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<u>LaShawn Jones et al., and the United States of America v. Marlin Gusman, Sheriff</u>

March 2, 2013

I. Introduction and Background

My name is Jeffrey A. Schwartz and my office is at 1610 La Pradera Drive in Campbell, California. I am the president of LETRA, Inc., a non-profit criminal justice training and consulting organization that has had offices in the San Francisco Bay area since its incorporation in June, 1972. I have worked full time with law enforcement and correctional agencies across the United States and Canada for approximately 35 years, both as LETRA's president and as a private consultant. The largest proportion of my work for the last 20 years has been with prisons and jails. I have worked with more than 40 of the 50 state departments of corrections and with small, medium and large jails and local departments of corrections. During my career I have worked with and toured literally hundreds of prisons and jails. A copy of my resume is attached to this report as Appendix A.

I have served as an expert on law enforcement and corrections issues for more than 15 years. Over the last ten years, expert work has constituted perhaps 15% to 30% of my total professional time. In general, I charge $250 per hour for consultation, document review and other preparation activities and $350 per hour for actual testimony at trial or in deposition. A copy of my fee schedule is attached to this report as Appendix B, and a copy of cases I have worked on as an expert is attached to this report as Appendix C. A list of my recent publications is attached as Appendix D.

In early May 2012, I was retained as an expert in this action by Katie Schwartzman, Esq., of the Southern Poverty Law Center (SPLC). Ms. Schwartzman and Elizabeth Cumming, Esq., also of SPLC, represent the class of Plaintiffs in this litigation. SPLC has a joint litigation agreement with the Special Litigation Section of the Civil Rights Division of the U.S. Department of Justice, representing the additional Plaintiff in this case, the United States of America. Katie Schwartzman and Elizabeth Cumming have since requested a written report of my professional opinions in this case.

Prior to preparing this report, I reviewed a large number of documents, and a list of those documents is attached to this report as Appendix E.

In addition to the documents listed above, I also reviewed the American Correctional Association Jail Standards, "Performance-Based Standards for Adult Local Detention Facilities", Fourth Edition, June, 2004, and the various standards of the National Commission on Correctional Health Care (NCCHC).

I requested a tour of the Orleans Parish Prison ("OPP") and that occurred the week of December 17, 2012. Subsequent to my visit to the Jails, I interviewed the head of SOD, Colonel Michael Laughlin,

by phone about some additional questions and I also had a short phone conversation with Colonel Juliet Langham about compensation issues.

I am not a medical expert and I have not been asked nor have I attempted to form opinions about medical treatment in this case. Similarly, I am not an expert with regard to language assistance, non-English services and accessibility, and I have formed no opinion about that area.

As this report is written, there are a large number of documents that I understand have been requested in discovery by Plaintiffs but have not yet been produced. These include some critical documents that I have specifically requested as important in informing my opinions, such as the OPSO PREA Reports for 2011 and 2012 and the SOD investigations of 2012 incidents. I reserve the right to add to or change the opinions in this report if and when additional relevant information becomes available to me after the date of this report.

II. Method

This is a class action suit about conditions of confinement in the facilities that comprise OPP. While the broadest issues in this case center around inmate-on-inmate violence, staff use of force and mental health services available to inmates, there are a number of other allegations of conditions or practices that fail to meet minimum constitutional standards. The nature of this case raises different kinds of questions and some of those, in turn, require different methodology to investigate those questions. In general, I have used three different methods to form my opinions in this case.

First, there are areas in which the key questions have to do with how a specific area or function of the Jail works, in order to determine whether it is appropriate. In these areas, there is often little or no dispute between Plaintiffs and Defendant about what is occurring although it is necessary for Plaintiffs to fully understand the current status. For example, the policies of the Orleans Parish Sheriff's Office ("OPSO"), are not difficult to determine. Similarly, the classification system and the inmate grievance system operate in a particular manner. As with the Orleans Parish Sheriff's Office (OPSO) policies, they may be appropriate or inappropriate but the first order of business is to determine what, in fact, they are. To this end, the first method that I have used is to review the Jail's polices and procedures as they are specified on paper and then tour the Jail facilities at length and in detail, determining whether actual practices match written policies and procedures closely and also reviewing Jail practices in areas not covered by written policy or procedure. Once policy, procedure and practices have been identified, they can be compared to contemporary correctional practices and standards.

Regarding my tour, I flew to New Orleans on December 16th and spent December 17th through December 20th touring the Jails and meeting with Jail staff and inmates. These meetings were sometimes scheduled and relatively formal but more often informal. Some discussions with staff and inmates were one-on-one while others were with small groups of individuals, typically conducted as I toured. I did interview a relatively small number of inmates privately, using either an attorney visitation room or a staff meeting room. At those interviews, I was accompanied by MaggieYates, an SPLC inmate advocate.

A second method has to do with Plaintiffs' contention that Defendant is responsible for unacceptable levels of violence in the jail, for an unacceptably low level of mental health services provided, etc. Within this second method, the initial step is to determine the applicable duties of identified staff, looking to relevant law and regulations, to department policies and procedures, to professional standards and to widely accepted practices. The next step is to determine whether the various duties

identified have been complied with or have been breached, by examining the documents and other information available in this case as well as facts from other sources, including my tour, that might illuminate the Defendant's compliance or lack of compliance with the duties identified. This method will speak to the question of whether OPP staff have a duty to protect inmates from violence from other inmates, for example, and whether staff have been and are complying with this duty. This second method is common to expert analysis of prisoner tort cases but it is also the general method used for auditing correctional institutions for accreditation, whether by the American Correctional Association (ACA) or by the National Commission on Correctional Healthcare (NCCHC). It is also used as a major component in critical incident reviews (also called "After action reports") following major crises or emergencies in jails or prisons. I have used this method for critical incident reviews following a number of very high profile crises in correctional institutions and I have also used this methodology as the central approach on many occasions when I have been commissioned to evaluate the emergency readiness of a particular correctional agency or correctional facility.

The third method has to do with situations in which there are fundamental disagreements about what factually transpired. For example, there are situations at OPP in which an inmate alleges he was sexually assaulted and staff contend that the allegations are false. Similarly, there are situations in which inmates claim staff used unnecessary or excessive force and staff contends that either no force was used or that the force that was used was reasonable in that situation. The first step in this procedure is to identify each action, behavioral procedure or other occurrence according to each side in the factual dispute (and it is possible that there are more than two sides). Then, each of these disputed steps, behaviors, actions, decisions or the like must be analyzed against prevailing practices in the facility, specific agency policies and generally accepted correctional practices. They must also be analyzed for internal consistency. That is, from the standpoint of correctional policies, procedures and practices in the facility as well as generally accepted correctional practices, are the various occurrences, decisions and behaviors described by Plaintiffs consistent with each other? Put in another way, does Plaintiffs' story make sense, not because of the credibility or lack of credibility of Plaintiffs, but because of what is known about jail policies, procedures and practices? Then the same analysis must be performed for Defendan's' version of events.

In preparing this report, I have not used inmate names, in the interest of privacy. Similarly, for the same reasons, I have not used staff names (with the exception of the Sheriff or a few high ranking administrators whose identities would be obvious from the discussion in the report). I have maintained, and will furnish upon request, a list of inmate names that correspond to the numbers (for example., "Inmate 14") used herein, and a comparable list of staff names.

III. Limitations

A. My ability to form opinions about some important questions in this case has been compromised to an unusual degree by Defendant's lack of cooperation and lack of production of relevant documents.

B. In arranging the logistics for my visit to OPP and my tour of the jail facilities, I emphasized that I would need access to all areas of the facilities and that I planned to go into some of the jails in the late evening or early morning hours on one or two days of the week I was in New Orleans. It is my understanding that the attorneys for the Southern Poverty Law Center ("SPLC") conveyed those requests to Defendant and were assured that they would not be a problem. On December 18th, while touring the jails and talking with staff members, I told Colonel Laughlin that I planned to work during the day, then a take a

break for dinner and then return and tour one or two of the jail buildings in the mid to late evening. Colonel Laughlin said that would not be a problem because his unit, SOD, had staff assigned to the second platoon and he would simply make sure that one of the SOD staff was alerted and would be available to escort me on my tour. I told Colonel Laughlin that I would confirm that I was going to tour in the evening and the time that I planned to reenter the Jail, later in the day.

I followed that plan and, later that same day, told Defendant, through Counsel, that I planned to come back to the Jail that evening at 9:00 p.m. I was informed through Counsel that I could not tour that evening or night. I emphasized that Colonel Laughlin had said it would not be a problem or a great inconvenience and also suggested that if it would be easier for the Jail staff, I could postpone my evening visit and do it on the following day. My request was summarily refused, without explanation.

A central issue in this case has to do with inmate supervision and the adequacy of Defendant's staffing patterns. The primary purpose of my evening visit was to observe inmate supervision and actual staffing levels during the evening and night shift. I was unable to do that.

C. In similar fashion, I was in the SOD office talking with SOD staff on December 19th and I suggested that I wanted to briefly look at both armories. I asked if it was a convenient time to do that. I also assured the SOD Lieutenant that I had been given a commitment that I would have access to all areas of the jail facilities. (I have toured hundreds of jails and prisons and it is my standard practice to at least briefly review armory content and procedures, whether I am conducting a security audit, an emergency preparedness audit or a more comprehensive operational review of a correctional facility).

The SOD Lieutenant asked me to wait a moment while he verified that he could take me through the two armories. Within a minute or two, the Lieutenant received a call back informing him that I was denied permission to look at either armory, on security grounds. He conveyed that to me and later that day, I renewed my request through Counsel and that requests was again denied without further explanation.

Use of force by staff is one of the biggest issues in this case. Some inmates have alleged that staff have brought firearms into the facilities, and specifically the tents, and threatened inmates with those firearms and also alleged that on at least one occasion a staff member fired a shot in one of the tents. I needed to go into the armories to see what kinds of less than lethal rounds were available for the shotguns, how those and other munitions were stored and issued, review the armory inventory and review the armory log and entry and sign out procedures. I was unable to accomplish that.

D. When I asked staff who was in charge of PREA investigations and reports, several staff said "Hazel Bowser". I asked to talk with Deputy Bowser twice and on one occasion I made a specific appointment to meet her at the SOD office. When I arrived, she was not there and Colonel Laughlin was waiting for me and said he was in charge of PREA and would answer any questions I had. My other attempt to talk with Deputy Bowser was similarly deflected. The majority of the PREA related investigation that have been produced by Defendant are the work of Deputy Bowser. In addition, it is unusual to have cross sex investigators as the first point of contact in sexual assault investigations. That is,

when women report rape or other sexual assaults, it is generally acknowledged that if possible it is best to have a female investigator respond initially. Similarly, some male victims of rape or sexual assaults may be more comfortable or more willing to talk openly with a male investigator than with a female investigator. I had wanted to discuss that with Deputy Bowser in addition to a number of procedural questions about the sexual assault investigations, which are a central element in this caes. I could not do that.

E. Some of the documents that have been requested of Defendant but not produced in this case are not just relevant, they are crucial. For example, investigations of potential sexual misconduct by staff or inmates, or allegations of sexual harassment, are investigated by SOD. I interviewed several inmates in detail about their version of events involving sexual misconduct and/or sexual harassment. I also carefully reviewed the declarations of a number of other inmates where those declarations included claims of sexual misconduct or sexual harassment. In some of these cases, the Defendant has adamantly denied the inmate version of these events and for some other of these claims, the staff position or version of events is simply unknown to Plaintiffs. The SOD investigations of these incidents have been requested, as have the incidents reports, all PREA reports and all other PREA related documents and communication. Some of that information has not been produced, making it difficult to fully evaluate the Department's practices with regard to PREA.

There are other clear examples of similar limitations. Defendant has not produced disciplinary records requested for the individual inmates that figure prominently in this case. As a result, it is not possible to analyze the inmate disciplinary system in any comprehensive manner, to review discipline hearing practices, etc. Those kinds of limitations also apply to a number of other important substantive areas in this case.

IV. Issues, Analysis and Opinions

A. Overview

In over 35 years of working with and reviewing jails and prisons across the United States and Canada, it is my opinion that OPP is one of the worst jail systems I have ever seen. It may be the worst. It is exceptionally dangerous for inmates and unnecessarily so. It is also significantly more dangerous for staff than most jails, and for no good reason. The first tenet of corrections should be parallel to the physician's credo: "First, do no harm". That is, at minimum, prisons and jails should be able to return inmates to their communities no worse than when they began their incarceration. Inmates should not leave a jail angrier or more violent than when they entered, and those inmates should be reasonably safe while incarcerated. OPP cannot make that claim and the current status of the jail works against public safety. Further, many policies and practices within OPP serve to distance inmates from family or other positive resources they may have on the outside. That also works against public safety.

It is relatively easy to analyze an organization if there are specific problems or deficiencies but where the general picture is one of positives and strengths. It is far more difficult to come to grips with an organization, and particularly to identify paths to a "turn around", when there are almost no areas of clear strength or excellence and when it seems that everything needs attention and improvement. That is the case with OPP.

It is thus challenging to attempt to sort down to the most basic problems with OPP. In my opinion they are history, leadership and management, the organizational culture and resources. Manifestations of those four basic problems may be seen almost everywhere.

1. History

   Hurricane Katrina hit New Orleans the morning of August 29, 2005 and was the most severe natural disaster in the history of this Country. At the time there were six thousand five hundred inmates in the New Orleans Parish Prison, a thousand of which had just been moved there from St. Bernard Parish in advance of the hurricane. That evening, the Orleans Parish Sheriff's Office (OPSO) asked the State Department of Public Safety and Corrections to evacuate all six thousand five hundred inmates. By then the Jail complex was without power and under five to nine feet of water. Another reason OPSO had to ask the state to evacuate the Parish inmates was the wholesale abandonment of posts by OPSO deputies. Miraculously, the evacuation was successful and did not result in escapes or deaths.

   After the hurricane had passed, the OPP Jail facilities remained closed and in early September the State Department of Public Safety and Corrections opened a make-shift jail that continued to serve the city until October, 2005 when the Parish Jails began to reopen. OPSO faced greater challenges than any jail system in the United States has had to confront in the past. Some of the Jail facilities were beyond repair. As of October, 2005, a month after Katrina, some two thirds of the Sheriff's staff had not reported back to duty and thousands of OPP inmates remained in various state prisons across Louisiana. A small number had been moved to federal facilities out of state. Records had been lost, getting the correct inmate to the correct Court for a scheduled hearing was not being done and it took years rather than months for the City and the Federal Government to decide which Jail facilities would be rebuilt, which would be renovated and which would simply be abandoned.

   In addition to Katrina, the Jail history had been dominated by a strong, controversial and colorful Sheriff who had run OPSO for more than thirty years before leaving to become the State Attorney General prior to the time Katrina struck. While the results and challenges of Katrina were obvious, the less obvious set of challenges to OPSO was to move out of the era of Sheriff Foti and modernize and professionalize the Department.

2. Organizational Culture

   It is clear that the organizational culture in OPP is dysfunctional and that it is not professional. Some of that is attributable to history, as the Jail had long been run more by personality than by policies and procedures. Some of it has to do with salaries, as deputies are not paid a professional wage; in fact, they are not even paid a living wage. Some of the organizational culture is a result of ineffective management and leadership.

In many ways, the most disturbing characteristic of the organizational culture is that it is at best self-perpetuating and at its worst a downward spiral. New staff are hired and many of those people, in a good organization, would develop into effective professionals. Some would become exceptional. In OPSO, those same new staff are exposed to dismal working conditions, inadequate pay, negative role models among experienced staff, lack of effective supervision and management, and quickly become unprofessional or worse. Some end up terminated and unable to get any other criminal justice job. Others may even be prosecuted. This is well beyond the question of living up to or down to expectations. The culture in OPSO is cannibalistic; it eats its young.

The remnants of a "good ol boy" system are alive and well at OPSO. There are clear indications of favoritism and serious allegations against senior managers go uninvestigated while an employee wearing a faded windbreaker that doesn't meet Department standards to work results in a 45 page investigation and a suspension.

3. Leadership

In general, OPP managers and administrators do not hold staff accountable in important ways. While a staff member may be investigated and disciplined for repeated tardiness, that staff member is unlikely to receive any attention for swearing at inmates, using racial slurs, being unnecessarily confrontational or operating a living unit badly. Managers and administrators spend little time with inmates or on the housing units. They are unconcerned with sanitation or maintenance, contributing to an appalling work environment and re-enforcing the negative organizational culture for frontline staff and for first line supervisors. Integrity does not seem to be a major concern for managers or administrators as falsified documents are common and issues like unreported uses of force or biased investigations raise no systemic concerns. The overall level of violence in OPP is stunning yet managers and administrators have made no comprehensive attempts to analyze it, to understand it or to develop initiatives to reduce and control it.

