creative corrections

Correctional Management Review

Final Report

Milwaukee County Jail

Milwaukee, Wisconsin

May 20, 2025

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Milwaukee County Jail: A Report on Corrective Action Plan Implementation and Outcomes

1. Executive Summary

This Corrective Action Plan (CAP) report serves as a continuation of the comprehensive Correctional Management Review (CMR) conducted by Creative Corrections LLC in October 2024. The original audit identified systemic challenges within the Milwaukee County Jail (MCJ), including deficiencies in suicide prevention procedures, mental health services, medical services, and operational oversight. In direct response to these findings, MCSO leadership, in collaboration with Creative Corrections, developed and implemented a detailed CAP aimed at addressing each area of concern.

This follow-up report documents the progress achieved between January 2025 and April 2025. Key improvements include the elimination of potentially harmful practices, enhancements to suicide prevention policies, revisions to training protocols, improved staffing accountability, and expanded documentation and monitoring processes. These corrective actions are grounded in industry standards and supported by Creative Corrections' ISO 17020:2012 accredited methodology for correctional facility inspections and reform.

The CAP outlines specific, measurable corrective actions and provides verifiable evidence of resolution. This report reflects the collaborative effort between MCJ, Wellpath and Creative Corrections to remediate critical issues and foster a safer, more accountable environment for staff and occupants. It also identifies remaining areas that require continued support and oversight to ensure complete and sustainable implementation.

Creative Corrections LLC remains confident in MCJ's continued trajectory of improvement provided that appropriate structural and fiscal support remains in place. Specifically, we emphasize the importance of **continued funding and support to achieve the needed infrastructure enhancements,** particularly for infrastructure enhancements such as holding cell renovations, updated protective equipment, and fully functional Key Watcher systems. These investments are necessary to achieve full compliance across partially met CAP items and to maintain sustainable reform.

Additionally, progress in reducing overcrowding and improving conditions of confinement could be significantly accelerated by expanding the acceptance criteria at the Community Reintegration Center (CRC) to include pre-trial female occupants. This strategic action would alleviate population pressures at MCJ and enhance the system's overall operational flexibility and safety.

2. Introduction

In October 2024, Creative Corrections LLC conducted a comprehensive Correctional Management Review (CMR) of the Milwaukee County Jail (MCJ), as requested by the Milwaukee County Board of Supervisors. The review revealed critical operational and procedural concerns, including deficiencies in suicide prevention practices and mental health response, and insufficient compliance review and oversight mechanisms.

Following the completion of the audit, MCSO leadership collaborated with Creative Corrections to develop a detailed CAP that addresses the findings of the initial report. The CAP outlines targeted reforms aimed at enhancing facility safety, operational integrity, and compliance with national correctional standards.

Each corrective measure included in this report is supported by a timeline, responsible parties, and documentation that demonstrates meaningful progress.

This CAP report connects the deficiencies outlined in the initial assessment with the responsive actions taken by MCSO leadership over a four-month period. It serves as a structured, transparent, and accountable roadmap for sustained facility improvement, with emphasis on improved occupant safety, staff preparedness, and institutional oversight.

3. ISO-Driven Corrective Action Framework

The structured format for addressing nonconformities, including a clear Nonconformity statement, a detailed Corrective Action Plan, and specified Evidence of Resolution, is essential because Creative Corrections, as an ISO 17020:2012 accredited organization, operates under the principles and requirements of ISO standards. By adhering to this structure, we ensure:

- **Systematic Problem Solving:** ISO standards emphasize a systematic approach to identifying and resolving issues. The "Nonconformity" section clearly defines the problem, which is the first step in any effective problem-solving process.
- **Planned and Documented Action:** The Corrective Action section requires a documented plan addressing the identified nonconformity. This aligns with ISO's focus on planning and controlled implementation of processes. It ensures that actions are not taken haphazardly but are thought through and documented for consistency and accountability.
- **Objective Verification:** The Evidence of Resolution component is crucial for demonstrating effective corrective action. ISO standards require objective evidence to verify that implemented changes have achieved the intended outcome and that the nonconformity has been resolved. This ensures that resolution claims are not

based on assumptions but on verifiable facts and data through direct observation, data review, and documented outcomes.

- **Continuous Improvement:** The entire process supports the ISO principle of continuous improvement. By systematically identifying, addressing, and verifying the resolution of nonconformities, the organization learns from past issues and takes steps to prevent recurrence, leading to ongoing improvement in processes and outcomes.
- **Compliance and Consistency:** This structured format ensures that our corrective action processes are consistent with internationally recognized ISO standards. This is vital for maintaining Creative Corrections' accreditation and demonstrating a commitment to quality and continuous improvement to stakeholders.

In essence, this structured approach isn't just a matter of form; it's a fundamental requirement of operating within an ISO accredited framework. It ensures rigor, accountability, and demonstrable improvement in addressing identified issues.

4. Application of the Corrective Action Framework

The following sections apply the ISO driven corrective action framework to each of the key areas of concern identified during the original Correctional Management Review of Milwaukee County Jail. For each area, the issue is clearly defined, corrective actions are outlined, and supporting evidence of resolution is provided. This structured approach ensures that all improvements are documented, verified, and aligned with internationally recognized standards for quality and compliance.

5. Key Areas of Concern and Corrective Actions Taken

5.1. Security

1. **Nonconformity:** Occupants were routinely restrained to benches for extended periods in the booking area and the special management housing unit. Individuals on suicide watch in the booking area were subjected to this restraint practice, which could potentially harm them**.**

    a. **Corrective Action:** Discontinue the practice of handcuffing individuals on suicide watch to benches in both the booking and specialized housing areas. Instead, ensure timely placement in approved suicide watch cells and adherence to established suicide watch protocols.

    b. **Evidence of Resolution:** MCJ has taken meaningful steps to address this issue. The facility has collaborated with the State Jail Inspector and Milwaukee County Architect to develop a plan for the removal of restraint benches and to identify suitable holding cell locations as alternatives. As of

April 15, 2025, MCJ is awaiting funding and formal approval to proceed with the construction of the designated holding cells. In addition, intake procedures have been revised to prioritize individuals requiring suicide watch. Upon arrival, these individuals now receive an immediate mental health evaluation and are expedited out of the intake area within one hour. If the one-hour timeframe is not met, supervisory staff are immediately notified, ensuring prompt reassignment to appropriate housing and minimizing risk. **Creative Corrections considers this CAP item *partially compliant***. Completion of this corrective action will depend on approved funding to construct two additional holding cells and eliminate the need for the use of restraint benches.

