficient and a waste of effort, especially because the logs currently have no meaning until a serious incident occurs. It has caused a focus on form over function.

iii) There is no meaningful management data to track trends or research serious incidents like uses of force, suicides, attempted suicides, medical distress, etc. The lack of data is a key contributor to some of the problems and failures of the current management processes.

iv) There are several instances involving high-risk areas that suggest training needs development.

v) There is a common perception by veteran staff that the quality of new hires is substandard; although, they recognize generational influences.

vi) Innovation in the LMDC is rare.

b) Recommendations

i) The policy manual should be rewritten into a meaningful document for line staff, removing the superfluous and purely administrative content. If the current policy manual is going to be maintained, a "Cliff's Notes" version should be created for line staff, although the lack of key points and direction in the current policy would make that difficult.

ii) Identify key metrics for successful outcomes and focus on those. As the attention to data increases, expand metrics as needed.

iii) Assess the XJail System software to determine if it can provide meaningful management data. It appears underutilized now, but it was not designed for a jail the size of the LMDC and likely does not have the capability needed for data-driven management.

iv) Track major incidents manually until a new system can be established.

v) Create a quality improvement process, potentially a team of middle-management and supervisory staff, to identify inefficiencies and poor processes. This will allow them to learn and develop as future leaders as well.

vi) Review the most recent Training Needs Assessment, Training Plan, Training Calendar and high-risk course content. Update if necessary. Compare against academy and in-service training. I expect this to uncover major deficiencies.

7) Staffing and Resource Allocation

a) Observations

i) There appear to be sufficient *authorized* positions for the safe operation of the jail.

ii) There is currently a high number of unfilled positions. The internal belief is that the LMDC cannot attract and hire enough qualified employees. High-performing organizations recognize that their employees are their best recruiting tool, but the current culture does not lend itself to being an attractive place to work. If the culture is improved, more and better applicants will apply.

iii) The current use of personnel resources is inefficient. There are several positions that are currently filled by sworn officers but could be filled by non-sworn staff. Building maintenance is the most obvious but other positions, like control room operators and intake positions that do not require inmate contact, could be filled by less-expensive non-sworn personnel who do not have to attend an academy.

Additionally, there are dedicated positions in the LMDC that are considered collateral duties for officers and sergeants in other jails.

iv) The organization of rank and duties in the jail appears inefficient, likely contributing to the weak supervision practices and staffing issues.

v) The previous discussion on redundant and inefficient operational processes unnecessarily consumes staff time.

b) Recommendations

i) Identify reductions in redundancies and the consolidation of efforts to improve efficiency. This may require a full workload analysis, but many efficiencies can be identified through continuing observations of operations and by asking questions. The most important efficiencies will occur from a reevaluation and realignment of administrative tasks and staffing allocations.

ii) Conduct a weekly workload analysis to identify tasks and then schedule them at predictable times to balance the workload. Areas of focus often include clothing, blanket and linen exchanges, mail delivery, recreation times, visiting times, etc.

iii) An informal staffing allocation study should be conducted, potentially leading to a formal study. There are several areas for improvement that are obvious but have not been considered. For example, using sworn officers as maintenance workers has long been known to be inefficient and contribute to poor maintenance, yet nothing has been done. An initial informal study would improve staffing efficiency more quickly and potentially save the City money.

iv) The results from above can be used to evaluate the need for a full staffing or allocation analysis.

v) Jails often operate on a 12-hour shift rather than the LMDC's 8-hour shifts. While this is likely a CBA issue, 12-hour shifts are often preferred by staff because of the additional days off. Common schedules are 4-on and 4-off, 4-on and 3-off

followed by 3-on and 4-off. The Fair Labor Standards Act 7(k) exemption allows the agency to change to a 28-day work cycle rather than a 7-day cycle and have an employee work for 171 hours within those 28 days rather than the 160 hours of a traditional schedule. The law does not require overtime compensation until the employee exceeds the 171 hours, but many agencies have negotiated that issue. More information can be provided upon request.

8) Healthcare practices

Most jails conduct initial healthcare screens at the time the arrestee enters the jail. This allows for the jail to identify injuries, infectious diseases and other medical concerns that may lead to immediate isolation or a request for hospital clearance. The LMDC accepts and books the arrestee before the medical screening process occurs. The problem with this practice is if someone enters with a highly contagious disease, like Covid-19, they can potentially infect several staff and inmates before they are screened and the condition is identified.

a) Observations

i) Arrestees are accepted into jail before the LMDC knows about injuries, communicable diseases, etc.

ii) There is currently a mostly verbal screening intake and then an exam 14 days later.

iii) Once in housing, healthcare staff voiced frustration with waiting to see their patients because the corrections staff say they do not have time. Correctional staff voiced frustration with the frequency and timing of clinical visits, often occurring during the day when they are busy.

iv) Healthcare staff report that they are often not called to conduct medical assessments after uses of force. This is concerning and should be changed immediately, if true.

b) Recommendations

i) Complete the initial healthcare screening before accepting the arrestee into the jail.

ii) Relationships and communication between officers and healthcare staff should be improved. Officers can be dismissive of healthcare staff needs and healthcare staff may be unnecessarily burdensome on officers' workload. This may be improved by a weekly workload analysis and improved scheduling of healthcare visits.

iii) Uses of force that exceed simple control holds should always be medically assessed and documented.

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