There is a paucity of leaders at OPSO. The Sheriff is not a "hands on" manager with the Jails and that is a significant part of the problem. Beyond that, the Sheriff relies heavily on a few manager's as his "fire fighters"; almost any substantial problem or challenge will end up with one of these individuals, quite independent of the subject matter or the managers other assignments or workload. The rest of the managers are, for the most part, very narrow in the way in which they define their job responsibilities. Within the security ranks, the Wardens and Deputy Warden's work more as higher level supervisors than managers. The managers in non-security positions such as personnel and finance are more divorced from jail operations than is typical. The need for strong, principled leadership that is steeped in jail expertise, is obvious and fundamental.

4. Resources

As mentioned earlier, staff salaries are so low that an officer cannot live in the New Orleans area and raise a family on a deputy's salary. At less than ten dollars per hour, deputies must rely on some combination of outside work details,

overtime or a spouse's salary, or they simply cannot make it. A recent change in overtime has exacerbated the situation. Deputies used to work one hundred and twenty hours per pay period. While that is a lot of work and a lot of time away from home, the thirty-four hours of overtime per pay period (OPSO uses an eighty-six hour standard per pay period, as allowed for police and correctional agencies by the Federal Fair Labor Standards Act (FLSA.)) The recent change was to the State Police System and now most deputies are simply working a straight eighty-six hours without overtime each pay period. Also, some deputies would qualify for raises if they completed required training, but the Department will not schedule that training, whether because of cost or staff shortages. The surrounding police agencies and parish jails pay much higher wages, as do State and Federal correctional positions. The result is that these surrounding agencies wait until a recruit has completed basic training and has demonstrated reliability at work, and then hire that person at a large salary increase. For OPP, that means very high turnover and, less obviously, that the Jails are self-selecting against quality in new staff.

The other most obvious resource problem is staffing. The single largest reason for the runaway violence at OPP is the lack of inmate supervision, and that, in turn, is a result of inadequate staffing more than anything else. OPP is not just understaffed in the way in which that term is used for most correctional agencies, meaning that perhaps five percent or ten percent more staff are needed. In the case of OPP, the realistic need may be for seventy-five percent or one hundred percent more staff, or even somewhat more than that. The current staffing levels are a nightmare for inmates and no picnic for existing staff. The Orleans Parish Jails are the most poorly staffed correctional facilities I have ever encountered.

The staffing issue has complications. First, a new main jail building is under construction currently and should open in 2014. That Jail will have approximately fifteen hundred beds and the general population units in that Jail will be "direct supervision". The plan is that all of the current OPP Jail facilities will close and that the new main Jail will house all Parish prisoners. There is a serious question as to whether OPSO can reduce its jail population to that extent, or will even want to. When the new Jail does open, if direct supervision is done successfully, it will allow a substantially thinner staff to inmate ratio than is the case currently with the existing facilities. Thus, there is conceptual agreement that all inmates will be housed in a new facility that will be more staff efficient and will only accommodate perhaps sixty percent of the current OPP inmate population. The dilemma, then, is that if the Jail is to operate safely tomorrow, or a month from tomorrow, a huge increase in staffing levels is needed. However, if the overall inmate population is managed down to the capacity of the Jail that is being built, and if the Jail is operated primarily with a direct supervision philosophy, the need for staff at that point may be substantially smaller than it is currently.

There is no plan for how the current population is to be managed even though it is perhaps 1000 inmates greater than the capacity of the Jail that is under construction. As long as the Sheriff's financial incentives are in the direction of increasing population, it is unlikely that the new Jail will supplant the current facilities. It is more likely that the current population will continue to increase.

(While the City of New Orleans has not regained all of the population that it lost in the aftermath of hurricanes Katrina and Rita, it is worth noting that the Jail population at the time of those two hurricanes was over 5000).

Another complication with the staffing issue is that the current Jail staff are not used well. That is, in most jails and prisons the priority is to staff housing areas and other mandatory posts. If there are not enough staff to operate those mandatory posts, staff assigned to specialized units and functions may be pulled and assigned to those security posts. In OPP, that usual approach is stood on its head. That is, all of the people assigned to specialized units or duties report there and all of the non-security posts are filled before finding out how many staff are available for assignment to the living units, yard, transportation and escort duties, etc. Thus, specialized units and assignments may all be operating in relatively normal fashion while in some of the buildings, officers are assigned to cover four tiers and inmates are hurt because of violence that could have been avoided if the tiers were staffed.

The final complexity in the question of resources has to do with the Department budget. Unlike most jails in the country, OPP does not have an annual approved budget with detailed expenditures. Instead, the Jail gets different sources of funding but the largest source is a per diem for each inmate held. That per diem remains at approximately twenty-two dollars per inmate per night, which is perhaps 1/3 of the average costs of jails across the country on an inmate per night basis. Even when the medical reimbursement and other revenues are added in, the total funding for the Jail is likely under thirty dollars per inmate night, or approximately one half the national jail average. Since most of the Sheriff's operation is fixed costs, the marginal revenue from increased inmate nights helps the Jail's financial position. In short, there is a basic and serious structural problem because the Sheriff has incentive to hold more inmates and keep inmates as long as possible. Even with that, OPP remains shockingly under-funded.

The New Orleans Jails do not engage in population management and have not encouraged alternatives to incarceration, primarily because of that highly unusual way in which the New Orleans Jails are funded by the city, and the financial incentives to keep more rather than fewer inmates locked up.

The Jails housing the majority of the inmte population, Templeman V, Conchetta, OPP and the Tents, are old, poorly designed, poorly maintained, staff intensive and unnecessarily dangerous for staff and inmates alike. "Old" does not apply to the Tents, but the other aspects of that description are apropos. These old jail facilities represent a "lose-lose". They require far more staff than a modern, podular or modular jail would need, particularly if that new jail were designed for direct supervision.

B. General Opinion

I have carefully reviewed the consent decree that has been proposed as a resolution to this case. It is my opinion that the consent decree as a whole, and its specific components, are

necessary and correct. (I exclude from that opinion the portions of the consent decree dealing with language assistance because, as stated above, I have no expertise in that area).

C. Harm

It is also my opinion that conditions and practices in OPP have led to serious harm for Plaintiffs, are currently causing serious harm to Plaintiffs and will predictably lead to more serious harm to Plaintiffs if not corrected by the measures specified in the consent decree. I have described in the following sections the specific types of harm that have or will befall Plaintiffs with regard to the areas discussed in this report but it is my opinion that each of the provisions of the consent decree is necessary to prevent harm to Plaintiffs that is serious, predictable and a direct result of current conditions and practices in the Jails.

D. Specific Remedies

The consent decree includes provisions of varying specificity. The draft agreement covers a large number of areas and, because of that, tends to be more general than specific. In my opinion, there is a great deal of work still to be done in "fleshing out" some of the general conclusions and remedies in the consent decree and agreeing upon all of the specifics that must be changed, how the change will be measured and what the specific criteria for success will be with regard to those measures.

E. Risk

The question of risk is closely related to harm. It must be emphasized that the risks in OPP are of life and death proportions. The risk of preventable suicide is unacceptably high. The risk of death to an inmate at the hands of other inmates is also unacceptably high. The risk of multiple fatalities from a fire is unacceptably high. These risks, and many more, are not the result of tenuous inferences or tortured logic; they are instead clear and present dangers.

F. Pre-sentenced and Juvenile Inmates

In can be argued that conditions within OPP should be regarded as even more outrageous since the majority of the individuals housed there are pre-sentenced and awaiting trial. They are being held for the protection of the community but they have not been found guilty and are not in Jail as punishment. In some cases, juveniles are not kept separated from adult inmates, as required. It is not clear how the pre-sentenced inmates could be treated more harshly if they were already sentenced. Juveniles, also, are generally afforded more services and a more treatment-oriented approach in correctional facilities than adult inmates. In OPP, the juvenile inmates fare very poorly. In reality, these distinctions do not seem important because no individuals should be treated as inmates are at OPP.

G. Deaths, Rapes, Stabbings and Beatings

1. The case record in this litigation is very large. Within the case record there are technical issues such as policy formulation, quantitative issues in spreadsheets and charts, incident reports and the like.

2. In reviewing and analyzing the voluminous case record, it is possible to lose sight of the larger picture. The New Orleans Jails are plagued with suicides and other in-custody deaths, rapes and other sexual assaults, stabbings and severe beatings. Use of force by staff is uncontrolled and inmate-on-inmate violence is similarly uncontrolled and of epidemic proportions. I would be horrified and frightened to my core if a member of my family had to spend as much as a weekend in the New Orleans Jails; I know of no reasons why other families should be subjected to this situations.

H. Policies and Procedures

1. Reading the policies and procedures of OPSO provides a grossly distorted of the agency. While some of the policies and procedures are incomplete and/or poorly written, that is not true of all of the policies and procedures. Many of the policies cover important issues.

2. The problem is that many, if not most, of the written policies and procedures are ignored or directly contravened, and that occurs on a wholesale basis. Examples abound but a few specifics may be helpful. There is a two-page policy on storage, control, and disposal of hazardous materials (701.6). That policy provides general guidelines and specific requirements. It requires that flammable, caustic and toxic substances are to be issued only under the supervision of a designated officer, issued only in single day increments, closely monitored by staff and subject to a perpetual inventory. Among the requirements are that all hazardous materials must be labeled, stored in secure areas and much more. However, when I toured Tent 1, an unsupervised and open access area contained an almost full three-gallon container of bleach. Other cleaning fluids were similarly stored where inmates could get to them without staff knowledge. There were also one-gallon containers of paint in that area. Cleaning fluids were also visible in other facilities within the Jails in areas open to inmates. None of these fluids were appropriately labeled. This particular policy is clearly written but staff are not aware of it, have not been trained to it and supervisors and managers do not enforce it, if they are aware of it. It may as well not exist.

3. Any perusal of a group of other policies will find the same situation. It is not that a particular provision of a broad policy has been lost or is being ignored and it is not that a particular policy is poorly written or just wrong. Those things do occur. This situation is quite different: the policies and procedures are largely irrelevant. The suicide prevention program (J-G-05) provides another clear example and deals with a subject that is clearly of life and death import. The policy calls for housing suicidal inmates on a housing unit, which is as "suicide resistant" as possible. The housing unit in question is the acute psychiatric unit in Templeman V, unit A-4. The cells are not "as suicide resistant as possible". In fact, the cells show no evidence that they have had any modification or retrofitting to make them

appropriate for suicide watch inmates. The policy calls for the use of suicide smocks to be utilized in lieu of Jail uniforms, but when I was in that unit on two different occasions during my week on site, there were more than twenty-five inmates in the unit on suicide watch and none of them were in a suicide smock on either occasion. The policy also requires that any inmate transferred to a mental health tier will receive a mental health evaluation within one hour of that inmate's arrival on the tier. That is not done. Deputies are required to conduct fifteen-minute observation checks on each inmate who is on suicide watch but in many cases these are not done (although they may be falsely recorded as if they were done). In the event of a serious suicide attempt or a successful suicide, affected inmates are to be offered critical incident stress debriefing. That does not occur. Once again, this is a sample, not an exhaustive list of the problems with the suicide prevention policy or the provisions of that policy that are ignored.

I. Inmate Classification

1. In 2011, OPP processed about thirty-five thousand inmates or an average of about one hundred per day. In 2012, data available for January through November indicated just over thirty-two thousand intakes so that the Jail appears to be on schedule for the same number of new bookings as in 2011.

2. OPP uses its own classification system. It is based on the proprietary North Point system and was developed in part by Dr. Gore, the OPP Medical Director. The motivation was that the North Point system was too expensive to purchase and, hence, the "locally developed" system. Staff is not clear on how the system differed from the North Point system and thought that the local system used some combination of points and tree branching. The new local system has only been in place since the spring and summer of 2012.

3. The classification system allows overrides in all sections of the system and then also at the end, with regard to the overall classification and security level.

4. The system has not been validated. When asked about validation, the staff said that that had only been done in individual cases, which is a strong indication that the staff do not understand how a classification system would be validated.

5. There is no data available on the use of overrides and the system does not track that in any manner.

6. In general, inmates are booked and have their initial intake work done in the intake center and are then sent to the tents for classification. Tent I (of the 8 tents) is dedicated to classification and staff explained that inmates are only held in Tent I long enough to be classified, which takes 24-hours or less. Then those inmates are moved to more permanent housing. In

reality, when I toured Tent I, there were a number of inmates who were there for days, weeks, or months. The 24-hour classification cycle may be a goal but there are many cases in which it is not operating in that manner.

7. The most blatant problem with the classification system is that it either doesn't work or isn't used. To understand why classification does not work, it is important to sort out the distinctions between booking and intake, and classification. A good deal of screening of newly admitted inmates takes place as part of the booking and intake procedure. Some individuals are identified as special needs inmates, because of physical disabilities or developmentally disabled status. Other inmates are screened and identified as serious mental health cases, acute suicide risks, etc. These screening decisions may be seen as part of the classification process but, more strictly, classification has to do with assessing risk and is done after the initial screening. The point of classification is to assess risk and then to use that risk assessment to determine appropriate placement within the Jail's available housing areas. Typically, a jail designates general population housing areas by security level. Some jails use the old and traditional three level system, with low, medium, and high custody designations. Other jails use a four level system, most often adding a "close custody" designation below maximum (or high) custody but above medium custody. There are many other names and sets of categories in use in various jails. The point of designating housing areas is, however, always the same. It is to provide different levels of security that can be matched to inmate classification scores (or risk levels).

8. Today, inmate classification is somewhat more extensive and sophisticated as, in addition to risk scores, jails are required by PREA to categorize inmates according to their likelihood of being sexual predators as opposed the likelihood that they will be victims of sexual assault. For small jails, all of this is a major challenge because there are not enough housing units to accommodate administrative segregation, disciplinary segregation, protective custody, special needs, acute mental health, and three or four levels of general population inmates as well as PREA designations. Most large jails do have enough separate and distinct housing areas to accommodate those various categories, as New Orleans does.

9. Unfortunately, OPSO has not designated housing areas by security level. As a result, new inmates complete classification and are then sent to a housing assignment based on where bed space is available rather than based on classification scores. OPSO also does not separate inmates based on PREA assessments. Violent felony inmates are housed with minor misdemeanor inmates and sexually predatory inmates are housed with inmates who are likely to be victims of sexual assault. The blunt fact is that there is no clear reason why OPSO spends staff time and other resources on classification when the classification results are irrelevant.

10. OPSO has failed to recognize "location seeking". That refers to behaviors inmates engage in so that they may be transferred to a specific location or,

frequently, out of a specific location. Inmates will request changes of location, sometimes to a different tier or living unit and sometimes to a different facility, and when those requests are refused, inmates may file grievances, report that they need protection from enemies, report that they are suicidal or homicidal or engage in other behaviors not helpful to the jails.

Much of the "location seeking" behavior in OPSO is a result of the lack of an effective classification system. That is, when predatory violent offenders are put in general population mixed with young, weak and/or elderly inmates, the potential victims know that they are in danger and are hugely motivated to find a way out of that housing unit.

If an inmate believes that it is likely he is going to be raped, stabbed, beaten or killed, he may assault other inmates or a staff member first, knowing full well that he will be moved to disciplinary segregation. As punitive and unpleasant as the disciplinary segregation is, it is better than the alternative. There are also a relatively large number of inmates who dislike disciplinary segregation so much that they simply declare themselves suicidal, thinking they will be moved immediately to the acute psychiatric unit in Templeman V. That, in turn, creates a large number of "false positives" on suicide watch and makes it far more difficult to effectively monitor those inmates who belong on suicide watch. There is no indication that staff in OPSO have recognized the breadth of this problem or that they have tried any Jail-wide strategies or initiatives to mitigate or eliminate this problem.

11. It is my opinion that after the lack of inmate supervision, the lack of effective classification may be the most significant cause of inmate-on-inmate violence in the OPSO Jails.

J. Inmate Supervision

1. The starting point for any consideration of how a jail is run is inmate supervision. Some jails use sophisticated patterns and approaches to supervision while other jails are traditional and use two or three shifts (or platoons) per day. Many newer jails and some converted older facilities use direct supervision, which has well documented and important advantages with general population inmates and inmates below maximum-security designations. With direct supervision, a staff member works "on the floor", typically amidst sixty to eighty five inmates, and that officer works that same unit regularly, getting to know individual inmates well. As a result, the officer is in a position to intervene early in developing conflicts, move someone or otherwise intervene when an inmate is headed for trouble either as a victim or a perpetrator, etc. The result in direct supervision facilities has been decreased costs because of thinner effective staffing ratios, combined with substantially reduced levels of violence and other negative incidents. For example, if a general population inmate is decompensating and moving toward a full blown psychosis, the "pod" officer, even without much mental health background, is in a good position

to observe the changes in the individual and react by getting appropriate help. With the older and more traditional indirect supervision, staff are separated from inmates and typically observe them from behind glass, from a control room or control "bubble", from behind bars, etc. "Indirect Supervision" results in decreased ownership by staff for a particular housing area, decreased communication and decreased accountability.