2. **Nonconformity:** The facility lacks detailed post orders which are essential for providing correctional officers with clear instructions on how to carry out their duties during their shifts.

    a. **Corrective Action:** Ensure post orders are specific to each correctional officer assignment and clearly outline duties by shift. Specialized Housing post orders should detail the responsibilities of each officer, and all post orders should include guidance on staff responses to emergencies.

    b. **Evidence of Resolution:** During the week of April 14, 2025, Creative Corrections conducted a review of post orders for several housing units, including the Specialized Housing Unit and Mental Health Units. These post orders are maintained electronically and clearly outline both post-specific duties and general operational expectations. They include procedures for emergency response, suicide watch (including one-to-one protocols), tool control, and count-time operations. Staff interviews confirmed that personnel were familiar with their respective post orders and had acknowledged and reviewed the duties associated with their assignments **Creative Corrections considers this CAP item *fully compliant*.**

3. **Nonconformity:** The current practice of maintenance work performed by county staff has serious deficiencies in managing tool security. Tools are not categorized according to their potential risk, and unit officers do not perform an inventory of tools entering and leaving their posts. This lack of tracking creates opportunities for tools to go missing or be misused without detection, increasing the risk of escapes, self-harm, and violence within the facility.

    a. **Corrective Action:** MCJ will develop and implement an enhanced tool control policy to ensure proper security protocols are followed when issuing, storing, and tracking tools within the facility.

b. **Evidence of Resolution:** MCJ has created a tool accountability protocol for correctional officers, which includes roll call training, updated post orders and officer acknowledgment via signed documentation. Training sessions are scheduled, and implementation is actively underway. Additionally, a designated tool storage area within the jail has been identified; however, the facility is currently awaiting the Milwaukee County DAS Facilities to assemble toolkits specifically designated for MCJ use.

   To support inventory control, the Information Management Services Division (IMSD) has integrated a new drop-down menu into the Jail Management System. This menu allows staff to document and track tool inventory digitally. This new system's official go-live date is May 12, 2025.

   The facilities supervisor was available during the April 14th visit to explain procedures and demonstrate the progress of the implementation. **Creative Corrections considers this CAP item to be *partially met***, as full implementation is contingent upon the completion of the toolkits by Milwaukee County DAS Facilities. Once toolkits are issued and the designated storage system is operational, the CAP will be considered fully resolved.

4. **Nonconformity:** Insufficient security practices were found. Specifically, there were instances where pod doors were left unsecured while facility staff conducted repairs, and restraints were unaccounted for, jeopardizing safety and security for staff and occupants. This deficiency in security protocols creates a significant vulnerability and increases the potential for unauthorized access, escapes, or contraband smuggling.

   a. **Corrective Action:** Implement a structured inspection system to ensure accountability and proper use of all restraints. Additionally, ensure correctional officers are trained in securing special housing unit doors and maintaining control of restraint equipment.

   b. **Evidence of Resolution:** During the week of April 14, 2025, Creative Corrections conducted on-site tours of both the special housing unit and the mental health unit. During these tours, inventories of restraints were observed, and the condition and security of the units were reviewed. While general maintenance activity was noted, no pod doors accessible to occupants were found unsecure. MCJ also provided documentation confirming that correctional officers received training on securing slider and pod doors, including signed attendance sheets verifying staff participation. Directions have been formally issued to staff regarding door security

protocols, reinforcing compliance expectations. **Creative Corrections considers this CAP item to be *fully compliant*** based on observed practices, staff training documentation, and current restraint accountability procedures.

5. **Nonconformity:** An armory inspection uncovered deficiencies, including missing inventory records and outdated or inadequate protective gear for staff. The lack of proper inventory control raises concerns about potential weapon mismanagement, while insufficient protective equipment leaves staff vulnerable in potentially dangerous situations.

    a. **Corrective Action:** Establishing an inspection system to ensure accountability of all Armory equipment. Provide evidence of the inspection system which includes daily issuance of equipment and monthly/quarterly inspections by supervisory staff.

    Provide sign-in sheets of correctional officers, supervisors and Use of Force (UOF) team leaders who were trained in Armory procedures.

    b. **Evidence of Resolution:** Inspection of the Armory revealed less lethal munitions were properly stored, inventoried with sign-in sheets provided. A master inventory list is maintained in the armory. Protective gear is also neatly stored and inventoried. Outdated (expired) equipment has been removed. It is noted the MCJ needs to pursue purchasing new updated protective equipment and less lethal munitions for staff to utilize during use of force and occupant disturbances. As a result, Creative Corrections found MCJ to be partially compliant. ***The closure of this CAP will need funding to provide new updated protective equipment and less lethal munitions for staff to utilize during use of force and occupant disturbances.***

6. **Nonconformity:** Current occupant counting practices need improvement. The policy lacks clarity about how often counts happen and the specific steps involved, and it does not include a way to track occupants who are temporarily away from their assigned areas. These issues could lead to inaccurate counts and potential security risks.

    a. **Corrective Action:** Update post orders and operational protocols to reflect an increase in official occupant counts within a 24-hour period. Ensure that clear procedures are in place for verifying counts, including out-counts, to maintain population accountability and safety.

    b. **Evidence of Resolution:** MCJ has implemented an additional official occupant count at 12:00 AM, increasing the frequency of formal counts within each 24-hour period. These counts are reported to the intake area for

verification. Additionally, all out-counts occupants temporarily located outside of their assigned housing units are verified by intake staff, who directly contact the respective locations to confirm the physical presence of the occupant. MCJ has updated both its policy and post orders to clearly outline the revised count procedures and responsibilities for staff. These documents now reflect the correct protocols for conducting, verifying, and reporting all counts, ensuring consistency and accountability across shifts. **Creative Corrections considers this CAP item to be *fully compliant*** based on implemented practices and the updated documentation provided.