2. In either case, it is essential that inmates be supervised actively and frequently by staff. Without active and frequent supervision, even a low security housing unit with an unsophisticated inmate population will sink toward the lowest common denominator as thefts, inappropriate relationships and informal cliques and gangs develop. In short, staff supervision prevents inmates from attacking each other, and prevents inmates from committing suicide, it identifies inmates who may be in medical distress and it provides a wide range of services to a population that is locked up and cannot avail itself of those services without staff assistance.

3. Within OPP, indirect supervision is a euphemism for no supervision. There are not enough staff to assign a staff member to every living unit or tier so it is common for a staff member to be assigned to two tiers for the shift. When staffing is even shorter, a staff member may be assigned to four tiers. The staff member cannot be in two or four places at once so many of the inmates are on tiers that have no staff presence for very long periods of time. Even the staff that are assigned to the tiers are too often doing something other than supervising inmates.

4. Minimum staffing standards

    a. Many jails and prisons have minimum staffing standards. That means that, say, for a particular jail there may be a policy requiring one officer for each living unit and two "utility" or "yard" officers plus a specified number of other staff for perimeter positions and other required and essential duties. Perhaps the jail has a minimum staffing standard of 16 officers for day shift, 14 officers for swing shift and 11 officers for night shift. That means that if, on a given swing shift, a few officers are away at training and a few officers are on annual leave or military leave and 15 officers are actually expected to work, but then three officers call in sick, the jail would only have 12 officers available for the swing shift. Since the minimum staffing standard is 14 officers, the jail must either call in two additional officers on overtime or hold two officers from the day shift on mandatory overtime to staff the swing shift.

    b. Without minimum staffing standards and particularly with pressure not to work staff on overtime because of budget constraints, the Watch Commander might decide to run the shift with 12 officers and hope that nothing terrible happened. With no limit on the number of vacancies that can be tolerated, staff get used to working

with unrealistically low numbers and inmates quickly learn that they will have long periods when they are unsupervised and can do whatever they wish. That is the situation within OPP.

c. A review of the staffing records produced by Defendant demonstrates beyond that many staff posts in living units are left unfilled shift after shift, facility after facility. For example, a review of the staffing for Templeman V for the period May 1, 2012 through May 7, 2012 shows that the first platoon had 18 posts to fill within the facility on each of those seven shifts. Instead of eighteen deputies, the facility actually had five deputies on May 1 and May 2, seven deputies on the May 3, six deputies on May 4 and seven deputies on May 5, 6, 7. That is, on some shifts, the facility could not muster one third of the standard and required staff. A review of the staffing patterns for the tents will show that even in the tents, the facility was unable to provide the required number of deputies on some shifts. This kind of pattern is characteristic of all of the facilities and is reflected on a month after month basis.

5. Cell checks ("Rounds")

a. "Cell checks" refers to a longstanding and standard correctional practice of requiring staff supervising living units to frequently observe each inmate in each cell and document that observation. ("Cell checks" are also referred to by a variety of other names, such as "rounds", "security checks", "welfare rounds", and other, similar terms.)

b. Cell checks serve several crucial functions. They ensure that an inmate has not escaped, perhaps leaving a dummy on the bunk under the cell blanket. They are intended to find out if there are obvious signs of digging or breaking cell walls or floors or compromising security bars, which would indicate an escape in preparation or in progress. Cell checks also should determine whether any inmate is in the process of attempting suicide or is in medical distress. They sometimes discover cellmates fighting.

c. Cell checks are best conducted frequently but on a slightly irregular schedule so that inmates cannot time them. Typically, jail and prison policies require cell checks every twenty minutes or every thirty minutes for general population housing areas although some agencies may specify every forty minutes by policy. Almost always, agency policy will require more frequent cell checks for special housing areas such as segregation units and acute psychiatric units. Inmates on suicide watch are almost always required to have cell checks every ten minutes or every fifteen minutes, by policy. It is also important that cell checks are documented.

e. At OPP, policy requires cell checks every thirty minutes except for the acute psychiatric unit (Templeman V, A-4), where they are required every fifteen minutes. In reality at OPP, cell checks are observed primarily in their absence. Unit logs will reflect that cell checks were done at certain times, but those are primarily false entries. The officer is by himself or herself and, in order to do a cell check, a second officer would be required before the first officer could go onto the cellblock or tier. There is no second officer available for that. If the officer is assigned to two tiers, then one of the tiers is completely un-staffed for half the shift. At best, the entries indicating cell checks are indications that staff do not see any problems from their position outside the living unit. They are certainly not looking into each cell and seeing flesh and movement, checking inmates for medical distress, etc.

f. On December 17, I toured the Conchetta facility. The second floor of Conchetta consists of three living units; two are open dormitories and there is also a linear tier with twenty-four two-person cells. Currently, the two open dormitories are general population and the tier ("2T") is set aside for juvenile protective custody housing. I spent time going through the unit logbook on the second floor. The juvenile protective custody tier should have its own logbook but since one officer covers all three units from a unit control room, a single log is used for the whole floor and it is kept in that control room. In reviewing the unit log, it was clear that cell checks are not conducted every thirty minutes, as spelled out in policy. It was also obvious that with a single officer assigned to the second floor, that officer cannot go onto the juvenile tier in order to look into each cell and verify the presence or welfare of each inmate. The staff member on that unit and staff on other units confirmed that cell checks are done when there is an opportunity but that generally what is recorded as cell checks are observations from a control room or office indicating that nothing looks amiss, rather than actual cell-by-cell and inmate-by-inmate observations.

g. Even on the intensive psychiatric unit (A-4, in Templeman V), where cell checks are appropriately required by policy every fifteen minutes, there is little or no compliance with policy and little attention is paid to the frequency or quality of the cell checks that are recorded. For example, on the afternoon of December 16, 2012, cell checks were recorded at 14:30 (military time), 16:08 and 17:38. That is, rather than conducing cell checks at approximate fifteen minute intervals as required by policy, these cell checks were conducted every hour and one half. That is not atypical and it is not difficult to find other units where hours pass between cell checks. The result is that a crucial inmate safety procedure has been rendered all but useless by

either not conducting cell checks or conducting them in a manner that is ineffective. As is true with many of the serious problems at OPP, it does not take great sophistication or deep expertise to identify these shortcomings. A supervisor, manager or administrator could walk through the housing areas in OPP, look at unit logs and spot these problems as quickly as I did. Unfortunately, the twin themes of lack of accountability and lack of hands-on leadership and management run throughout too many areas of OPP operations.

6. Other barriers to inmate supervision

   a. The organizational culture at OPP is dysfunctional and worse. One facet of that is staff professionalism, which is extremely low. Thus, even though staff are aware that they are short handed and that inmates are being left to their own devices, the few staff that are assigned to the tiers too often leave their posts to go and find other staff to socialize with, to nap or to do other things that prevent them from supervising their assigned areas. During my tours of the Jail facilities, I saw tiers with no officers assigned but I also saw tiers which did have an assigned officer, but the officer was not on the tier for some of the time that I was there. Another obvious problem is that with too few staff to cover the tiers, there are also no staff to assign to duties such as movement of high security inmates, relief for officers taking meal breaks, transportation for unexpected hospital runs, etc. Thus, the officers who are on the tiers have little available help and that is a major safety issue for staff as well as for inmates.

   b. These problems are compounded by unfortunate policies, such as a policy requiring a second staff member on the tier before the assigned staff member can actually go onto the tier, even though the inmates are all locked in their cells. The intent of that policy is to prevent an inmate from faking illness or otherwise enticing a staff member to come down the tier and then either taking that staff member hostage or attacking the staff member. That kind of policy makes sense for a high security housing unit or a segregation housing unit but for general population areas, it simply prevents staff from responding even in cases of life and death emergencies. If a staff member is assigned to two tiers and if the nearest additional staff member has left his or her post for some reason, the staff member may have to wait a long time until back-up arrives so that he or she can go down the tier that they are supposedly supervising. Since the OPP facilities are old, badly designed and have particularly poor visibility, having an officer sitting at one end of a housing tier, unable to go down the tier and see what inmates are doing, is not terribly different than having no staff member there at all. As with much too much at OPP, that is not

the end of the bad news. Most jails and prisons use some combination of dormitory housing, double celled living units and some small number of single cell housing units. At OPP, a number of the facilities have four person cells or larger congregate "tanks". In and of itself, that exacerbates all of the other problems because two persons cells work reasonably well and, while violence is far from unknown among cellmates, most inmates adapt and find a way to get along with their cellmates. With four person or larger cells, that is not true. Group dynamics take hold and there is frequently conflict or violence with three inmates extorting commissary or other property from one weaker inmate, or beatings or forced sex, etc.

K. Staff-Inmate Relations

1. It would be most surprising if staff inmate relations were anything other than quite poor. That is, with living conditions and services for inmates all in need of massive improvement and with tensions high in the facility because of inmate-on-inmate violence and lack of staff presence, it is to be expected that many inmates will be difficult with staff. For their part, staff are not well trained, well paid, well supervised or well led. Putting these two groups of unhappy and often angry people together creates rather a toxic stew. Staff are supposed to be the professionals and they are the individuals who should set the tone of the facilities. However, without a reservoir of core professionalism, staff attitudes and communication are too often indistinguishable from that of the inmate population.

2. There are substantial numbers of staff who are able to maintain positive attitudes, treat inmates with respect and strive to be professional. On the other side, there are inmates who are appreciative of even small things that staff do for them and these inmates are positive and easy to work with. Based on my tour of the Jail facilities I would estimate that less than half staff and less than half the inmates belong in the positive groups that I have described. It is other inmates and the other staff, who are the most visible, because they are angry and often loud. Those are the inmates and staff who set the tone.

3. The frequent, low key and informal but mutually respectful communication that characterizes good jails is not much in evidence within OPSO. Even when there are relaxed interchanges between staff and inmates, they too often contain obscenities and humor that may be based on racial slurs, obscenities, homophobic references, etc. More often, staff-inmate communication is not humorous and it is common for staff to yell at, insult or talk down to inmates.

4. On some occasions the negative relationships between inmates and staff may lead to unnecessary use of force situations or assault on staff by inmates. Many inmates complain that staff retaliation is frequent and serious whether it is for a comment a staff member didn't like, a grievance

the inmate filed or an incident that may have occurred days or weeks before. It may be over something as simple as an inmate not following a staff order quickly enough to satisfy the staff member.

L. Security

1. In general, security throughout the OPSO Jail facilities is very poor and many important elements of contemporary jail security are simply missing. Security equipment and security practices do not meet nationally accepted standards for jails and in most cases they do not come close. Security is also inconsistent. I have conducted detailed security audits of large jails and prisons but this report should not be regarded as that kind of comprehensive and rigorous security analysis.

2. The serious and wide-spread security problems in the Jails have been apparent to management for years. Each of the two findings letters from the U.S. Department of Justice documented deep-seated problems with security, among other topics. So did a technical assistance report from NIC some four years ago. The Jails have received other reports outlining security failures. It is noteworthy that almost all of those problems given to OPSO in writing, remain unmitigated today. It remains a mystery why the management of the Jails would receive report after report specifying security failures and would then make no attempt to address those issues.

3. The best exemplar of this situation are the prior reports and inspections detailing security failures within the Jails and recommending specific solutions. Many if not most of the problems delineated in those reports, audits and inspections have not been addressed and those documents were not produced in discovery. Defendant's counsel said that they did not have copies of those reports, audits, inspections, etc., because the Sheriff saw no need to keep them. If the Sheriff read a particular report and found it to be inaccurate or unreliable, or unhelpful in other ways, it would be understandable if the Sheriff chose to disregard that report. However, to get detailed reports on everything from Jail security to health and mental health care to inmate programming, with some of these reports prepared by nationally recognized experts and then to acknowledge discarding those reports without reading them, speaks to a callous disregard for the safety of inmates and staff alike, and for the protection of the New Orleans community.

4. Some of the problems identified in these various reports, whether they be state jail inspections, audits by the Fire Marshal, technical assistance reports that the Sheriff requested or letters of findings from the Civil Rights Division of the U.S. Department of Justice, identify potentially life and death situations. Some of those identified problems were not dependant on budget and could have been fixed without additional costs. Other problems could have been fixed quickly and the recommendations for how to fix them were contained in those same reports. If an important and potentially dangerous problem in the Jail had an identified remedy that was

quick and without substantial cost, why would the Sheriff and the Jails not make that change? I can offer no answer.

5. Key control is foundational to jail security. OPSO has no system of key control. It is not possible to determine how many copies of a given key have been made, when they were made or the locations or staff members to whom they were distributed. Broken keys are not inventoried and no one knows how many keys or which keys have gone missing. Emergency keys are not segregated into separate rings that are colored coded for ease of use, notched for use in a smoke filled environment, soldered, identified and counted. The lack of key control is primarily an escape issue but it can also result in an inmate takeover of portions of a jail, assaults on protective custody inmates or a wide variety of other emergency or crisis situations.

6. The locking mechanisms within some portions of the Jail facilities are old and worn and can be compromised almost at will by inmates. That is, in some areas of the Jail, inmates can open the doors to cells or congregate rooms that are ostensibly locked, and then have unfettered access to other areas and to other inmates. Many of the inmate declarations in the case record cite this specific problem and it also was raised several times in the interviews I conducted. It is difficult to reconcile inmates getting in and out of their cells and into the cells of others, with the term "jail security". In addition to the assaults and stabbings produced by this state of affairs, it is important to recognize the sheer terror that a young or weak or elderly inmate must live with, knowing that after lights out and after there is no staff supervision in the area, inmates can enter his cell and do anything they want with him.

7. Tool control is another important and basic jail security system that cannot be found in the New Orleans Jails. Class A tools are not identified, shadow boarded, inventoried or checked out. Maintenance and repair people take a wide variety of tools into the Jail and there is no system to ensure that some of these tools are not left behind or stolen by inmates. Here again, escape may be the primary risk but the potential use of tools as weapons to assault other inmates would be a close second.

8. Other, more discreet, security problems were rife during my tour of the facilities. There is no consistency in the manner in which staff escort inmates and if there is training on that subject, it is ineffective. Staff do understand that maximum security and segregation inmates are supposed to be escorted two on one and typically by SOD deputies. Instead, high security escorts are determined by "who is available?" Sally ports sometimes open together, and access to control rooms is not carefully controlled. Basic security founders on the twin shoals of staff complacency and staff convenience.

9. Some security cameras are broken and remain so. Some monitors do not work. The result is that the system of security camera coverage is spotty and unreliable.

10. The level of weapons available to inmates within the OPSO facilities is frightening. I have not been able to do a systematic review of the results of searches and shakedowns because the requested shakedown logs have not been produced. However, after one particularly brutal stabbing on the B-2 tier, a large number of officers went into that area to shake down both sides of the tier. On one side they found three shanks along with other miscellaneous contraband. On the other side, they found five shanks and three pieces of a fan that were partially sharpened and on their way to becoming effective shanks. They also found a cigarette lighter on each side.

11. It may have been apparent from the discussion of staff supervision of inmates earlier in this report but it is important to note that because of the acute shortage in staffing, the utility officers, yard officers and "rovers" that are intended to be an integral part of the staffing pattern for each of the facilities, do not exist on most shifts. That has a number of implications for the operation of the Jail, and those implications are entirely negative, but the most important may be that the response to an alarm is too slow and too thin. That is, when one a staff member radios or calls for immediate assistance, there are usually not enough deputies in close proximity to provide an adequate response. That directly endangers the deputy who needed assistance and may also endanger inmates who are in a fight or being assaulted, or even engaged in a suicide attempt. The lack of a minimally acceptable staffing pattern and the resulting lack of an adequate response to alarms could lead directly to a hostage incident or an escalating disturbance in which part of the Jails fell under inmate control.

M. Suicide Prevention

1. I did not review this area as comprehensively or in as much detail as I typically would have because both DOJ and SPLC had mental health experts touring the Jails the same week that I visited.

2. It is my understanding that there have been five suicides at OPP during the last few years and perhaps a sixth in the last few weeks. I have not verified this from actual records or reviewed the circumstances of the suicides because requested documents have not been available as of the time of this report. It is not certain but it appears likely that an inmate death in the two weeks before this report was written, was the sixth successful suicide.

3. A relatively large number of suicides would not be surprising because suicide prevention efforts at the Jail are abysmal. There is little that is positive or appropriate about suicide prevention at OPP. Policy is inadequate and staff training is similarly either missing, inadequate or ineffective.

4. The foundation of the suicide prevention program at OPP is direct observation. An inmate on suicide watch is supposed to be observed continuously and directly by a staff member until that inmate is off suicide

watch. Since inmates put on suicide watch are housed in the acute psychiatric unit, they are also required to be seen by security staff every fifteen minutes on cell checks and four times per shift by a nurse. None of that happens. Some cell checks by security staff may be at fifteen-minute intervals but others may be a matter of hours. Nursing staff may be on that unit (A-4) to check on suicidal inmates but more often the nurse is there for a medication pass and does not observe or check every inmate on suicide watch. The result is that suicide watch inmates may be checked and observed four times per shift on some shifts, if the nurse on duty is committed to following that policy, but on other shifts, suicide watch inmates may be seen by nursing staff once, twice or not at all. For example, during the week I toured the Jails, on December 16th, a nurse was on the unit three times during the 6:30 to 18:30 shift, once for sick call and twice for medication pass. The following day, on December 17th, the unit log for the 6:30 to 18:30 (dayshift) time reflects nursing staff on A-4 four times, twice for general medication pass and twice to administer medication to an individual inmate. Neither of those shifts reflected any occasion on which the nurse on duty actually checked all of the suicide watch inmates.

5. It might be argued that the fifteen minute cell checks required by policy are redundant and unnecessary since the same inmates are being continuously observed. While that argument is not relevant to the mandatory visits by nursing staff, it might make sense for security staff except that the direct and continuous observation is itself a sham. When there are inmates on suicide watch on the A-4 unit, a second staff member is assigned so that the primary officer on the unit has the usual unit supervision responsibilities and the second officer on the unit is supposed to do direct observation of the suicide watch individuals. That is not what happens. On two separate visits to A-4, and on two separate days, both officers assigned to the unit could be found sitting on either side of a staff desk that is placed against the wall just to the left of the entry door to the unit. The two officers spend most of their time talking to each other and on several occasions when I was on the unit, one or both officers left the unit to do something else.

   If both officers were comfortable leaving the unit and leaving suicide watch inmates unsupervised while there was an official visitor on the floor, it is not unreasonable to think that those officers would leave the unit more frequently and for longer periods of time when there was no one else there. That is exactly what inmates on the unit said is the case, and it was also reinforced in the analysis of an incident (detailed in the following section of this report) that occurred on A-4 during the days I visited the unit.

6. It must also be emphasized that when both officers were on the floor, neither was doing direct observation or continuous observation, or anything close. It is not possible to see into the majority of the cells on the unit from the positions on either side of the staff desk.

   Without the required nursing observation taking place regularly, and without regular cell checks by security staff, and with the staff on the unit

paying little attention to the inmates for long periods of time, it would not be difficult for an inmate to fashion a noose and hang himself in his cell.

7. The primary defense against suicide has little to do with anything OPP has planned or designed. It is that the acute psychiatric unit is usually crowded and most of the suicide watch inmates have a cellmate. Correctional experience has shown that even inmates who may be depressed and/or suicidal themselves, if they see another inmate engaged in a suicide attempt, will call for help. That may not always be the case but it is usually so and it is the crowded condition in A-4 that probably protect suicidal inmates better than anything designed or operated by OPP.

8. There are no special cells available even for those inmates who may be at extremely high risk of suicide. The cells on A-4 have not been hardened against suicide and offer a range of ways in which a rope fashioned from clothes or some other ligature could be tied to the bunk, the walls, windows or ceiling to facilitate a suicide by hanging (and suicide by hanging accounts for well over 95% of jail suicides nationally).

9. Neither the staff nor the facilities are well prepared to deal with a suicide attempt, astonishingly, there were no cut-down tools on A-4, in spite of the fact that there were more than 25 inmates on the unit or suicide watch and supposedly under continuous observation. Then were also no cut down tools in any of the eight tents or on either of the two juvenile units. I personally asked three or four line level staff about cut-down tools and none of the staff I asked knew what those were. When I explained that they were designed to cut through cloth ropes and the like in order to forestall a suicide attempt, the staff members I talked with immediately understood but said they had not seen anything like that kind of tool and did not believe that one existed on the units they were working. A Lieutenant, who was serving as Watch Commander for the tents, was asked and said that there was a cut down tool in the tents and then started asking staff where it was. He was told that it had been in a small black bag along with some other emergency equipment. The Lieutenant went to the office in one of the tents and started to look there but the small black bag could not be found. He asked another staff member who said that the black bag had been there at some point in the past but had obviously been moved to some unknown location. Suffice it to say, an inmate waiting on staff to locate a cut down tool would have been dead before the staff even realized that the tool wasn't where it was supposed to be and could not be located.

10. If the Jail has provided pre-service or in-service training on suicide prevention issues, that training has either been too short to be effective or it has been of questionable quality. Staff do not know basic issues about suicide in jails.

11. In talking with inmates on the unit, one suicide watch inmate was anxious to show me that he had a small bag full of psychiatric medications and second container also full of the same kinds of medications. Between

them, the two containers appeared to have perhaps seventy-five pills, but it could have been many more than that. The inmate explained that when they came around for medication pass, they simply handed him his pills and kept going. They did not wait to see him ingest the pills, or use any protocol that prevented "cheeking" or "squirling away" the pills. His two containers included Zoloft and Respirdol and at least one other type of psychoactive medication. I was amazed by what the inmate was showing me and, since my role is supposed to be non-participant observer as much as possible, I did not request that the inmate give me the excess medications. Instead, I reported the situation to Dr. Gore. The problem with allowing that kind of medication excess to accumulate in an inmate's possession is both that the excess pills could be used for a suicide and also that some psychiatric medications can be used to barter. As with other contraband that is perceived as valuable, the pills can be the basis for inmate-on-inmate violence.

12. On an acute psychiatric unit that also serves as the primary housing area for suicide watch inmates, hoarded medication can not only be sold or used for a serious suicide attempt, it can also be ingested by an acutely psychotic inmate. Within the last two weeks, it appears that an inmate death may have been caused by an inmate ingesting excessive prescription medications and it may be that death will turn out to be the sixth suicide with Jails in the last few years.

13. Inmates on A-4 reported that they are allowed no phone calls, no visits and no recreation. It is particularly troubling that the Jail would respond to a psychiatric crisis on the part of an inmate by denying that inmate contact with his family. In specific cases, there may be reason to stop phone calls or visits where family issues seem to be a provoking factor in the suicidal crisis. In most jail suicide cases, however, family is a source of strength for the inmate, counteracting some of the suicidal inclinations.

14. I spoke with one inmate on the unit who was diabetic but had no insulin. He said that a nurse had taken him off of insulin a month before, when he came back to the Jail from upstate. He had not seen the doctor. He was unable to keep the pills down and was vomiting and was very concerned about his lack of insulin. I encountered that compliant frequently from inmates throughout the Jails. That is, an inmate would explain that he had been on maintenance doses of some medication, often but not always psychotropic medications, but that the Jail had stopped his prescription and he had been receiving no medicine since entering the Jail. That picture was corroborated by Dr. Gore, who said that many inmates come to the Jail over-medicated or with prescriptions they do not need. He went on to explain that his practice is to discontinue those long-term prescriptions for a large percentage of new inmates, to determine how they will do without the medication and what is really needed. That approach would be logical if there was a reliable system for reassessing those inmates at a predetermined time, and if inmates could reliably get to sick call if the absence of the medication resulted in what the individual believed was

medical distress. It does not seem that either of those prerequisites reliably apply, calling into question the strategy of extended drug holidays or cancellations of long-term prescriptions.

15. Part of the theory of direct observation is that security cameras are focused on some of the cells and the unit control room officer should be able to observe the inmates on camera. That notion fails for several reasons. First, camera coverage and a monitor are not a substitute for actual staff observation. The staff in the control room have many other things to do and may be busy with an incident or some other duty for an extended period of time and not looking at the rotating view of cells on the camera monitor. Second, in most cases the camera can only see inmates if they are in the front few feet of the cell. Third, some of the cell fronts have shattered glass or plexiglass windows and others have plexiglass that is badly clouded. In either of those cases, the cameras are useless with regard to their view into the cells. It should be pointed out that a staff member on the floor is similarly restricted in terms of visual surveillance within the cell and if the cell does have clouded or scratched plexiglass or shattered glass windows, the staff member must go to the front of the cell and look carefully if anything is to be visible.

16. There was incident on the unit (A-4) the night before I visited it. An inmate was having trouble breathing and had chest pains. He thought he was having a heart attack. He says that the deputy on duty would not call medical and wouldn't listen to him or do anything. Then the deputy left the tier for a while and no one was there. His cellmate believed that he was having a heart attack and needed medical attention so the cellmate climbed up on a bunk and knocked off the sprinkler head in the cell. That flooded the cell and then flooded the floor of the unit and eventually the flooding spread into the hall and down towards other units before staff responded and cut off the water at the outside pipe chase. The fact that staff were not able to deal with the situation until the entire unit was flooded strengthens the inmate's and his cellmate's contention that there were no staff on the unit for an extended period of time. At 10:00 a.m. the next morning, the staff were still cleaning the floor on A-4 and in the hallway outside the unit. The incident created a major mess and a great deal of work for staff. Staff responded by placing the inmate who had started the problem and his cellmate in separate cells with no mattresses and no other property, an ad hoc punishment that violates the disciplinary policy, but was obviously condoned by supervisors. One of the two cells had a set of bunk beds but with no mattresses or linens. The staff also, according to the inmate, threatened him with one staff member telling him that he would be beaten and another staff member saying that it would only take a pack of cigarettes to get another inmate to jump him and take care of him.

17. In the incident described directly above, in the late morning I asked the deputies on duty in A-4 to see the unit log and the individual observation sheets for each of the suicide watch inmates. They both said there weren't any log entries since the flooding was discovered and there were no

individual records either, because they were too busy with the flooding clean up. Since then, the Defendant has produced a log book with entries for A-4 on that night and morning, that were obviously falsified and added to the log after the fact. It is that kind of lack of integrity that calls into question much of what occurs in OPSO.

18. The shower on the acute psychiatric unit was one of the worst I saw in touring the facilities. It had a large quantity of black mold on the ceiling and on the walls.

19. Some inmates were in cells without mattresses and, when staff were asked, the explanation was that they had just been moved there but staff acknowledged that sometime they did not have enough mattresses when they were overcrowded. There is no justification for forcing inmates to regularly sleep on the floor without so much as a mattress, and that is particularly unacceptable for an acute psychiatric unit. Portable sleeping shells ("boats") are readily available for purchase and keep inmates off the floor. They are made to hold mattresses. Many jails keep a supply of "boats" for unexpected periods of overcrowding. OPSO just puts inmates on the floor or on steel bunks without mattresses.

20. The jail does not have a comprehensive suicide prevention plan, although it has a suicide prevention policy that would be a major improvement if it were followed.

21. There is little or no accountability with regard to suicide prevention efforts. No one inspects the cells used for inmates on suicide watch. No one checks to make sure that direct observation is being conducted as specified in policy. No one checks the unit logs or individual inmate logs to determine if they are within policy or even accurate.

N. Use of Force Policy

1. OPSO adopted a new use of force policy (801.16) on January 30, 2012, just over one year ago. There is a companion policy called "Use of Force Reports" which is evidently part of the Department's operations manual. That latter policy is not dated.

2. The new use of force policy is a marked improvement over the Department's prior use of force policy. The new policy distinguishes between planned and immediate uses of force, requires a separate use of force report, prohibits the use of force for punishment or humiliation, and requires the review of all use of force incidents. While the old use of force policy established reviews of use of force only at the facility level, the new policy requires the establishment of a Use of Force Review Board that is mandated to review all use of force incidents.

3. The two policies are not well coordinated. On one basic provision, they directly contradict each other. That is, the use of force policy does not

require a use of force report in instances where force was used below the level of "hard hands" or chemical agents and where there is no injury or complaint. In contrast, the use of force report policy requires a use of force in any situation in which staff do use force. (The latter policy is appropriate).

4. The new use of force policy is far from optimal. It does not require staff witnessing a use of force to write an independent report; it does not make failure to report a use of force grounds for termination; it does not deal with a variety of necessary specifics, such as positional asphyxia; etc.

5. The biggest problem with the new use of force policy is that staff are not familiar with it and it is roundly ignored.

    a. The new policy requires annual in-service training for all uniformed staff on this policy. That has not happened.

    b. The policy requires use of force reports to go to IA for review. They do not, they continue to go to SOD for review.

    c. The policy calls for a Use of Force Review Board that will examine every use of force incident in the agency. It has been over a year and no such review board exists.

    d. The policy requires IA to produce a yearly analysis of use of force incidents. That has not happened and is unlikely to happen as long as SOD remains as the entity that reviews and investigates use of force situations.

    e. The policy requires the supervisor of an officer using force to report to the scene and interview all involved parties and all witnesses. That is not done, and is not appropriate policy in any event.

    f. Neither policy requires camcorders on scene and video of planned use of force situations.

O. Inmate Situations Involving Staff Use of Force or Inmate-on-Inmate Violence

1. On one occasion, inmate one was out of his cell and inmates stole his commissary. He found his items in several cells but those inmates teamed up against him. He grabbed a cooler top to defend himself but one of the inmates hit him in the head with the cooler. He went down to the floor and was momentarily unconscious. When he got up he was hit with an Igloo cooler. He described staff watching the fight from the doorway but not venturing in to stop it. He named a specific Lieutenant with the staff. The medical staff sent him to a hospital and he got staples in his head. The incident happened on Templeman V, A-4. No one interviewed him but a few days later he went to the SOD office and told SOD staff what had

happened. The inmates who had assaulted him were sent to segregation but said they were suicidal and were transferred to suicide watch. In five days, those same inmates were returned to the same tier with him.

The same inmate (inmate 1) watched another inmate, also named, take commissary from another inmate by force with a knife.

In another incident, inmate 1 watched another named inmate get hit by a younger inmate, fall and hit his head on the floor. The inmate went to the hospital with him in an ambulance. Inmate 1's understanding was that the inmate who had gone to the hospital was initially in ICU but was then returned to the medical tier for several weeks.

Inmate 1 is a mental health inmate who is on psychotropic drugs generally. At the time of my interview, he had been off all medication for approximately four months, since he first arrived at the Jail. He said that he sees Dr. Higgins about every 90 days but only for a moment or two each time. He also said that he had never seen a social worker since he had been in the Jail.

2. I interviewed inmate 4 the same day. He described an inmate fight in which another inmate knocked out two of his teeth. That had happened on the A-3 unit about one month before I interviewed this individual. He said that the same inmate who had knocked out his teeth had also hit another inmate and "busted his head" resulting in a hospital stay of weeks for that inmate. After a short period of time, this inmate's assailant was put back on the same tier with him. A Lieutenant, a Sergeant (and a nurse who asked him questions at medical) interviewed inmate 4 after the fight. SOD also interviewed him at that time.

3. Inmate 5 has been in the Jail for several years. He described a situation in which staff believed he was throwing water at staff members. He denied that. He said that SOD took him from his housing unit and beat him in an elevator. He said there was another inmate on the elevator who was also assaulted by SOD. The second inmate had an open wound above eye and ended up with a leg injury that was still a problem for that inmate at the time I interviewed inmate 5. He also said that before he got on the elevator, a female staff member had used chemical agents on him but that he was given no opportunity to decontaminate himself.

   Inmate 5 also had complaints about medical treatment. He said that when he was at the House of Detention he went without his medications for two weeks and would ask to see rank but no one would see him. He also said that when he puts in sick call slips, they don't see him and that a nurse told him the doctor had taken him off of sick call.

4. Inmate 6 is well known to staff. In May, 2012, he was a worker on Unit B- He was serving meals standing next to a deputy when another inmate wanted more fruit. Inmate 6 told him no, that there was not enough fruit

for second helpings. The other inmate hit him in the eye in front of the deputy. He was sent to the hospital that same day and the hospital staff said he had a detached retina and made an appointment for him to have surgery on his eye. Staff at the facility then sent him to his surgery appointment a day late and the surgery was not performed. The medical staff made a second appointment for him to have corrective surgery but staff again got him to the surgical appointment too late for the surgery to be performed. At the time of the interview, inmate 6 had gone over six months with no corrective surgery. (A number of years ago, I suffered a detached retina while I was out of town on a business trip. I didn't know what a detached retina was and did not get to an eye doctor until several days later. By then, the detachment had become more complicated. After five hospital surgical procedures and three office lasers procedures, my retina was finally reattached but not before I had lost a substantial portion of vision in my left eye. I am acutely aware of how painful a detached retina can be and how dangerous it is if the condition is not treated promptly). Inmate 6 said that at the time of the interview he had already lost all sight in that eye and that it hurt badly. To make matters worse, his mother had called the Jail and the Jail staff had told her that he had had his surgery. A deputy asked him questions about the incident but he never saw SOD. Also, a ranking staff member placed him on restrictions, which he said was done to prevent him from talking about the problem.