7. **Nonconformity:** The facility needs to implement the Key Watcher system promptly to improve security by preventing key loss and unauthorized access.

    a. **Corrective Action:** Demonstrate implementation of the Key Watcher system by providing visual evidence and related documentation. Include records of staff training on key control and accountability procedures, as well as documentation showing how keys are counted and tracked (e.g., key rings labeled with the number of keys via chits or tags).

    b. **Evidence of Resolution:** As of this follow-up review, the Key Watcher system is not yet fully operational. Lock shop staff are actively organizing key rings and removing obsolete keys, but the process remains ongoing due to other duties assigned to the maintenance team. MCJ plans to fully implement the Key Watcher system in May 2025 as part of the annual refresher training cycle for staff. During the facility tour conducted by Creative Corrections, no deficiencies were observed in the security or accountability of keys. Additionally, MCJ has communicated its intended operational timeline and outlined steps to ensure staff are trained in key tracking and control once the system goes live. Currently, MCJ has one Key Watcher system in use within the supervisor's office. **Creative Corrections considers this CAP item to be *partially met***, as full implementation is dependent on the completion of the key-ring organization by the Milwaukee County DAS Facilities. Continued progress and successful deployment of the Key Watcher system will be necessary for full compliance.

8. **Nonconformity:** The jail lacks a vigorous system of internal compliance audits for security practices. Implementing regular, ongoing audits is crucial to ensure consistent adherence to correctional standards and proactively identify areas needing improvement.

    a. **Corrective Action:** Develop and implement a comprehensive compliance policy supported by a perpetual audit system to ensure ongoing internal

accountability. As part of this initiative, Creative Corrections provided a Perpetual Audit Tool to MCJ in February 2025 for consideration and use.

b. **Evidence of Resolution:** MCJ has initiated internal compliance reviews across several key operational areas, including food service logs, suicide watch documentation, and use of force reports. In addition, MCJ has received and reviewed sample audit tools from Creative Corrections to guide the development and implementation of a broader compliance strategy. Discussions with MCJ staff confirm that the current audit efforts will be expanded to include all areas of security and facility operations, reflecting a shift toward a continuous quality improvement model.

   Creative Corrections considers this CAP item to be *fully compliant* based on the steps taken to establish a sustainable compliance review process and the facility's stated commitment to expand and formalize these efforts.

9. **Nonconformity:** During both the day and evening shifts, there was insufficient supervision within the specialized housing units. This creates a potentially dangerous situation for both occupants and staff, as there is no supervisor readily available to respond to emergencies, address conflicts, or provide support.

   a. **Corrective Action:** Assign a designated first-line supervisor to oversee operations in the Specialized Housing Units during both day and evening shifts, Monday through Friday, to ensure consistent supervision and accountability.

   b. **Evidence of Resolution:** As of this follow-up review, MCJ has assigned supervisory staff to the Specialized Housing Units, which provides coverage across the day and evening shifts. One supervisor is scheduled from 08:30 to 16:30 hours with Mondays off and alternating weekends, while a second supervisor is scheduled from 11:30 to 19:30 hours with Fridays off and alternating weekends. Additionally, supervisors on all three shifts have been directed to conduct regular rounds and respond to all calls for assistance within the Specialized Housing Units, further strengthening oversight and responsiveness. **Creative Corrections considers this CAP item to be *fully compliant*** based on current staffing assignments and clearly established supervisory responsibilities across all shifts.

10. **Nonconformity:** The facility needs to develop clear procedures for transferring occupants to suicide watch rooms in a timely manner. These procedures should be followed consistently by both booking staff and correctional supervisors to ensure the safety and well-being of at-risk individuals.

a. **Corrective Action:** Establish and implement procedures to ensure that individuals placed on suicide watch are housed in an approved suicide watch cell within one hour of mental health staff notification. The procedure should also require a minimum weekly in-person meeting involving mental health staff, hospital staff, correctional supervisors, and executive leadership to review the status and progression of individuals on suicide watch.

b. **Evidence of Resolution:** MCJ has revised its booking procedures to include a **color-coded card system** to identify individuals requiring suicide watch placement.

   Milwaukee County Sheriff's Office staff monitor potentially suicidal individuals in the pre-booking area until they are formally evaluated by mental health personnel. Following this evaluation, MCJ staff expedite the escort of the individual into the booking area, where the booking process is prioritized for those showing suicidal behavior. Individuals identified for suicide watch are now evaluated and transferred to appropriate housing within one hour, in alignment with this corrective action requirement. Additionally, booking staff have been directed to notify supervisory personnel if processing is delayed. It is also noteworthy that during the most recent site visit, **Creative Corrections staff observed no instances of individuals being restrained to benches in the booking area**. **Creative Corrections considers this CAP item to be *fully compliant*** based on updated procedures, verification during the on-site visit, and documentation provided.

11. **Nonconformity:** The current calculated use of force policy lacks specific guidelines for all team members, including medical and mental health staff, on how to appropriately apply calculated force. This lack of clarity could lead to inconsistencies in practice and increase the risk of incidents escalating unnecessarily.

    a. **Corrective Action:** Implement clear procedures for Calculated Use of Force (CUOF), including role assignments, approval steps, use of less-lethal munitions, de-escalation tactics, and after-action reviews with hospital, mental health, supervisory, and executive staff. Ensure all relevant staff complete the training with documented sign-in sheets.

    b. **Evidence of Resolution:** On March 14, 2025, Creative Corrections participated in a Teams meeting with MCJ to review CUOF policies and provide de-escalation training. Supervisory staff received follow-up instruction, and prior use-of-force incidents were reviewed for compliance.

Because of improved procedures, MCJ reported **a 46% reduction** in use-of-force incidents. **Creative Corrections considers this CAP item *fully compliant*.**

12. **Nonconformity:** Suicide watch procedures involving one-on-one observation, need restructuring. It is critical to ensure the observing staff members always have a clear and unobstructed view of the individual to maximize their safety.

    a. **Corrective Action:** Identify and utilize suicide watch cells that allow for continuous, unobstructed monitoring by staff to ensure the safety of individuals placed on suicide watches.

    b. **Evidence of Resolution:** Direct observation of suicide watch cells confirmed that MCJ has begun implementing improvements. Plexiglass has been replaced in several cells, allowing for clear, unobstructed visibility. Electrical modifications are also in progress, including enhanced lighting, removal of outlets and switches, and improved safety design in Housing Units MHU and 4D. In addition, smoke detectors are being reconfigured to reduce the risk of tampering. While significant progress has been made, **Creative Corrections considers this CAP item *partially compliant***. Full compliance will require additional funding to complete the remaining maintenance upgrades including the replacement of multiple cell doors in suicide watch rooms and relocating light switches outside of cells

13. **Nonconformity:** MCSO Leadership needs to perform weekly rounds in all the housing units.