Inmate 6 has other health problems. He described coughing up blood on one occasion and telling a nurse. She in turned called the doctor who said that he should fill out a sick call slip. He further said that when he does fill out sick call slips, it is weeks or months until he is seen.

Inmate 6 asked to be placed on the medical tier because of his eye and because of sickle cell anemia. Staff refused and twice told him they would put him on a general population tier. He refused that on both occasions because he feared violence from other inmates. Staff reacted by putting him in disciplinary segregation. While there he was notified by letter that his younger brother had died. He requested permission to make an emergency phone call to his family but staff refused.

5. I interviewed inmate 7 on December 18, 2012. He described that on approximately June 20, a small young inmate was brought into the unit. Shortly thereafter he saw six inmates beating this new arrival. Then a named inmate stabbed him with two knives (all of this occurred at OPP on Unit B-2). The young inmate had a punctured lung and deputies reported that he went to the hospital on life support. The whole unit was placed "on ban" and a named Lieutenant told the assailant who had done the stabbing "That was your work. Don't do that again." The named assailant came back laughing from talking with the Lieutenant.

Because of the ban, inmate 7 asked to be able to call his family because they were driving a long distance from out of town to visit him. Staff refused.

Inmate 7 grieved that situation but received no answer. He has also grieved the black mold in the showers and received no answer.

Inmate 7 described to me that in the few days preceding our interview, the same named inmate who had done the stabbing on OPP, B-2 had also stabbed an inmate on the docks (an OPP tank). The inmate had used the same two knives he had used in the earlier attack, six months previously. Inmate 7 described in detail how this other inmate keeps these two large, good quality knives wrapped in toilet paper and hidden in his "butt crack". Inmate 7 says that other inmates know that he has the knives and that he has stabbed people with them.

Inmate 7 is in Jail on non-violent drug charge but is housed with inmates who are charged with murder. He has seen other inmates beaten and stabbed with some regularity. He also described witnessing a named Sergeant beating an inmate in the corridor outside the living unit. He said that most of the time there is no staff member on the unit to supervise the inmates.

6. Inmate 8 is also well known to staff. He has been in the Jail for approximately five years. His wife has also been incarcerated for those same five years. They have been allowed no contact whatsoever and are not even able to correspond with each other.

Inmate 8 complains that staff are unprofessional and that they bring too much "street culture" with them into the Jail. He said that staff have a demeaning attitude toward inmates and that they will pull up your criminal charge on the computer and then use it against you.

He has had fights in the Jail. A tier rep in the House of Detention would not give him a meal. An altercation ensued and he hit a named Lieutenant after which several deputies beat him.

In 2008 on the fourth floor, South, of the House of Detention he saw an inmate stabbed seventeen times. He has seen a lot of "bushing", local jargon for when a gang assaults an individual. In the House of Detention, on the fourth floor, South, he saw a transsexual inmate get gang raped. He also saw a gay inmate forced to accept a protector in return for sex. In late 2010, on Unit A-1, he saw an eighteen year old inmate kept in his cell and given drugs for sex by a guy called "E". One of those two inmates was almost stabbed to death. He has witnessed deputies taking money in return for hitting an inmate and he saw inmate 9 have a seizure that was so extreme he had brain damage. That seizure was on Unit D-1 and no staff were present.

Inmate 8 is diabetic and hypertensive. At the time of the interview, he had had no medication for hypertension for two years. In July of 2008 he had a pain in his eye. He filed grievances and was told to write to a doctor, who would then refer him. After two years, he finally went to the hospital in

2010. He was losing his vision and ballooned to 270 pounds because of high blood pressure. He subsequently passed out on Unit D-2 and was sent back to the hospital where they said his kidney function was down to 10%. The hospital suggested dialysis, which he refused. They increased his lasik, which exacerbated his condition. He put in a sick call slip and it took two weeks to see a doctor. At that point he was not breathing well and needed help walking. The doctor told him he was very sick but she was not going to send him to the hospital. A telemedicine conference was arranged and on July 1, 2011 inmate 8 almost passed out. A nurse got an ambulance and the university hospital doctor said, "Why did you wait so long?" They inserted a tube and removed eight liters of fluid. He was in the hospital for approximately fifteen days (beginning July 1, 2011) and missed his trial date. Three of those days were in ICU. He returned to the Jail and soon passed out for a second time. He was revived and agreed to dialysis. He has lost his right eye because of high blood pressure over an extended period of time. On May 24, 2012, he was on his way to dialysis with two deputies accompanying him in the car, when a Cadillac slammed into their vehicle. He was not wearing a seatbelt and was knocked unconscious. He now has bad pain in his eyes.

7. I interviewed inmate 10 in Templeman V on the A-4 unit. He is a diabetic who came back from incarceration upstate approximately one month prior to my interview. When he came back to the Jail at that time, a nurse took him off of insulin injections. He did not see the doctor. He told me that he cannot keep pills down and that he is vomiting but cannot get medical assistance.

8. I interviewed inmate 11 on December 19, 2012. He had a black eye and said that he has been beaten by staff on different occasions. He was on A-4 at Templeman V at the time of the interview. He described a lengthy and serious mental health history and said that he had been on Respirdol, Cogentin and Deprecote but that he is not getting any psychiatric medication now. He also said that he was seriously depressed and his manner and affect were consistent with that description.

   The inmate described a situation in which a named deputy came onto the unit for feeding and inmate 11 told the deputy that he was feeling homicidal and suicidal. Instead of calling rank, the deputy tried to physically push him back into his cell. The deputy started to choke him and the inmate got the deputy by the throat and was choking him back. The deputy attempted to call for back up although a deputy at the end of the hall was watching all of this. The deputy dropped his radio while trying to use it and the inmate kicked the radio. Then the deputy punched inmate 11, who then hit the deputy hard, knocking teeth out of the deputy's mouth. Other staff arrived with the deputy still holding onto inmate 11. They took him off the unit and into a sally port where an SOD deputy saw that he was okay and uninjured. That deputy left and four named deputies and a named Lieutenant stomped him, kicked him and hit him in the head with a radio. They put him in handcuffs and one of the four deputies got him by the

shirt collar and pushed his head into doorsills and then into windows. A named female Sergeant watched all of this. These staff members then took him to a cell across from the Watch Commander and left him there for approximately thirty minutes and then took him to the nursing station to calm down. The nurse told the staff that he had to go to the hospital and they had him spend another thirty minutes in the cell across from the Watch Commander and then took him to the hospital. At the hospital staff were taking pictures and asking what happened to him. In the nursing area he heard the named Lieutenant telling a named Captain that it had been five against one. They took him to be rebooked and a named Sergeant told him that everybody knew what had happened and that he got what he deserved and that they were going to do worse to him. He was never interviewed by SOD staff or any other staff about this incident.

Inmate 11 described an earlier incident that happened August 26, 2012. While inmates were being evacuated because of a hurricane, this inmate cursed at deputies and one of the SOD deputies then punched him in the face. That happened in Tent 1. Deputies took him to segregation and kept him there for seven days and then wrote him up.

On the current incident, he had written a grievance on Monday, 2 days before my interview with him, but he had received no response yet. He has been rebooked for a new crime (criminal damage) because of the windows that were broken when the named deputy pushed his head into those windows. He said that the inmates on the C-1 Unit saw that current incident.

Inmate 11 also described an incident in which he was not directly involved. A named Sergeant had words with inmates 12 and 13 after the hurricane. Inmate 12 came out of his cell to complain about that confrontation to a higher-ranking staff member. Then a named Sergeant or Lieutenant punched inmate 12 and, along with deputies, took inmates 12 and 13 off of the tier and beat them. They were not taken to the hospital but inmate 12 had both eyes blackened.

9. Inmate 14, a juvenile, has a roommate who is ADHD and gets aggressive. Inmate 14 has asked to be moved but deputies tell him there is nowhere for him to go. He wanted to file a grievance but could not get a grievance form. When he did get a grievance form and write it out, the deputies refused to pick it up. Inmates across from him on the unit are sending messages to his cellmate to jump him.

   Another inmate had been at Templeman V on Unit A-3. That inmate thought he was going home so he voluntarily signed off of protective custody and was then enticed by some of the inmates across from inmate 14 to "chill" with them. A named Captain had moved this inmate in with inmate 16, thinking that would be safe. However, since the staff do not care which cell you are in when it is lockdown time, inmate 15 went into the cell across the corridor with the inmates who had been enticing him

and then was locked in with them in the evening. After lights out, inmate 14 saw inmate 15 getting beaten by the other inmates in the cell and then that turned into sexual abuse. Inmate 14 could see it well from where he was. Inmate 14's cellmate, inmate 17 also witnessed what was happening and tried to beat on the window to get staff attention. The inmate who was raped did not report it. Inmate 14 and inmate 17 both tried to report what had happened but the deputies ignored them. No staff member ever interviewed or talked with inmate 14 about the situation, at least not before this litigation was initiated.

Inmate 14 described another incident that occurred Christmas, 2011. He was in a booth visiting with his mother when another inmate attacked him in front of the deputy supervising visiting. He had to fight because the deputy did nothing. Once back up staff arrived they did pull the other inmate off him. On another occasion, he (inmate 14) was put in a holding tank in the hall on the first floor of OPP with two other inmates who were there waiting to go to Court. They were juveniles with whom inmate 14 had had trouble previously at Templeman V. One of the two inmates started a fight with him and he said it had obviously been planned. They were directly opposite from one of the ranking staff members offices but that staff member came out of the office and told other staff "Let them fight". A named deputy eventually broke it up but inmate 14 had a swollen eye as a result.

In Conchetta, he saw a stabbing victim being brought down but did not see the stabbing itself. At OPP, on C-1, he twice saw an inmate block his cell lock with paper so that it wouldn't close and all other cells could be opened, then one inmate stabbed another inmate. One of the two times the victim was stabbed in the neck. Those two stabbings occurred on the same day, roughly a week before my interview with him. The same day as those two stabbings, an inmate was taken off the tier by about six deputies and came back holding his ribs. Inmate 14 had seen that inmate punch a deputy before the inmate was taken off the unit.

Inmate 14 is pretrial and juvenile and should not be housed with adults but he has been on more than one occasion. He has also been told that he wouldn't be housed with people he had trouble with in Templeman V but he is now housed directly across from them. They verbally harassed him. He was in Conchetta on 2-T but he is now doing seventy days "in the hole" for arguing with a deputy and the deputy also said he broke a window. He is unhappy that while he is in the hole, he is not allowed to go to school.

10. Inmate 18 was in D-3 in OPP at the time of my interview. He had been in Jail for approximately eighteen months and was pre-trial. He reported that he had been assaulted on the eighth floor of the House of Detention. He was trying to sleep when three deputies grabbed him. He was lying on the floor and it was perhaps 12:00 or 1:00 a.m. He did not have a cellmate. The deputies pulled his pants and down and he felt something enter him then they left. He knew one named deputy of the three. The assault

happened on a Monday and on that Wednesday he told Maggie, the SPLC inmate advocate. SOD deputies picked him up on Friday and took him to the SOD office and then took him to the hospital. They returned him to Templeman V, on suicide watch. One or two weeks later another deputy interviewed him and he recanted his story. Once he recanted, he was booked for a new criminal offense for filing a false charge. Last fall, inmate 18 was stabbed in the shoulder. Another inmate pulled out a knife and rushed him and stabbed him. He told his mother and she called into the Jail but he said it had never happened.

He has seen other inmates get assaulted by staff or by inmates. He saw a named Lieutenant punch a named inmate in the face because that inmate had been kicking the door of a holding tank on the first floor. The inmate was not given medical assessment or treatment.

In August of 2011 (approximately) a new inmate on Unit C-4 was stabbed by several other inmates.

Several days before my interview, on Unit D-3, a new inmate was jumped by a second inmate, who was using two knives. The inmate assailant had a nick name which inmate 18 knew.

Inmate 18 was also unhappy that he had not had any outside exercise in the last three weeks.

Finally, when I discussed some of these situations, and the inmate-on-inmate violence in general, with Mike Laughlin, the head of SOD, he immediately began to talk about inmate 18. He made the point that inmate 18's story was false and that he had subsequently recanted. The SOD interview in which inmate 18 recanted is discussed in some detail later in this report but my opinion about what actually happened with inmate 10 is dramatically different than Colonel Laughlin's conclusion.

11. Inmate 21 was on D-1 in OPP at the time of the interview. He had come there from Unit A-1 in Templeman V.

    On November 11, 2012 while he was in Conchetta, a named inmate was asking about his tennis shoes and also talking about his butt in the shower room. Inmate 21 purposely showered early in the morning in order to stay out of trouble, usually going to the shower at 7:30 or 7:45 a.m. On November 11, he was in the shower when he felt something hit him in the head which knocked him out. He was raped by two of three inmates and all three inmates forced him to perform oral sex. He lost control of his bowels. When he returned to the bunk area he had to walk past those three inmates and they threatened him, telling him to keep quiet.

    A named deputy came onto the unit and he told the deputy he wanted to talk. The deputy took him off the tier and listened to him. A named Lieutenant tried to get the deputy to put inmate 21 back on to the tier.

Instead, he was put in a holding tank and seen by two named SOD deputies. They were crude with him and disbelieving and told him that if his information was false they would rebook him on another offense. Other inmates were brought down in front him while he was in the holding tank and one of those was one of his attackers. He got to the university hospital at 1:00 a.m. and the deputies escorting him loudly told the full waiting room "We need a rape nurse". At 8:00 a.m. the next morning he was sent back to the Jail.

A female shift commander tried to put him in Conchetta on Unit 3-1. He objected and was put in a holding tank in Conchetta and then taken to Templeman V and to their clinic. Then he was moved to suicide watch. At 3:00 a.m. a psychiatrist arrived to talk to him and asked him if he was suicidal or homicidal and he said no. None of the staff talking to him gave him any privacy with other inmates or staff about his rape. He was then placed on the step down tier. A named Lieutenant and a named SOD staff member took him off the tier and told him the hospital results did not support his story. The SOD deputy was yelling at him and intimidating him pointing a finger in his face. Then Sheriff Gusman came to the unit to talk to him. The Sheriff said that he would call inmate 21's lawyer and that he would also personally look into the situation. Then he asked inmate 21 what he wanted out of all this. The same SOD deputy then came back at 2:00 a.m. and again took him off the tier. Inmate 21 had told this deputy that he wanted Maggie Yates, an SPLC inmate advocate or Katie Schwartzmann, the SPLC lead attorney, to be present if he was going to be interviewed. That ignored that. He was shown pictures as part of a photo line up and he cooperated.

Some time after the sexual assault, he had had a seizure and as he came out of the seizure a deputy grabbed his shirt and held him by the chest and put him into a holding tank. The next morning a named Major and named Captain both swore at him.

12. Inmate 23 was on Unit C-2 in OPP two months prior to my interview with him. He was detoxing from heroin. He was on the floor of his cell with his jumpsuit off because it was very hot in the cell. His cell mate was in the cell and one additional inmate came in. The deputy on duty was downstairs watching a New Orleans Saints game. One of the inmates in the cell with him sexually abused him. They choked him out and he was unable to fight back. He was sick and he was overpowered. He later told the deputy what happened to him and he was put in a holding tank. He was kept in the holding tank for three days and then he told staff that he was suicidal. He was moved to the psychiatric unit and he told superior officers there and they notified SOD. The SOD deputies took him to the OPP office and from there, back to suicide watch. The next day the SOD deputies came with pictures of the inmates on the tier. Inmate 23 was able to identify two people from these photographs. No one else talked to inmate 23 about the situation and he was not taken to a hospital or seen by a doctor. He was later seen by a psychiatrist in order to get off of suicide watch. He has no

idea if anything happened to his assailants. He asked for counseling but could not get any information and no one has seen him about the sexual assault.

13. Inmate 24 was 15 years old at the time I interviewed him. He had been in the Jail for several months. He was on one of the two juvenile tiers, OPP, A-3. It seemed to him like the whole tier was trying to stab him. He had come in from a juvenile center with two other inmates and the three of them were placed in a four-man cell. He and the other two new arrivals on the juvenile tier were all getting threatened. On two different occasions, inmates held his cell door open while also holding their own cells doors open, so that after the tier was ostensibly locked down, these other inmates could get at the three newcomers. They were actually saved because court cases were coming back at that time into the unit. He told three or four male deputies but none of them did anything. Then a female deputy told rank and the three new juvenile inmates were moved to Conchetta.