    a. **Corrective Action:** Include documentation, such as housing unit sign-in sheets, verifying that jail administration is conducting weekly rounds throughout the facility.

    b. **Evidence of Resolution:** Review of unit logs and staff interviews confirm that MCSO leadership is consistently conducting weekly rounds. Staff reported that administrators have been engaging with both personnel and the occupant population during these visits. **Creative Corrections considers this CAP item *fully compliant*.**

5.2. Training

1. **Nonconformity:** Probationary staff need enhanced training to effectively work with occupants experiencing mental health crises or exhibiting suicidal behaviors. This training should equip them with the knowledge and skills to recognize warning signs, de-escalate situations, and provide appropriate support.

a. **Corrective Action:** Develop procedures to ensure probationary staff receive training on suicide awareness and managing individuals with mental health needs. Include a copy of the training agenda as part of the documentation.

b. **Evidence of Resolution:** While probationary staff are not assigned to specialized housing units, the training academy has updated lesson plans to include content on mental health crises, suicide prevention, and identifying suicidal behaviors. These materials are now part of the required training curriculum for all probationary staff. **Creative Corrections considers this CAP item *fully compliant*.**

2. **Nonconformity:** Existing staff, particularly correctional officers, require targeted training on suicide prevention and mental health awareness. This training should go beyond general concepts and include real-life examples relevant to the correctional setting.

    a. **Corrective Action:** Include a copy of the MCJ-specific training agenda for non-probationary staff focused on suicide awareness and the management of individuals with mental health needs.

    b. **Evidence of Resolution:** Creative Corrections developed a targeted lesson plan tailored to MCJ's operations, addressing suicide awareness and the management of mentally ill occupants. The training content was reviewed and approved by Wellpath Psychology and will be delivered by mental health staff. This training is scheduled to be provided to all staff as part of annual refresher training that began on May 19, 2025. **Creative Corrections considers this CAP item *fully compliant*.**

3. **Nonconformity:** The jail's communication strategy needs improvement to ensure all occupants feel safe and supported. Currently, there is a lack of multilingual signage, which can create barriers for those who do not speak the primary language. Also, there's limited information available to occupants regarding suicide awareness and mental health resources.

    a. **Corrective Action:** Provide clear, accessible informational materials including pamphlets, signage, and booking area monitors—that inform occupants how to access mental health services, request support, and understand suicide prevention resources. Ensure materials are multilingual and booking monitors are always operational.

    b. **Evidence of Resolution:** Creative Corrections observed bilingual signage (English and Spanish) in housing units outlining how to access mental health and suicide prevention services. MCJ also utilizes a language line for non-English speakers, and both orientation videos and facility handbooks are

provided in English and Spanish in the booking area. **Creative Corrections considers this CAP item *fully compliant*.**

4. **Nonconformity:** There is a gap in training for Correctional Supervisors regarding Calculated Use of Force procedures.

    a. **Corrective Action:** Include training sign-in sheets covering proper procedures before, during, and after a Calculated Use of Force (CUOF). The CUOF training agenda should be submitted to the subject matter expert (SME) for review and input prior to implementation.

    b. **Evidence of Resolution:** Use of Force training was provided to MCJ supervisory staff April 16, 2025, and included instruction on CUOF protocols and policy requirements. During the follow-up review, a Creative Corrections SME offered additional insights and guidance to supervisory staff. The collaborative training addressed pre-force planning, incident response, debriefings, de-escalation techniques, mental health considerations, medical support, and CUOF team coordination. An annual Use of Force training document and a one-hour lesson plan were developed, with all supervisors scheduled to receive this training annually. **Creative Corrections considers this CAP item *fully compliant*.**

5.3. Safety

1. **Nonconformity:** The current safety program lacks sufficient oversight by a qualified safety professional.

    a. **Corrective Action:** Include training certificates of completion for three safety training programs specific to jail safety operations.

    b. **Evidence of Resolution:** The Captain over Safety attended the Milwaukee County Risk Management quarterly meeting on March 10, 2025, and has enrolled in the OSHA safety training program. As of this review, five of the ten required modules have been completed. **Creative Corrections considers this CAP item *fully compliant*,** based on verified enrollment and active participation in the approved safety training initiative.

5.4. Food Service

1. **Nonconformity:** The facility needs to implement a knife inventory system to improve knife security.

    a. **Corrective Action:** Implement a daily inventory system to improve accountability for knives and other equipment. This should include a logbook or digital database for tracking, a designated staff member responsible for

oversight, and clear procedures for checking tools in and out. Regular inspections must be conducted to prevent loss or misuse.

b. **Evidence of Resolution:** MCJ established a knife and equipment inspection system, which includes daily inventory forms submitted to Creative Corrections for review. Additionally, Creative Corrections conducted an on-site inventory verification within the food service area and observed that procedures for tool control and accountability were properly followed. **Creative Corrections considers this CAP item *fully compliant*.**

2. **Nonconformity:** Food service staff should provide written menus, posted in housing units and tablets, to improve communication with occupants about meals.

   a. **Corrective Action:** To enhance communication and transparency regarding meal service, food service staff should provide written menus for occupants. These menus should be posted in housing units and made available on tablets, ensuring all occupants are informed about daily meals.

   b. **Evidence of Resolution**: While this CAP calls for documentation or copies of posted menus, menus are not yet posted in housing units due to ongoing renovations at the Community Reintegration Center (CRC). The CRC's "Pit" area, where meals are prepared for the MCJ using the cook-chill method, is currently under construction. Meals continue to be delivered daily, but as of April 28, 2025, menu posting has not yet been implemented. **Creative Corrections considers this CAP item *partially compliant*.** Full compliance will be achieved once CRC Pit renovations are complete and menus are consistently posted as planned.

3. **Nonconformity:** The cleanliness of the religious diet meal preparation area needs attention. Specifically, the ceiling tiles and A/C ventilation above this area were covered in dirt and dust.

   a. **Corrective Action:** Improve the cleanliness and hygiene of the religious diet meal preparation area, specifically by addressing the dirty ceiling tiles and dust-covered A/C ventilation above the food prep space. These issues pose potential sanitation risks and must be promptly resolved to maintain food safety standards.

   b. **Evidence of Resolution:** MCJ submitted work orders for ceiling tile replacement and provided a photo of the cleaned religious diet prep area. During the follow-up site visit, Creative Corrections staff toured the Food Service operation and found the area to be clean, sanitary, and appropriate for safe meal preparation. **Creative Corrections considers this CAP item *fully compliant*.**

4. **Nonconformity:** All garbage containers in the kitchen should have lids to ensure proper sanitation.

    a. **Corrective Action:** To enhance sanitation in the kitchen, all garbage containers should be equipped with lids. While containers are currently lined and maintained, adding lids will help prevent contamination and deter pests, aligning with best practices in food service hygiene.

    b. **Evidence of Resolution:** MCJ submitted photographic evidence showing that all trash cans in the food service area now have fitted lids. Additionally, a training sign-in sheet was provided, documenting that both staff and occupants assigned to food service received instruction on proper sanitation standards. **Creative Corrections considers this CAP item *fully compliant*.**

5. **Nonconformity:** Install safety lock release mechanisms on the doors of walk-in coolers two and three.

    a. **Corrective Action:** Install internal safety lock release mechanisms on the doors of walk-in coolers 2 and 3 to prevent accidental entrapment. These mechanisms are essential safety features to ensure anyone inside can exit in an emergency

    b. **Evidence of Resolution:** The Food Services Administrator removed the chains previously used to keep Coolers 2 and 3 closed when not in use, eliminating the risk of accidental entrapment. During the follow-up visit, Creative Corrections staff entered and inspected both coolers, confirming there is no longer any safety hazard. **Creative Corrections considers this CAP item *fully compliant*.**

6. **Nonconformity:** The facility should provide non-slip safety shoes with specialized soles to enhance the safety of occupant workers.

    a. **Corrective Action:** To improve safety for occupant workers, the facility should provide non-slip footwear with specialized soles to reduce the risk of slips, falls, and related injuries in food service areas.

    b. **Evidence of Resolution:** The Food Services Administrator procured non-slip shoe covers for all staff and occupants working in the food service department. This action mitigated the risk of slip-and-fall incidents. During the site visit, Creative Corrections observed both staff and occupants wearing the approved footwear, confirming adherence to the safety requirement. **Creative Corrections considers this CAP item *fully compliant*.**

7. **Nonconformity:** The Food Service Administrator must inform the Correctional Supervisors of any menu changes to maintain order among the occupant population.

    a. **Corrective Action:** Trinity must comply with the MCJ contract requirement to notify correctional supervisors of any menu changes, allowing security staff to properly inform occupants of the updates.

    b. **Evidence of Resolution:** The Food Services Administrator now sends email notifications to correctional supervisors regarding any changes to the menu, in accordance with contractual obligations so that this information can be communicated to occupants. Documentation of this communication process was provided. **Creative Corrections considers this CAP item *fully compliant*.**

8. **Nonconformity:** To ensure the security of the facility during deliveries, occupants should be removed from the garage area while deliveries are taking place.

    a. **Corrective Action:** Food Service and Security Supervisors should jointly review rear dock delivery procedures to ensure that all security protocols are being followed and that the process prevents any potential for escape.

    b. **Evidence of Resolution:** New security procedures were implemented requiring all occupants to be removed from the rear dock area during deliveries. Once the off-loading is complete, the garage door is secured, and only then are occupants permitted to return and transfer supplies into the food service area. During a follow-up visit, Creative Corrections observed the milk delivery process and confirmed compliance with the updated procedures. **Creative Corrections considers this CAP item *fully compliant*.**

5.5. MCJ Maintenance

1. **Nonconformity:** The suicide watch cells need immediate improvements. The scratched glass on the cell doors should be replaced or repaired, as it hinders proper observation.

    a. **Corrective Action:** Provide photographic evidence of suicide watch cells that have been upgraded with new plexiglass, clean and safe conditions, and functional lighting. Additionally, email confirmation should be sent to Creative Corrections verifying that all approved suicide watch cells designated for 1:1 observation have been reviewed.

    b. **Evidence of Resolution:** Direct observation by Creative Corrections confirmed that most plexiglass in suicide watch cells located in Housing Unit

MHU has been replaced, allowing for unobstructed visibility. The cells were found to be clean, well-lit, and appropriately configured for 1:1 monitoring. **Creative Corrections considers this CAP item *partially compliant*.** Full compliance will require additional funding to complete remaining maintenance upgrades including the replacement of doors in suicide watch rooms and relocating light switches outside of the cells.

2. **Nonconformity:** The light switches should be relocated outside of the cells to prevent occupants from controlling the lighting, which is a crucial safety measure in suicide watch situations.

    a. **Corrective Action:** Relocate light switches to the exterior of suicide watch cells to prevent occupants from turning off lights, which can hinder staff observation and compromise safety.

    b. **Evidence of Resolution:** MCJ submitted a quote for the relocation of light switches to the Milwaukee County Capital Improvement Committee for approval. These quotes amount to $67,000 to relocate light switches in the mental health unit with an additional $33,000.00 to relocate light switches in the 4D unit. Additionally, a supporting document from the County Architect was submitted on Friday, March 28, 2025, outlining the proposed changes. **Creative Corrections considers this CAP item *partially compliant*.** Full compliance will require additional funding to complete the remaining maintenance upgrades.

3. **Nonconformity:** The presence of extensive graffiti throughout the cells creates an unwelcoming and potentially distressing environment for occupants.

    a. **Corrective Action:** Submit emails to the maintenance department requesting graffiti removal and provide before-and-after photos documenting the cleanup efforts in affected housing units.

    b. **Evidence of Resolution:** During the follow-up review, MCJ personnel were observed actively removing graffiti in Housing Unit 4D. Creative Corrections also reviewed documentation related to POD rehabilitation efforts for graffiti removal in Units 3-A-B-C, 4-D, and 6-A-B-C-D. To address recurring issues, MCJ implemented an additional measure by replacing pencils with pens that use easily removable ink, reducing long-term wall damage caused by graffiti. **Creative Corrections considers this CAP item *partially compliant*,** with continued monitoring by correctional supervisors and preventive maintenance measures to support full resolution including replacement of pencils with removable ink pens, occupant work details to remove graffiti and holding occupants accountable through the disciplinary process.