    On one occasion an inmate put a knife in inmate 24's face, but deputies came into the tier and stopped the situation before anyone was hurt. However, they did nothing to the inmates who had been threatening him including the inmate with a knife.

    Inmate 24 told me about a named inmate whose jaw had been broken by other inmates. Evidently, the deputies had been told but didn't do anything to stop the beating. Inmate 24 also said that you get feces and urine thrown on you in the Jail and that in the juvenile center he had been given psychiatric medications but in the Jail he was receiving nothing.

P. PREA and Staff Response to Allegations of Sexual Assault

1. The taped interview of inmate 18 by S.O.D., analyzed in the section following, is a graphic and horrific example of the failings of jail staff in response to sexual assault allegations.

2. A review of inmate grievances reveals that there is a very high number of grievances that allege sexual assault and/or sexual harassment. A review of the sexual assault investigation reports produced by Defendant demonstrates that the number of investigations into charges of sexual assault are miniscule by comparison. This is consistent with a finding by the US Department of Justice (US DOJ) within the last few years that OPSO was one of the worst jails in the country with regard to the incidence of rape and other sexual assaults. OPSO is featured, negatively, in a major US DOJ publication on the best and worst correctional facilities in the country with regard to PREA.

3. Inmates who report sexual assault should be taken immediately to a hospital for a rape kit and SANE protocol. Instead, inmates in the New

Orleans Jail who report sexual assault are often put in holding "tanks" for many hours and frequently for days.

4. Inmates reporting sexual assault should be given immediate access to medical services and then, after that, immediate access to psychological services. Psychological services including various forms of counseling are not made available to inmates reporting sexual assaults.

5. Inmates reporting sexual assaults are often subjected to crude jokes, insults and repeated suggestions that they are lying about what happened.

6. In some cases, inmates who have reported sexual assaults have not been immediately separated from the alleged perpetrators and have been left vulnerable to retaliation for reporting the assault. The alleged perpetrators of sexual assaults are often left on their living units rather than being locked up and isolated pending investigation.

7. The New Orleans Jails do not have alternate ways to report sexual assaults as required by PREA.

8. If the New Orleans Jails have provided training to all staff on PREA and more specifically on the response to allegations of sexual assault, that training has been unsuccessful. Staff in the Jails continues to publicly call some inmates homosexuals or punks and continue to make crude jokes about homosexual sex.

9. In summary, what actually happens to inmates who report sexual assault or related sexual incidents is, most often, nothing. That is, inmates may try to report these situations to staff on their living units but there is ample testimony, in inmate declarations and in my inmate interview results, that staff frequently refuse to pay any attention to an inmate trying to report an incident, or react dismissively or angrily. Since the jail does not comply with the PREA requirement to provide alternate methods to report such incidents, including at least one avenue that can be used for anonymous reporting, the only obvious alternative for OPSO inmates is to use the inmate grievance system.

   When an inmate does use the inmate grievance system to report a sexual assault incident, the first thing that happens is delay. Grievances should be triaged and any grievance alleging a sexual assault should be regarded as emergency grievance and responded to immediately. That does not happen and it may take from several days to several weeks for an inmate to get an answer to an allegation of sexual misconduct or assault.

   The next thing that typically happens is that staff are sent to talk with the inmate. Most frequently that will be a staff member from SOD. That staff member, and perhaps other staff, will begin by suggesting to the inmate that the incident did not happen, that the inmate is fabricating the story, that the inmate may be charged with a new crime for filing a false report,

etc. Then, typically, if there is any follow up at all it consists of putting the inmate in a holding cell for hours or days. The inmate may also be brought to the SOD office for a more formal interview. Through all of this, the chance that a SANE exam will produce medical corroboration of inmate's allegations or evidence about the identity of the assailant, decreases as time passes.

There is no consideration of providing the inmate with psychological help in the form of crisis counseling or anything similar. It should be noted that throughout this sequence of events, the SOD staff continually violate the most crucial principle of medical care and mental health care in jails. That principle is that custody and security staff may not act as gatekeepers for health or mental health services. Here, in the case of allegations of sexual assault, SOD security staff make decisions about whether or not the inmate's allegations are valid, and if SOD decides that the allegations are likely invalid, then they also decide not to avail that inmate of even cursory medical assessment. They also fail to provide appropriate mental health care for the inmate by refusing to arrange crisis intervention services, counseling, mental health assessment and the like. In short, SOD has decided that they are themselves the appropriate gatekeepers for medical and mental health services in spite of policy and consensually accepted national practices to the contrary.

10. During booking and classification, the New Orleans Jails fail to identify those inmates who would be likely to be sexual predators and to identify those inmates who would be likely to be victims of sexual assault, and to then house those two groups separately. Instead, likely sexual predators are regularly housed with likely sexual victims.

11. When an inmate reports a sexual assault, that individual obviously needs immediate medical and psychological assessment and perhaps treatment. However, that individual also needs compassion and sensitivity and the New Orleans Jail staff provide neither.

Q. Investigations of Use of Force and Inmate Violence

1. It is imperative for any correctional agency to have strong investigative capacities and practices. It is true that in some jurisdictions, situations that rise to the level of new criminal offenses may be handled by state police, a municipal police department or some other external agency, depending on local and state practices and statutes. It is also true that many correctional agencies have two levels of investigation themselves. For example, a Sheriff's Office may have an Internal Affairs Division that investigates staff uses of force (unless it appears the staff may be charged with criminal offenses) and that same Sheriff's Office may have a Detectives Division that investigates inmate offenses that are too serious to be dealt with in the administrative discipline system. In spite of these differences in structure and applicable statutes, jails and prisons generate incidents which need to

be investigated. Those investigations must be thorough, unbiased, professionally competent and rigorous.

2. In the New Orleans Jails, both use of force incidents and most inmate-on-inmate violence situations are investigated by SOD. That presents an immediate and serious problem. It is inappropriate for SOD to investigate staff use of force situations because a substantial number of uses of force incidents within the Jails involve force used by SOD members. Perhaps not surprisingly, a substantial number of the complaints about use of force, whether from inmate grievance, inmate family members, claims and lawsuits, etc. are allegations that SOD deputies have used excessive or unnecessary force.

3. SOD is a desirable assignment for most deputies and is seen as something of an elite unit within the OPSO staff. It is also a tight knit unit. It is an obvious conflict of interest for SOD deputies to investigate complaints about use of force against other SOD deputies. That conflict of interest is not minor or technical, it is blatant.

4. From the training records provided, it does not appear that members of SOD have received any in depth or specialized training on investigations. The P.O.S.T. training that deputies in OPSO have completed does include materials on field investigations (F.I.'s) and on car stops but that is aimed at police duties rather than correctional duties, and is also intended for frontline police officers rather than detectives. There is no indication of regular or in-service training on the conduct of actual investigations.

5. There is also no written policy or procedure that has been produced which provides guidance in conducting investigations.

6. The combination of lack of policy and procedure and lack of training on the conduct of investigations is particularly troublesome. Almost all investigations are conducted by members of SOD. It is also surprising that while each investigation report is submitted to a mid manager within SOD or to the head of SOD, the majority of the reports are unsigned by the deputy submitting them. More importantly, there is no signature or date indicating that a manager or administrator has reviewed the report. However, the most telling omission is that there is no indication that these investigative reports are ever followed up with the reviewer's request that additional information be sought, that an investigation be reopened, etc.

7. The investigations, in general, are of very poor quality. They frequently show bias on the part of the investigator and it is typical that the investigations raise questions which are important but which are then dropped without further investigation, and without resolution.

8. It does not appear that Defendant has produced all investigation reports requested. With regard to investigations of sexual misconduct allegations, the Defendant produced thirty-three investigations for 2012 (OPSO

Reports 000253-000346, with some reports being multi-page). Of those thirty-three investigation reports, none are dated in January, one is dated February and none are dated in December. Assuming that allegations of sexual misconduct are submitted somewhat randomly over time within a jail as large as OPSO, the odds that thirty-two of thirty-three investigative reports would happen to occur in nine of the twelve months by chance, while the other three months would account for only one report, are too small to be coincidence.

9. In an investigative report dated May 25, 2012, Deputy Hazel Bowser investigated two allegations that inmate 26 was sexually assaulted by several inmates on April 20, 2012, while housed in Conchetta, dorm 2-1. Deputy Bowser interviewed a number of inmates who had been present on the living unit at the time of the alleged assault. Her report says that inmate 26 was very close to another inmate who was working with the Southern Poverty Law Center (SPLC) and had made allegations against the Jail. Deputy Bowser's report goes on to say that this other inmate coaxed inmate 25 "To hop on the lawsuit bandwagon with the SPLC." Obviously, "Hop on the lawsuit bandwagon with the SPLC" is Deputy Bowser's framing of that issue, not inmate 26's. The same bias, that almost all of the allegations of sexual assault within the Jails are unfounded and are a result of coaching and instigation by the lawyers or inmate advocates of the Southern Poverty Law Center, were expressed to me in two separate informal discussion with OPSO top administrators.

10. The most alarming and outrageous example of what is wrong with the investigative practices within the Jail can be found in two interviews conducted with inmate 18. That inmate had alleged that he was gang raped and then forced to perform oral sex on three inmates in the shower, while on Templeman A-5. The term "interviews" is clearly a misnomer. The two sessions are interrogations and the goal is to get the inmate to agree with the preconceived conclusion of the SOD investigators that inmate 18 invented the entire story out of whole cloth. Fortunately, both sessions were recorded with audio and video.

    a. The two sessions go on for hours, literally. They use high-pressure techniques of the kind that, when used by police, produce false confessions. The investigators repeatedly lie to inmate 18. Then they pressure him with questions that are based on the false information they have just provided. For example, they tell the inmate that they have the results of the medical exam and that those results prove that he is lying and that those medical tests would show even if so much as a finger penetrated the inmate's rectum. Then they ask him why, if he is telling the truth, do the medical results not bear that out.

    b. Inmate 18 is not sophisticated and he is not particularly articulate. However, he is very consistent and quite detailed

about what has happened to him. The investigators repeatedly ask him to admit that he was put up to making these charges by another inmate and Maggie Yates, SPLC advocate. They also pressure him to admit that he has been promised some advantage by Maggie Yates or the attorneys at SPLC. They also try, again repeatedly, to pressure inmate 10 into agreeing that he wants to be transferred out of OPP or is making these charges looking for some other advantage. Through all of this, inmate 18 remains adamant that his charges are valid.

c. On page 37 of the transcript of the first session, the investigator goes beyond merely being offensive. He asks, "Where are the blood stains?", and inmate 18 responds, "Who said there were blood stains?" The deputy replies, "But you said somebody used a hammer". That deputy knows full well that the inmate has repeatedly said that he was anally penetrated and that he thought it was the rubber handle of a hammer he saw. That is a deeply disturbing way to treat someone who is attempting to report a sexual assault.

d. The inmate is asked "Why didn't you tell your mom?" and inmate 18 says that he did talk to his mom about whether the doctors would be able to tell something had happened if he went to the hospital. The officer ignores that. Throughout, the deputies interrupt inmate 18 repeatedly and place heavy pressure on him. The sessions are clearly intended to confuse and intimidate the inmate. It seems likely the two deputies doing the two interviews believe the inmate is not high functioning because they ask him about a competency issue that is supposed to be decided by the court.

e. The deputies switch gears and begin to pressure the inmate with how terrible this is going to be for the people that he is accusing, that they have families, etc. Then they go back to the hospital exam and tell him "This test ain't gonna lie". Actually it is the deputy who is lying. Is neither impossible nor improbable that inmate 18 was forcibly penetrated but does not have tears or other evidence of trauma. One of the deputies goes on to say "Nobody did nothing to you." The deputy asks the inmate whether his (the inmate's) mother is a nurse, but in a sarcastic way trying to demonstrate that his mother did not know what she was talking about when she encouraged the inmate to have a hospital exam.

f. Then, in the second session, the deputy makes it clear that the inmate is going to be charged with a new crime for filing false charges. The inmate says that he does not want to recant and then get charged. After that there is some discussion from the second investigator, making the point that the inmate must be lying because he did not tell his attorney what happened immediately, although the inmate responds that he told both the other inmate and Maggie Yates that same day and then on the next day. However, at that point it is clear that the inmate is concerned with getting charged and that he is somewhat beaten down. Inmate 18 finally says, "It ain't happened." After the hours of interrogation and all the details that were discussed a number of times about the assault, the officer accepts that as a full and complete denial in spite of the inmate's page after page of insisting that it did happen and providing details about the incident.

g. At the end the second interview it is quite clear that inmate 18 is still saying that the incident happened. In fact, he ends the interview by saying that he is mad at himself that he did not come forward earlier with what happened to him.

h. If the PREA commission or the PREA staff is looking for a videotape that would demonstrate how not to deal with a potential victim who is reporting a sexual assault, they should consider getting a copy of the videotape of these two sessions and distributing that tape nationally.

R. Tier Representatives

1. Tier representatives ("tier reps") are common within OPP. Most dorms or tiers have both a tier rep and an assistant tier rep. According to staff, the tier reps help with communication between the staff and the inmate population, represent the living unit when inmates are given a say in decision-making and sometimes help organize inmate workers.

2. Many inmates at OPP complain that the tier reps use their positions of authority to extort commissary goods or personal property from inmates on the unit, to control phone time, to make decisions about inmate housing and even to administer beatings to inmates at the behest of staff. There is ample evidence in the case record that some of these allegations are valid. There was widespread agreement among inmates and from various sources of evidence in the case record that tier reps regularly serve meals without staff supervision. Since food is one of the small number of "hot button" items for almost all inmates, that immediately gives the tier rep inappropriate leverage and authority. Some inmates may be given smaller portions or no food at all while other inmates get large portions or seconds.

That kind of power can be used to extort from inmates wanting food and it can also be a source of confrontation and violence.

3. The use of tier reps is a corrupt practice. Staff appoint the tier reps and it is in evitable that some staff feel indebted to the tier reps, give the tier reps favors or extra privileges and/or use the tier reps in other inappropriate ways. It is also inevitable that some of the tier reps will abuse their positions and use them to their personal advantage with other inmates. Other inmates may feel compelled to give in to the tier reps because of the perceived link between the tier reps and the unit staff. This practice has no place in American correctional management and it is a direct violation of an ACA standard on the subject (standard 4-ALDF-2A-09: "No inmate or group of inmates is given control or allowed to exert authority over other inmates.)

4. Both the inmate grievances and the interviews I conducted include a number of references to tier reps. These references are almost without exception negative. Also, most of these references assume that everyone knows that tier reps exist, that they are picked or appointed by staff and that they have inappropriate control over what happens on the living unit. In the case of one SOD investigation of charges against a female staff member, several of the inmates interviewed in the course of the investigation talked about the relationship between the female staff member being investigated and a female tier rep. Several of these inmates interviewed independently said that the tier rep had a great deal of control over other inmates on the unit, including a description of this tier rep telling the staff member where to transfer specific inmates. A male inmate casually referred to the fact that the staff usually picked the person they perceived to be the toughest inmate on the unit as the tier rep.

S. Fire Safety

1. Fire safety should be one of the highest priority concerns at OPP, but it is not. There is a real possibility of a catastrophic fire event with multiple to many fatalities. The lack of awareness of that risk and the lack of concern for fire safety is deeply disturbing.

2. Even a modern concrete and steel low-rise jail with contemporary fire suppression systems can have a fatal fire. The paint on walls can burn and it takes relatively small amounts of polyurethane materials to fill a correctional facility with toxic smoke in several minutes or less. The OPP facilities are not modern low-rise modular or podular buildings; they are old, multi story linear facilities with questionable locking systems. Perhaps most importantly, they are dramatically understaffed by primarily inexperienced and under-trained officers. That is a recipe for a potential disaster. It is worth remembering that more jail inmates have died in this country in fires than in hostage incidents.

3. A fire marshal's report on OPP for 2011 has been requested but has not been produced. Perhaps it does not exist.

4. The current stance of the Fire Marshal would be particularly important to understand because prior fire protection deficiencies had led to the issuance of short term, temporary occupancy permits for some of the OPP buildings. It does not appear that those problems have been fixed. Most importantly, the fire alarm systems in both Conchetta and Templeman V have been broken for many months, perhaps longer. The "work-around" has been an agreement between OPSO and the Fire Marshal that a " fire watch" would be substituted as an alternative to a fire alarm system. The "fire watch" is supposed to be two officers assigned full time to patrolling Templeman V and Conchetta, looking for excess fire loading (large amounts of books, clothing or other flammable materials in inmates cells, etc.) fire exit access, fire ignition potential, and the like.)