5.6. A&O Handbook

1. **Nonconformity:** The occupant handbook should be updated to include the new visiting procedures.

    a. **Corrective Action:** Conduct an annual review of the occupant handbook to ensure all content is current, including updated visitation procedures and any other relevant operational changes.

    b. **Evidence of Resolution:** The follow-up review confirmed that the occupant handbook is reviewed annually and now includes updated visitation procedures as part of its most recent revision. **Creative Corrections considers this CAP item *fully compliant*.**

5.7. Medical

1. **Nonconformity:** Health Services does not consistently follow established tuberculosis screening guidelines. Specifically, the policy does not state a timeline for completion of chest x-rays.

    a. **Corrective Action:** Conduct 100% chart audits until 60 consecutive days of sustained compliance is achieved with tuberculosis screening guidelines, as outlined in Wellpath Policy HCD-100 B-02 Infectious Disease Prevention and Control (dated April 9, 2025, Section 6.1.5, Page 2), which states: *"Patients reporting a positive HIV status will complete a chest x-ray within 14 days."*

    b. **Evidence of Resolution:** The follow-up review confirmed that ongoing compliance monitoring is being conducted by the Infection Prevention and Control (IPC) RN. Data collected from January 1 to April 16, 2025, indicates a notable improvement, with compliance rates **increasing to 83%** and the average time to complete **chest x-rays is 14.8 days.** This span of 14.8 days represents 100% of patients receiving x-rays, which has increased from 20% of patients previously receiving x-rays. Although progress has been made, continued monitoring is necessary. The IPC RN should maintain 100% chart audits until sustained compliance is achieved for the required 60-day period with additional monitoring on a quarterly basis. **Creative Corrections considers this CAP item *partially compliant*.**

2. **Nonconformity:** The intake process has a critical gap in drug screening procedures. Some occupants who tested positive for pregnancy at intake were not subsequently given a drug screen.

    a. **Corrective Action:** Ensure that any female occupant who tests positive for opiate use during the receiving/booking process is promptly referred to health care staff for further evaluation.

b. **Evidence of Resolution:** Wellpath clarified that “screening” at intake refers to verbal questioning or self-reported information rather than diagnostic or lab testing. As a result, no policy revision was deemed necessary, but staff education was recommended to ensure consistent understanding. Booking medical staff received training on the definition of "screening" within this context to align practices with Wellpath’s interpretation. **Creative Corrections considers this CAP item *fully compliant*.**

3. **Nonconformity:** While the facility conducts emergency medical drills, a crucial step is missing in developing formal corrective action plans to address any weaknesses identified during these drills.

    a. **Corrective Action:** Conduct an Emergency Response/Disaster Drill between now and mid-March and include documentation of implementation and completion of all corrective actions identified during the drill.

    b. **Evidence of Resolution:** The Health Services Administrator revised the Emergency Response/Disaster Drill Critique form to include a Follow-Up section and final signature line, ensuring accountability for addressing and completing all listed corrective actions. Evidence of corrective action completion was also submitted. Additionally, the administrator conducted a retrospective review of all 2024 quarterly drills, confirming that corrective actions from each drill were completed and that supporting documentation or training records were attached to each report. **Creative Corrections considers this CAP item *fully compliant*.**

4. **Nonconformity:** There is inconsistency in how the responsible physician or medical director reviews health assessments.

    a. **Corrective Action:** Review the Wellpath policy requiring documentation of health assessment reviews with positive findings by a responsible physician/medical director and determine whether this aligns with State of Wisconsin regulations and standards.

    b. **Evidence of Resolution:** A review of Wellpath Policy HCD-100-E04 (dated January 30, 2025) was completed. The policy has been updated to require documentation by the "responsible healthcare provider", rather than limiting this responsibility to a physician or medical director. At MCJ, initial health assessments are conducted by nurse practitioners, who are recognized as independent providers under Wisconsin state law. Since the updated policy now reflects compliance with state standards and permits qualified providers to conduct and document these reviews, no further chart audits

are required. **Creative Corrections considers this CAP item *fully compliant*.**

5. **Nonconformity:** The commissary needs to update its list and signage to accurately reflect available items. It also needs to ensure the Medical Director and HSA are involved in selecting commissary items, as required by policy.

    a. **Corrective Action:** Incorporate contract language requiring the Medical Director and Health Services Administrator (HSA) to be involved in the selection of commissary items, as outlined in Wellpath policy. They should also participate in regularly scheduled commissary meetings (quarterly or annually) to provide clinical oversight on health-related items.

    b. **Evidence of Resolution:** Although Wellpath does not have direct authority over the commissary vendor, the Medical Director and HSA provide subject-matter expertise and recommendations on Over-the-Counter (OTC) medications and other health-related commissary items directly to MCSO leadership. This process allows Wellpath to fulfill the intent of the policy by offering clinical input, even though they do not engage in direct vendor negotiations. MCSO leadership incorporates this guidance when making decisions regarding commissary offerings. **Creative Corrections considers this CAP item *fully compliant*.**

6. **Nonconformity:** The current medical leadership practices lack a proactive approach to addressing occupant health concerns. Specifically, they do not conduct weekly rounds within the housing units.

    a. **Corrective Action:** Establish a weekly rounding schedule in occupant housing units, to be conducted by the Health Services Administrator (HSA) and the Director of Nursing (DON), either jointly or on a rotating basis, to enhance leadership visibility and occupant engagement.

    b. **Evidence of Resolution:** During the MCJ Administrative Meeting on April 15, 2025, led by the Jail Administrator, it was reported that weekly rounds are actively being conducted by the HSA and DON. These rounds have resulted in positive outcomes, including a notable reduction in written grievances, attributed to increased leadership presence and direct communication with occupants. **Creative Corrections considers this CAP item *fully compliant*.**

7. **Nonconformity:** Nurses were observed accessing bulk stock medication to administer to occupants. These medications were not properly prepared and labeled by pharmacy staff.

a. **Corrective Action:** Obtain formal guidance from the Wisconsin Board of Nursing regarding the permissibility of nurses administering medications from bulk stock bottles. If approved, revise WellPath policy to reflect this practice and develop a local formulary specifying which medications may be administered in this manner.

b. **Evidence of Resolution:** WellPath has taken initial steps to assess the use of bulk stock medications. The Health Services Administrator has engaged in ongoing discussions with the supply vendor, Clinical Solutions, focusing on transitioning to blister card packaging as a safer and more fiscally responsible alternative. This reflects progress in evaluating best practices for medication administration.

   However, the required confirmation from the Wisconsin Board of Nursing on the practice to administer from bulk stockand the creation of a local bulk stock formulary have not yet been completed In addition, Wellpath policy regarding bulk stock has not yet been revised. While the shift toward blister card use may signal a change in strategy, the original intent of this CAP to formally assess and implement bulk stock administration based on regulatory approval has not been fully realized. **Creative Corrections considers this CAP item *partially compliant*.**

8. **Nonconformity:** A review of the sharps and needle count logs revealed inaccuracies in the inventories.

   a. **Corrective Action:** Ensure accuracy and completeness in sharps and needle count logs across the pharmacy, dental clinic, medical booking, and medication carts by implementing a corrective action plan requiring a weekly review of 10% of log entries until 60 consecutive days of full compliance is achieved.

   b. **Evidence of Resolution:** A physical inventory conducted on March 23, 2025, across centralized bulk stock and eight sub-stock carts revealed no discrepancies in actual needle and sharps counts. Compliance with bulk stock documentation was confirmed at **100% for both March and April 2025**. However, sub-stock cart documentation for beginning- and end-of-shift counts was incomplete in March and improved to **80% compliance in April 2025**. While no items were physically missing, the documentation does not yet meet the standard of full compliance for every shift where healthcare staff are present. The process for the weekly 10% log review, which is completed by hospital administrators and the director of nursing, as outlined in the CAP is ongoing and will continue until 60 consecutive days of consistent, complete documentation is achieved across all locations.

Following this, monitoring should be done on a quarterly basis. **Creative Corrections considers this CAP item *partially compliant*.**

9. **Nonconformity:** Wellpath needs to improve communication with occupants who have language barriers or require special accommodations. A review found inconsistent documentation of interpreter use.

    a. **Corrective Action:** Conduct weekly audits of clinical encounter documentation for individuals with Limited English Proficiency (LEP) until 60 consecutive days of consistent compliance with language assistance documentation requirements are achieved.

    b. **Evidence of Resolution:** Documentation of language assistance for LEP and hearing-impaired individuals reached **100% compliance** for **intake screenings** following the implementation of a new electronic health record (EHR) drop-down field. However, documentation for other clinical encounters, while improved to 100% in April 2025, was **inconsistent in March 2025 (14%)**, due to reliance on manual entry. As a result, the goal of sustained, facility-wide compliance across all clinical encounters has not yet been fully achieved. Ongoing efforts, including staff education, potential EHR field enhancements, and continued weekly chart audits, are necessary to ensure lasting compliance. **Creative Corrections considers this CAP item *partially compliant*.**

10. **Nonconformity:** The TTY device for deaf occupants was not medically certified, limiting its use.

    a. **Corrective Action:** Obtain confirmation of a medically certified TTY (Text Telephone) device to ensure communication accessibility for individuals with hearing impairments.

    b. **Evidence of Resolution:** MCJ has implemented Voyce Global, a platform recognized as a medically approved communication device for the hearing impaired, meeting accessibility requirements for clinical and correctional settings. **Creative Corrections considers this CAP item *fully compliant*.**

11. **Nonconformity:** While the current Continuous Quality Improvement (CQI) program effectively tracks task completion and adherence to procedures, it needs to broaden its scope to include outcome-driven studies.

    a. **Corrective Action:** Enhance the Continuous Quality Improvement (CQI) program by expanding its focus beyond task completion and procedural adherence to include outcome-driven studies. Provide appropriate training and resources to the designated CQI staff member to support the development and implementation of these comprehensive initiatives.

b. **Evidence of Resolution:** MCJ has transitioned its CQI program to a more outcome-focused model by adopting enhanced resources and tools. This includes integration of Wellpath's CQI Calendar for long-term planning, structured performance tracking reflected in the CQI Annual Review and Meeting Minutes, and the use of evidence-based tools such as the PDSA Worksheet and Action Plan Template from the Institute for Health Care Improvement, with supplemental guidance from Department of Health and Human Services (DHHS).

   The use and review of these materials demonstrate that a robust framework is now in place to support the implementation of outcome-based CQI studies, effectively meeting the goal of broadening the program's scope. **Creative Corrections considers this CAP item *fully compliant*.**

12. **Nonconformity:** Booking Nurses are inconsistent in notifying mental health staff prior to placing an occupant on suicide watch.

    a. **Corrective Action:** Provide training to ensure Booking Nurses consistently notify Psychology Services prior to placing an occupant on suicide watch. When Psychology Services staff are present in the facility, Booking Nurses will defer the decision to them. Comprehensive training will cover proper suicide watch placement procedures, including immediate notification protocols and guidance for deferring decisions to on-site Psychology staff.

    b. **Evidence of Resolution:** Training has been successfully implemented to ensure Booking Nurses follow established procedures for notifying Psychology Services prior to placing an occupant on suicide watch. A protocol is now in place requiring nurses to defer suicide watch placement decisions to Psychology staff when available. While the number of suicide watch placements has remained constant at 616, the placement time on suicide watch has decreased from 3.8 days to 2.8 days as a result of this training and procedural change. This reflects more appropriate utilization of mental health evaluations and achieves the intended goal. **Creative Corrections considers this CAP item *fully compliant*.**

5.8. Mental Health

1. **Nonconformity:** Wellpath policy requires a minimum 24-hour suicide watch, regardless of an individual's actual condition. This rigid rule disregards professional judgment and may unnecessarily harm occupants who are not suicidal.

   a. **Corrective Action:** The Wellpath Psychology Department should reassess overly rigid expectations regarding suicide watch protocols at MCJ and develop a strategy that empowers clinicians to exercise professional

judgment when making decisions about suicide watch placement and removal.

b. **Evidence of Resolution:** Wellpath Policy HCD-100-B05 was revised on December 2, 2024, to reflect a more flexible, clinically guided approach. The previous 24-hour minimum requirement for suicide watches has been removed, and the updated policy now allows clinicians to discontinue suicide watches based on clinical judgment. **Creative Corrections considers this CAP item *fully compliant*.**

2. **Nonconformity:** Operational reviews need to be more focused and detailed, especially when dealing with incidents as serious as a suicide attempt.

    a. **Corrective Action:** Enhance post-serious incident operational reviews (e.g., suicide attempts or acts of self-harm) by requiring a thorough analysis of event sequences, risk factors, warning signs, and the effectiveness of preventive measures. This approach ensures adherence to root cause analysis principles and supports continuous improvement in safety practices.