   The plain truth is that the "fire watch" is not a substitute for a fire alarm. Assuming the "fire watch' is done properly, its goal is to reduce the possibility of a fire starting and to reduce the chance that a fire, once started, would spread. However, the goal of a fire alarm system is to provide an immediate or early warning in case a fire <u>does</u> occur so that fire suppression and/or fire evacuation procedures can begin as quickly as possible. Those are very different goals. There is nothing about the fire watch, as defined at OPP, that would provide early notice that a fire had begun. The lack of early warning might well mean that fire suppression efforts were too late to stop the fire from spreading and/or that the failure to begin evacuation early might lead to fatalities.

   In addition to the problems summarized above, there are serious questions about whether OPP is complying with the fire watch agreement itself. The week of December 17, four experts toured the OPP facilities, with two experts touring for four days and the other two for one or two days each. For most of their time in the institutions, the experts were touring individually, in different locations. None of the four experts, in the four days of touring through Conchetta and Templeman IV, ever encountered either of the two officers who were supposed to be assigned full time to "fire watch".

   There is additional evidence the agreed upon fire watch procedures are not being followed. On several tiers in both Conchetta and Templeman IV, inmate cells had towels or blankets across the front of the cells and/or towels or blankets across the back of the bunks, facing the cell door, so that there was no visual access to the bunks themselves. On the second floor of Conchetta and on the third floor, there is a locked emergency exit that provides secondary egress in case of fire. The officer working the second floor was asked where the key was for that emergency exit on his floor. He could not find it and he asked another staff member who also did not know where it was. A search for the key ensued and after more than fifteen minutes a staff member returned with the emergency key. Once staff tried

to operate the emergency exits, they found that it was the wrong key. Perhaps it is too obvious to need stating but if an active fire or thick smoke were blocking the primary entrance and exit to the floor, there would have been a high likelihood of a large number of inmate and staff deaths long before staff located what turned out to be the wrong key. It is not possible to reconcile two deputies assigned full time to fire watch in Templeman V and Conchetta with a fire exit door that staff do not know how to operate and a key to that door that cannot be found.

5. In touring the Tents, the Lieutenant who was the Watch Commander said that fire drills were very frequent, at least monthly. He described a staff member coming over to announce that in ten or twelve minutes they were going to announce a fire drill. It would appear that fire drills are announced rather than unannounced. While announced fire drills and "staff walk throughs" (non-evacuation drills) are both useful when staff are learning fire procedures, neither provides a realistic test, evaluation or valid practice for a real fire. For example, the length of time it takes staff to evacuate a living unit when they have ten minutes advance notice that a drill is going to be called may bear no relation to the amount of time it takes to clear the same living unit when the drill occurs with no warning. Also of serious concern was that I asked two separate front line officers in the Tents about the last time they had been on duty when a fire drill had occurred and each of them said that they could not remember the last time they had been involved in a fire drill. I repeated that question to two other staff (one in Conchetta and one in Templeman V) and they had the same answer: that they did not remember ever having been involved in a fire drill while on duty.

T. Emergency preparedness

1. There is no system of emergency preparedness within the New Orleans Jails and the level of preparation for a major emergency, ranging from riot or hostage situation to tornado or major fire, is almost non-existent.

2. The emergency plans are brief, unsophisticated and impractical. They are probably not relevant, because the staff are not familiar with them in any case. There has been no department-wide training on emergency preparedness and the Department is not current with the federally mandated training requirements on NIMS (National Incident Management System).

3. Key emergency equipment is not available and emergency policies have not been developed. Additionally, the staff have not engaged in emergency tabletop exercises, emergency functional exercises or large scale simulations. SOD does train for tactical situations and the Jail's emergency plan can be accurately paraphrased as "SOD will take care of it".

U. The Inmate Grievance System

1. Inmate grievance procedures have improved markedly in the last year or so but they still fall far short of constituting a comprehensive and effective system.

2. The inmate grievance system has little or no credibility in the eyes of most of the inmate population.

3. A single designated staff member now collects grievances from all units once each day, weekdays only. That change helped counter inmate allegations that grievances were often thrown away or torn up by staff who did not like them. However, a once per day pick up is not effective for emergency grievances and emergency grievances are an important part of any inmate grievance system. As it stands now, an inmate can submit an emergency grievance but it may be 72 hours before anyone reads the grievance.

4. In addition to providing an outlet for inmates complaints and an informal path to resolve many such complaints, an inmate grievance system also fulfills a crucial function as an early warning system for management. In the New Orleans Jails, that function of the grievance system is rendered useless because there are no weekly, monthly or quarterly reports showing the number of grievances by housing area or facility, by shift or by subject matter. Thus, there is no way for management to know whether grievances are dramatically up or dramatically down overall, or in a given area of the jail.

5. Management does not get adequate information and in some cases gets no information, about the percentage of grievances determined to be well founded, the percentage appealed, the percentage denied on appeal, the percentage of grievances responded to within policy timelines, etc.

6. When grievances are collected and reviewed, they are sent directly to a staff member or a unit best able to answer the grievance. Those answers then get sent back to the inmates initiating the grievances, unfiltered. As a result, the answers to too many grievances fail to answer the issue raised by the grievance.

7. Grievance processing is now done by hand. The absence of a automated chronological log in which each grievance is given a unique number and entered in the log (or spreadsheet) as it comes in, and then documented when it is sent for an answer and documented with the date of the answer and the date on which the inmate receives the answer, makes it difficult and time consuming to answer questions about the status of a specific grievance, or even to find individual grievances that an inmate claims have been lost. Without a chronological log in the form of a searchable database, there is no good way to query the system or generate reports.

8. There are other, fundamental problems with the grievance system. Inmates do not retain a copy of a grievance submitted. Thus, if there is no answer forthcoming then there is no way for that individual to establish that he actually submitted a grievance. In some jails, grievance forms are printed on multi-part paper so that the inmate keeps one copy and two are submitted. Then, of the two that are submitted, one stays with the grievance office and one is routed to the person identified to answer the grievance. Other jails simply make a photocopy of the grievance, once filled out, for the inmate to keep.

9. Other basic problems include that grievance answers sometimes do not make sense and there are also long delays in answering grievances which should have been triaged into the "emergency" category. For example, a grievance submitted on December 3, 2009, said that the inmate's life was in danger and that he needed to be moved from HOD. The response to that grievance was written on January 19, 2010, a month and a half later. The response said "You were interviewed on January 10, 2010, and you said that you were okay." How fortunate for the Jail that the inmate was wrong about his life being in danger and that interviewing him five weeks after his grievance did not present a problem. Another inmate grievance was filed on February 2, 2011, saying that the inmate feared for his life and wanted a transfer. He mentioned that he had already been stabbed twice. A week and a half later, on February 13, 2011, the inmate submitted another grievance saying that his life was in danger on a daily basis and that he had been beaten in his current location and had a broken finger. He said that he had no answer to his first grievance and asked if someone would please answer his latest grievance or provide a second level answer to his initial grievance. An answer to that grievance was written on March 1, 2011, a month after the initial grievance was submitted. The answer said that the inmate had been moved that same day (March 1). What would OPSO say if the inmate had been murdered in the intervening month while no one responded to his grievance? Other, similar examples can be found throughout the inmate grievances Defendant has produced.

V. Inmate Disciplinary System

1. I could not review the inmate Disciplinary System in detail because so many crucial documents were not produced, but it does not appear to be working properly.

2. Inmate who are found guilty of a disciplinary offense may be sent to disciplinary segregation as their sanction, provided they are found guilty of the violation at a disciplinary hearing. Disciplinary segregation involves a loss of all or almost all inmate privileges. Typically, compared to general population inmates, inmates in disciplinary segregation are restricted with regard to recreation, commissary, phone calls, family visitation, reading materials and library privileges, programs, and more. Many of those items may be prohibited rather than restricted.

3. When an inmate commits a serious rule violation and needs to be taken off of his living unit or tier and locked up immediately, that inmate should be sent to administrative segregation. Administrative segregation is not punishment but is rather housing that is restricted with regard to security, for the convenience or safety of the institution. Inmates are held in administrative segregation until a disciplinary hearing and then, if found guilty, transferred to disciplinary segregation. That process is very much parallel to the distinction between an inmate on pre-trial status awaiting the outcome of criminal charges and an inmate after conviction, serving time.

4. In OPSO, inmates are not sent to administrative segregation on pre-hearing status. Instead they are sent directly to disciplinary segregation although the disciplinary hearing has not yet been conducted. That is improper.

5. Deputies who are supervisors writing disciplinary reports sometimes recommend that the maximum punishment be applied. That kind of punitive attitude on the part of the staff member writing the disciplinary report is also improper. Certainly a disciplinary report may contain extenuating circumstances or may contain a description of events that demonstrates that the violation was intentional, unusually blatant, etc. The determination of sanctions, however, is part of the role of the disciplinary committee or disciplinary hearing officer.

6. Plaintiff's requested disciplinary records for a number of individual inmates who have reported excessive force by staff, sexual assault, other serious injuries at the hands of other inmates, etc. Defendant has been unable to produce those disciplinary records and have explained, through counsel, that disciplinary records do not become part of an inmate's permanent file in OPSO. Instead, the disciplinary records are kept in a temporary folder that is maintained by the individual facility that houses the inmate. That folder does not travel with the inmate and when an inmate is transferred to a different facility, the folder remains and a new folder is started at the next facility. Further, once an inmate has left a facility, the disciplinary records in the facility folder may or may not be maintained. It requires a time consuming search to find out if they have been maintained.

7. It is most strange that in 2013, a jail the size of OPSO has not automated its inmate disciplinary records. That is direct violation of an ACA standard for jails.

8. The deeper concern is that an inmate's disciplinary history is not available to the disciplinary board or hearing officer at the time of a new disciplinary hearing. One of the major factors that is applied in determining the appropriate sanction for a particular disciplinary violation is, precisely, that inmates disciplinary history. An inmate who refuses to go back to his cell at the end of recreation will and should receive a very different number of days in disciplinary segregation if it is a first offense compared to a fourth time for the same offense. There are also rules about a certain number of minor violations constituting a major violation. None of that can be done

or even considered in OPSO because disciplinary histories are not available. That compromises the integrity of the inmate disciplinary system in a fundamental manner. Also, there is no way to track repeat offenders, which contributes to allowing predatory inmates throughout general population housing and, in turn, escalates inmate-on-inmate violence.

9. There is another basic problem with the inmate disciplinary system. Inmates do not like disciplinary segregation. In fact, most hate it. However, that is the point; if inmates liked it, it would not be an effective sanction. However, in OPSO , it is well known among the inmate population that if you are sent to disciplinary segregation ("the hole"), all you need to do is to say that you are suicidal and you will be transferred to the acute psychiatric unit in Templeman V (unit A-4) and placed on suicide watch. Several inmates on A-4 told me clearly and as if it was not of much concern, that they had not wanted to be on disciplinary segregation and had said that they were suicidal in order to get to the psychiatric unit. The staff know this is occurring and are frustrated but at the time of my tour of the facilities, nothing had been done to change the situation. A substantial number of the inmates on suicide watch were, by their own admission, not really suicidal. That produces a toxic stew of acute psychiatric inmates, acute suicidal inmates and disciplinary segregation inmates. It is an accident waiting to occur.

W. Staff Discipline

1. Staff disciplinary records can be very helpful in understanding an organization. Just as use of force situations and investigations are often emblematic of an organization's attitudes towards inmates, staff disciplinary investigations and decisions often reflect an organization's attitudes towards its own employees. Further, in correctional agencies, they often add to the understanding of the organizational stance toward inmates.

2. Defendant produced a total of seventy-one staff disciplinary investigations and/or disciplinary hearing results. A review of those records produced a number of unexpected results.

    a. Only two of the seventy-one investigations were about staff use of force.

    b. Only two other investigations were about staff dealing with inmates. One of those was a romantic relationship between a staff member and an inmate and the other involved a staff member passing contraband drugs to inmates. The other sixty-seven of the seventy-one investigations were predominantly personnel issues such as reporting to work late while staff confrontations with other staff was the second most common subject.

c. Overall, these records presented a picture of an organization in which staff-on-staff conflicts and confrontations are relatively common and in which staff interpersonal dynamics are taken much more seriously than working with inmates or other parts of the organization's real mission. The lack of disciplinary investigations concerning staff use of force is striking (no pun intended), particularly when there have been so many detailed and serious complaints about staff use of force from inmates.

d. One of the two use of force situations was clear and straight-forward. An inmate flashed a female deputy and the second time he did it, she sprayed him with chemical agent even though he was locked in his cell and presented no threat. She did not document or report her use of force. Appropriately, she was terminated.

e. The other use of force situation is complicated and was handled very badly. An inmate in one of the tents got into a verbal altercation with a female deputy. She told him she was going to move him to Tent 6. He objected, saying that he had enemies in Tent 6 and that he would be hurt or killed. She called for help and the inmate was escorted to Tent 6 even though all of the beds in Tent 6 were full and there was space in at least one other tent. As soon as the inmate went into Tent 6, he was seriously assaulted by a group of inmates. He came out of Tent 6 very angry and reportedly holding a broomstick and saying "I am going to kill everyone". One of the deputies who had escorted him to Tent 6 punched him several times and put him in restraints. Almost every staff member involved in the situation was investigated. According to the investigative report, the deputy who had punched the inmate admitted to punching him after he was in restraints and to having another deputy write his report, which he signed and submitted. There was also an allegation that the same deputy had told a tier representative in Tent 6 that he would pay him if he got inmates in that tent to assault the inmate being transferred.

   According to the investigative report, the investigator does not ask the deputy under investigation whether he hit the inmate after the inmate was restrained. The investigator interviews several other staff including people who were on the scene and does not ask them that crucial question either. The deputy also fails to interview any of the inmates involved in the assault and, in particular, does not ask the tier representative whether he was put up to organizing the assault by the accused deputy. No one else is asked about

that either. The report reads as though the deputy very carefully avoided asking questions which he did not want to be answered. Consistent with that reasoning, the recommendation was to find all of the charges "not sustained". Even if it were to be assumed that the investigator failed to ask questions about the allegations of setting up this inmate by paying off another inmate and also failed to ask questions about the deputy's admission that he punched the inmate after the inmate was restrained, and that these failures were unintentional oversights or incompetence, which borders on the preposterous, the idea that this investigation of an incident that was receiving a great deal of scrutiny from management, would have escaped notice of managers and administers, is beyond preposterous.

This investigation and the findings of the disciplinary hearing are simply corrupt practices on plain view. The result is that an officer who admitted to an offense that should lead to termination or at the very least to a long suspension and more, has been given a message that he acted properly. Moreover, since there are few secrets in a jail or prison, the message that punching an individual in restraints, submitting a false report, and perhaps setting up an inmate to be attacked by other inmates, is condoned by management, has been sent to other deputies and supervisors as well.

3. The other two disciplinary investigations that had to do with staff and inmate contacts, were also very different.

    a. A female deputy was charged with various infractions arising out of entering into a romantic relationship with a male inmate. The deputy admitted to the improper relationship and resigned. The case should have been forwarded to the District Attorney's Office for potential criminal charges, but was not.

    b. In the second instance, a deputy was investigated for passing contraband drugs to inmates. The deputy acknowledged that she was caught trying to give a package to inmates which included pills but said she had no idea the pills were in the package she had, along with some chess pieces and a few other items. However, when the package was taken from her in the Jail and opened in front of her and the pills were found, she did not say "Oh no" or, "How did those get there?". Instead, she immediately said to a supervisor, "You put those there!" She received a suspension. Smuggling contraband drugs into a jail to give

to inmates should always be a terminating offense for staff. To do otherwise is to leave a ticking time bomb in the midst of your workforce.

4. Another shocking decision with regard to a disciplinary investigation of a deputy involved a situation in which two deputies got into a verbal confrontation and then a physical fight in the lobby in one of the facilities. As the deputies struggled with each other, one of them took out a folding knife from his pants pocket. They were separated by other staff. The folding knife was impermissible on jail facility grounds but despite that and despite his attempt to use the knife against another deputy, he was not terminated.

5. While glossing over extremely serious situations, as described above, other investigations go to great lengths to punish deputies for very minor situations. For example, in addition to the female deputy who was investigated as if she had committed a capital crime when in fact she had worn a department-issued windbreaker to work that had faded to the wrong color, and she had also perhaps disobeyed an order and/or been disrespectful to a superior officer, there is another extensive investigation of a different female deputy who reported to work with her hair dyed an unapproved color (blonde) and braided in some unapproved fashion. In both of these cases, and others in this group, it is painfully clear that OPSO or some individual high-ranking managers were out to get these particular deputies.

   In most departments, an unapproved hairdo or an unapproved item of clothing would occasion an informal discussion and the supervisor and subordinate would leave that discussion constructively and without negative baggage.

   While at first glance these petty and biased investigations seem almost funny, there is no humor in them for the deputies who are being harassed by upper management.

6. The group of staff disciplinary investigations is perhaps as significant for what it does not include as what it does. There are some of these investigative packages in which the deputy alleged to have committed the wrongdoing has himself or herself made very serious allegations about a manager or administrator. For example, a male deputy who was suspended after a complex and questionable investigation, had leveled serious and detailed charges against a Major who was involved in the investigation. In an unrelated incident, one of the female deputies who was investigated for a relatively minor matter and perhaps harassed or retaliated against, also made serious allegations about the same Major. There is no investigation of the Major in response to either set of allegations. That, again, speaks more to corruption and a "good ol boy system" than to anything technical in these investigations.

7. For regular staff, none of the seventy-one investigations involves anyone above the rank of Sergeant (one Lieutenant was investigated but he was a reserve officer).

8. Good organizations use the concept of supervisory accountability. That is, successfully higher ranks are held to successfully higher standards. That is not empty philosophy. When a frontline deputy does something wrong and is given, say, a one day suspension without pay, there is a serious review of whether that deputy's Sergeant and that Sergeant's Lieutenant, etc., should have known about the situation and should have taken corrective measures before it became a problem. While the deputy who actually committed the infraction may get a one day suspension, it is not unheard of in good organizations for the Sergeant to get a three or five day suspension and for the Lieutenant to perhaps get a ten day suspension. The concept of supervisory accountability appears to be foreign to OPSO. Instead, when something happens, there seems to be a rush to "land" the problem on a frontline deputy.

X. Sanitation and Maintenance

1. Both sanitation and maintenance are deplorable. Of the two, maintenance is worse.

2. Shower rooms throughout the facilities were particularly egregious. On the acute psychiatric unit, A-4 in Templemen V, the shower ceiling and walls had large amounts of black mold. Other shower rooms throughout the facilities were contaminated with some combination of mold, rust and long-term, built up dirt.

3. In several different locations visited, the toilets within individual cells leak from the pipes under the floor so that sewage seeps into the cell from where the toilet meets the floor of the cell. In many cases, these are living units that are fed in cell, so that inmates are forced to eat next to leaking toilets and sewage smells.

4. Individual showerheads do not work in a variety of locations. A major maintenance issue has to do with ventilation, which in most of the facilities is very poor. During my tours in mid December, the heat was on and some living units were hot and stuffy while others were too cold. The units that were overheated also had so little airflow that condensation formed on almost all surfaces.

5. A specific example may be helpful. In touring OPP, Unit B-1 is maximum-security housing (In reality, it is administrative segregation and there is no "maximum security housing area within the Jails). That unit is on the left and on the right hand side is general population housing. Walking down that corridor, it was necessary to walk carefully and stop around an area where water is pooling on the floor. One cell door was standing open and that cell was unusable because the door was broken. Inmates had placed

blankets over the end of the double bunks nearest the corridor in a number of the cells. A deputy doing security rounds or otherwise patrolling that corridor would not be able to see what inmates were doing as long as they were on the bunks and could not even tell if they were in the cell. Deputies responding to a problem would be endangered both by the water on the floor and by the open cell door, which was a potential weapon. This was not some trustee housing area; it was the highest security housing area in the entire Jail complex. The area was also filthy and rust was visible in many locations. It is also noteworthy that at the time I toured that unit, the capacity was 28 but the actual population was 12. Thus, the maximum unit was less than half full at the same time that high security inmates were scattered through general population housing areas that I toured the same day.

6. After OPP, the next facility that I toured was Templeman V, a facility built in 1927-1928. The ventilation in the building seems non-existent and, with the heat on, there was dripping condensation on almost every surface. The building was generally not as filthy as OPP but sanitation was still at an unacceptably poor level. On a disciplinary segregation unit, staff visibility was extremely poor because of expanded metal screens that required staff to be almost in front of an area or a cell before anything could be seen. As with the maximum-security housing unit in OPP, visibility into many cells was impaired by towels hung over the cell front bars or blankets over the double bunks. It is frequent to find jail facilities in which inmates use towels or blankets to try to block cell fronts, either as a barrier to visibility or to reduce airflow. In well run facilities the problem is infrequent because staff deal with it immediately and inmates understand that it is unacceptable and will result in a disciplinary infraction. In other facilities, it is something of a shift-by-shift battle because staff are not consistent and inmates find that the towels or blankets are sometimes left unchallenged for relatively long periods of time. When the situation is common on high security units and particularly when it remains uncorrected in spite of a tour of official visitors including high ranking staff and attorneys from outside the Department, it is a clear sign that staff have generally given up on enforcing day-to-day security regulations. An even better exemplar of the same point was that the senior staff accompanying me and others on the tour, generally did nothing about these rule violations as we walked through units. They were not surprised by the situation nor did they seek out the frontline staff member or supervisor responsible for the area to ask why nothing was being done.

7. One maintenance problem is also a most serious security issue. That is, some of the locking mechanisms are so old or in such bad repair that they do not work reliably. There are areas of the Jail in which inmates can lock and unlock themselves at will by defeating the locking mechanism on the individual cells. That is a completely unacceptable situation because it directly endangers staff and inmate lives while also dramatically increasing the risk to the community because of potential escapes.

8. Sanitation is inconsistent, with some areas much worse than others. However, the overall level of sanitation throughout the facilities is very poor. Meal trays are not always collected and individual cells contain food stored from prior meals and, in some cases, trays from prior meals. Staff do not hold inmates accountable for the condition of their cells so the cleanliness of a particular cell is dependant on the inmate or inmates that live there. Similarly, although there is a great deal of idleness in the Jails and more than enough low security inmates to form work crews, the common areas of the Jail and the dayrooms and other open areas of the living units are not kept clean.

9. Rodents are an issue but inmates complain much more strongly about gnats and having no way to contend with clouds of gnats that maybe in the cells at some times. The incidence of skin problems among inmates who have not had a prior history of skin disease or skin problems, is obvious, and Dr. Gore acknowledged as much.

10. Female units are usually cleaner than male units in jails or prisons. That was true in OPP but, for example, on Templemen V, A-2, the showers were filthy with rust and mold and some of the individual cells needed cleaning. Female inmates explained that they are unable to stop the toilet leakage in the cells and that they would keep the rest of the unit much cleaner but that they are denied cleaning supplies by staff

X. Medical and Mental Health Staff and Violence in the Jails

1. In many jails in which violence seems excessive, and particularly when a primary concern is staff use of force, the medical and mental health staff intervene, act as inmate advocates or otherwise work to mitigate the violence.

2. That is not the case in some jails and it is not in OPSO. While the National Institutes of Health recognize violence as a public health concern, the medical and mental health staff in OPSO do not view the epidemic of violence plaguing their patients as a matter with which they must be involved.

3. Thus, there is no protocol for interviewing patients, even informally, if injuries seem likely to have resulted from staff use of force or from inmate-on-inmate violence. There is also no data from medical or mental health, or direct reporting, on violent injury situations. The result is that a group of staff that are trained to deal with violent injuries and are on duty in the Jails on a 24-7 basis, remain on the sidelines as the violence persists and their patients suffer.

Y. Food Service

1. I did not systematically review food service.

2. I watched the noon meal served on Templeman, A-4. Two inmate workers were handling the lunch, making trays on the unit from small bulk containers. No staff member paid any attention to what the two inmate

workers were doing or how the lunch was being handled. The meal was rice and gravy with beans and sausage (only a little of that) and steamed carrots. One of the two inmates was obviously not alert mentally and was doing nothing except taking trays to cells after the first inmate served the rice and then the gravy with beans and, arguably, sausage. After a number of inmates had been fed, an inmate starting yelling that they were supposed to have the carrots and the first inmate noticed that the second inmate had not been adding the steamed carrots to any of the trays. The inmate yelled at the second inmate to serve the carrots and they began doing so although they never did give carrots to the perhaps 1/3 to ½ of the inmates who had already gotten their trays. Similarly, they only gave bread with the trays after the same inmate on the unit started yelling that they were entitled to it. Portions were very small which also elicited loud comments from many of the inmates. Presentation and quality appeared disgusting.

Z. The Relationship of the New Orleans Jails to National Correctional Standards and Practices

1. As indicated earlier in this report, OPSO is not typical of jails in the U.S.; rather, it is an anomaly.

2. Currently, there is only one set of nationally recognized standards for correctional facilities. That is the set of standards promulgated by the American Correctional Association (ACA). ACA also uses those standards to audit jails and prisons pursuant to requests for accreditation. The ACA standards have no force of law. Further, while a substantial number of jails and prisons and departments of corrections are ACA certified, a much larger number are not. However, the standards are well known and well recognized throughout American corrections. A correctional agency may have a wide variety of reasons for not wanting to seek ACA accreditation, ranging from the costs, which are substantial and ongoing, to disagreement with some specific standards. However, it is not uncommon for agencies that are not accredited or seeking accreditation to nevertheless cite the relevant ACA standards when publishing their own policies. Importantly, the ACA standards are minimums. Many well run correctional facilities and correctional agencies go far beyond the ACA standards in many areas.

3. The New Orleans Jails fail to meet the ACA minimum standards in many, many areas. The following list is a small sample of ACA standards, ranging from general to specific, which OPSO does not meet:

    a. There is a written document delineating the institution's mission within the context of the total correctional system. This document is reviewed at least annually and updated as needed (Standard 4-4002). The individual institutions within OPSO have no such written mission statement and the Department's mission is not reviewed annually and updated.

b. Written policy, procedure and practice that the Warden/Superintendent formulate goals for the institution at least annually and translates them into measurable objectives (Standard 4-4003). This is not done.

c. Written policy, procedure and practice demonstrate that employees participate in the formulation of policies, procedures and programs (Standards 4-4004). There is no such written policy or procedure and this does no happen in practice.

d. Written policy, procedure and practice demonstrate that related community agencies with which the institution has contact participate in policy developments, coordinated planning, and inter-agency consultation (Standard 4-4005). That is not done.

e. The qualifications for the position of Warden/Superintendent include, at a minimum, the following: A bachelor's degree in an appropriate discipline; five years of related administrative experience; and demonstrated administrative ability and leadership. The degree requirement may be satisfied by completion of a career development program that includes work related experience, training, or college credits at a level of achievement equivalent to the bachelor's degree (Standard 4-4009). There is no such policy or detailed requirement.

f. Written policy, procedure and practice provide that new or revised policies and procedures are disseminated to designated staff and volunteers, and, when appropriate to inmates prior to implementation (Standard 4-4014). Policies are disseminated after they are written. In most cases there is no effective date on policies. In some cases, the policies are not disseminated to staff nor are staff trained to the new policies even after they have been written, and staff remain unfamiliar with those policies.

g. Written policy, procedure and practice provide for a system of two-way communication between all levels of staff and inmates (Standard 4-4016). That is neither policy nor practice.

h. Consistent with policy, the Warden/Superintendent is responsible for fiscal policy, management and control. Management of fiscal operations may be delegated to a designated staff person (Standard 4-4025). Fiscal policy, fiscal management and fiscal control are all managed well

above the level of Warden and the Wardens have little to do with budget development or budget management.

i. Written policy, procedure and practice provide for an independent financial audit of the facility. This audit is conducted annually, or as stipulated by statute or regulation, but at least every three years. If the facility is a part of a state system, an internal audit section or department of the agency's central administration and/or statutory agency shall be considered independent of the facility to be audited (Standard 4-4036). That does not happen.

j. The institution uses a formula to determine the number of staff needed for essential positions. The formula considers, at a minimum, holidays, regular days off, annual leave, and average sick leave (Standard 4-4051). There is no such formula.

k. The Warden/Superintendent can document that the overall vacancy rate among the staff positions authorized for working directly with inmates does not exceed ten percent for any eighteen-month period (Standard 4-4052). Vacancy rates for staff in inmate contact positions are far higher than that.

l. Written policy, procedure and practice provide that all new correctional officers receive an added one hundred and twenty hours of training during their first year of employment and an added forty hours of training each subsequent year of employment. At a minimum, this training covers the following areas:... (Standard 4-4084). These training requirements are not met.

m. The institutions' criteria for evaluating overall institutional performance are specific and defined in writing (Standard 4-4105). There are no such defined criteria.

n. Circulation is at least ten cubic feet of fresh or re-circulated filtered air per minute per occupant for inmate rooms/cells, officer stations, and dining areas, as documented by an independent, qualified source (Standard 4-4152). There is no such documentation and circulation does not meet that standard.

o. Correctional officer posts are located in or immediately adjacent to inmate living areas to permit officers to hear and respond promptly to emergency situations (Standard 4-4177). Officers assigned to more than one tier cannot hear emergency situations and cannot respond promptly. In

some locations officers assigned only to one living unit cannot respond promptly to emergency situations.

p. Written policy, procedure and practice facilitate personal contact and interaction between staff and inmates (Standard 4-4180). There is no such written policy. In practice, the opposite objective is sought after and frequently achieved.

q. Written policy, procedure and practice govern the control and use of keys (Standard 4-4195). There is no effective key control.

r. Written policy, procedure and practice govern the control and use of tools, culinary and medical equipment (Standard 4-4196). There is no effective tool control.

s. Written policy, procedure and practice provide for the preservation, control, and disposition of all physical evidence obtained in connection with a violation of the law and/or institutional regulation. At a minimum, the procedure shall address the following: chain of custody, evidence handling, location and storage requirements (Standard 4-4207). There are no such practices.

t. Written policy, procedure and practice provide that a written record is made of the decision and the supporting reasons (for disciplinary decisions) and that a copy is given to the inmate. The hearing record and supporting documents are kept in the inmate's file and in the Disciplinary Committee's Records. (Standard 4-4245). Inmate disciplinary records are not kept in the inmate's file. In many cases, an inmate's disciplinary history cannot be used to help establish an appropriate sanction when the inmate is found to have violated regulations.

u. Written policy, procedures and practice allow freedom and personal grooming except when a valid interest justifies otherwise (Standard 4-4283). The Jail uses force when necessary to require inmates to submit to haircuts and shaving of facial hair beyond any rational need based on safety, security, identification or hygiene.

v. The preceding list is, in reality, but a limited sample of the large number of minimum ACA standards which OPSO violates or otherwise fails to comply with.

w. There may be a similar list of NCCHC standards that OPSO is not in compliance with, but that is not clear

because the jail has not produced the most recent NCCHC audit.

AA. Summary and Conclusions

A. The OPSO Jails are extraordinarily badly run. They are desperately under staffed and badly under funded. They lack effective, principled leadership.

B. Primarily because inmates in the Jails are all but unsupervised, inmate violence is of epidemic proportions and many inmates are in constant danger of beatings, stabbings, sexual assaults and even death.

C. Staff use of force in the Jails is frequent and sometimes goes unreported. The majority of inmate complaints about inappropriate staff use of force are not investigated. The investigations that are conducted are of poor quality, frequently biased and subject to conflicts of interest on the part of the investigators.

D. The Department does not comply with federal PREA requirements and the frequent allegations of, and instances of, sexual assault are handled in an unprofessional and incompetent manner.

E. The inmate classification system does not work and predatory inmates are likely to be housed with inmates at high risk to be victimized.

F. The organizational culture within OPSO is dysfunctional and staff inmate relations are frequently negative and unprofessional.

G. Key security provisions are not in place or do not work and overall facility security is very poor.

H. Fire safety and emergency preparedness within the facilities are far from adequate and fire safety, in particular, is so thoroughly compromised that multiple fatalities could result from a fire because of these problems.

I. The inmate grievance system and the inmate disciplinary system are both fundamentally flawed and investigations of staff disciplinary situations are frequently inconsistent and sometimes strongly biased.

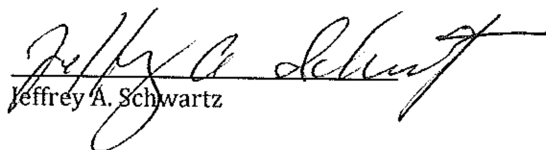
J. The OPSO Jails are out of compliance with a large number of the standards established by the American Correctional Association, and are similarly out of compliance with well-established and accepted practices throughout American corrections.

K. For all of the above reasons, and the analyses and opinions presented in the body of this report, it is my opinion that current and future inmates within the OPSO Jails are at grave risk with regard to inmate-on-inmate violence, staff use of force, suicide and mental illness and that the proposed consent decree is appropriate, necessary and represents the least intrusive method of correcting deep-seated problems within the Jails. It is also my opinion

if that the problems in the Jails that I have enumerated in this report are allowed to continue unabated, severe harm, up to and including death, will befall inmates within these Jails.

- END -

Signed at Campbell, CA
March 4, 2013



Jeffrey A. Schwartz