    b. **Evidence of Resolution:** Wellpath Psychology has implemented standardized, multidisciplinary operational reviews for all serious suicide attempts and significant acts of self-harm at MCJ. These reviews utilize a Creative Corrections-developed template to guide comprehensive evaluations, allowing for a deeper understanding of contributing factors and enhancing suicide prevention protocols. **Creative Corrections considers this CAP item *fully compliant*.**

3. **Nonconformity:** Wellpath has not met all of its training obligations. Records show that contractors have not received the mandatory annual suicide prevention training.

    a. **Corrective Action:** Achieve full compliance with training standards by ensuring that all Wellpath contractors complete mandatory annual suicide prevention training, equipping staff to effectively safeguard occupant well-being.

    b. **Evidence of Resolution:** All contracted Psychology staff have successfully completed the required annual suicide prevention training. In addition, Wellpath Psychology Supervisors have established enhanced monitoring with the compliant tracking system to monitor ongoing training completion and ensure continued compliance. **Creative Corrections considers this CAP item *fully compliant*.**

4. **Nonconformity:** The facility should offer open-ended and open-door treatment groups to better support occupants with mental health issues.

    a. **Corrective Action:** Implement standalone, open-ended psycho-educational classes for the MCJ occupant population by May 2025, focusing on wellness, mental health awareness, and coping strategies.

    b. **Evidence of Resolution:** A series of open-ended psycho-educational classes covering topics such as wellness, stress, emotional regulation, and medication compliance have been collaboratively developed and implemented by Psychology Services and Creative Corrections. These classes were launched ahead of the May 2025 target date, providing timely support and resources to the MCJ population. **Creative Corrections considers this CAP item *fully compliant*.**

5. **Nonconformity:** Track mental health medication administration and follow up with occupants who miss doses.

    a. **Corrective Action:** Implement a robust tracking system to monitor mental health medication administration and ensure timely follow-up with occupants who miss doses, thereby supporting continuity of care and effective medication management.

    b. **Evidence of Resolution:** Wellpath Psychology maintains continuity of care through a **multi-tiered approach** to monitoring psychiatric medication adherence. When an occupant misses three doses of prescribed psychiatric medication, the medication administration nurse notifies psychiatry, prompting a follow-up with the psychiatric nurse and/or psychiatrist. In addition, mental health clinicians regularly review the medication records of their assigned caseloads and bring any non-adherence issues to the attention of psychiatry during daily staff meetings. **Creative Corrections considers this CAP item *fully compliant*.**

6. **Nonconformity:** To achieve 24/7 mental health coverage, the facility needs a comprehensive staffing plan.

    a. **Corrective Action:** Optimize Psychology Services staffing coverage by eliminating one full-time position and establishing two part-time positions to improve scheduling flexibility, support weekend and overnight coverage, and attract a broader pool of qualified clinicians.

    b. **Evidence of Resolution:** Wellpath has initiated the revised staffing model has been initiated, with two part-time positions posted to replace one full-time role. However, the intended goals of increased flexibility and enhanced

weekend/overnight coverage have not yet been achieved, as the facility is still awaiting qualified applicants. **Creative Corrections considers this CAP item *partially compliant***, pending successful hiring and integration of the new Wellpath positions into the staffing schedule.

5.9. Communication with External Stakeholders

1. **Nonconformity:** MCSO leadership should attempt to communicate with the CRC Superintendent to move 70 females to the Annex.
    a. **Corrective Action:** Engage proactively with the CRC Superintendent, through the appropriate chain of command, to evaluate the feasibility of transferring 70 female occupants to the Annex. This initiative is intended to improve **housing efficiency and resource allocation** at MCJ.
    b. **Evidence of Resolution:** MCSO leadership has initiated communication with the CRC Superintendent regarding the proposed transfer. Although the transfer has not yet been approved, the Superintendent has agreed to reassess the request in July 2025, reflecting progress in the dialogue and a commitment to revisit the proposal. **Creative Corrections considers this CAP item *partially compliant*,** pending further engagement and formal approval from CRC leadership to proceed with the transfer.
2. **Nonconformity:** MCSO leadership should attempt to communicate with the CRC leadership to enhance the classification system for occupants being moved to CRC.
    a. **Corrective Action:** Initiate communication with the CRC leadership to collaborate on enhancing the classification system for occupants transferring to CRC. The goal is to support a more effective and streamlined transition process that aligns with operational and clinical priorities.
    b. **Evidence of Resolution:** MCSO has initiated communication with the CRC leadership to discuss improvements to the occupant classification system for CRC transfers. While this represents a positive first step, the goal remains partially met as the CRC is still reviewing the proposal, and no formal decision or collaborative plan has been established. **Creative Corrections considers this CAP item *partially compliant*,** with further engagement and a clear outcome from CRC leadership required to meet the corrective action in full.
3. **Nonconformity:** A classification system for female occupants should be created that is consistent with current jail practices.

a. **Corrective Action:** Develop and implement a female-specific classification system that accounts for the unique needs and circumstances of female occupants, while maintaining alignment with current jail practices and addressing the distinct differences from male classification standards.

b. **Evidence of Resolution:** MCSO and CRC leadership are actively engaged in the development of a gender-responsive classification system through their participation in the Equivant Corrections Conference (June 16–18, 2025). This collaboration supports the creation of a system that recognizes the unique considerations of female occupants and promotes consistency across facilities. While this represents significant progress, **Creative Corrections considers this CAP item *partially compliant***, as the system is still under development and has not yet been formally implemented.

4. **Nonconformity:** MCSO leadership should communicate with the County DAS Maintenance leadership to develop a plan of action to address maintenance concerns within the jail.

    a. **Corrective Action:** Establish ongoing communication with County Maintenance leadership to collaboratively develop and implement a comprehensive plan of action to address and resolve existing maintenance concerns within the jail facility.

    b. **Evidence of Resolution:** MCSO has initiated communication with County Maintenance leadership, and a plan of action is in progress, as demonstrated by completed work in Housing Units MHU and 4D, as well as the creation of key rings to support security upgrades. However, additional maintenance projects remain outstanding, and further progress is needed to fully resolve the facility-wide concerns. **Creative Corrections considers this CAP item *partially compliant*,** with continued collaboration between the Milwaukee County Sheriff's Office and DAS Facility Maintenance and completion of pending work required for full compliance.

6. Conclusion

The Milwaukee County Jail has made measurable and meaningful progress in addressing the deficiencies identified in the original Correctional Management Review conducted in October 2024. Through the implementation of targeted corrective actions, MCJ has demonstrated a commitment to operational reform, staff and occupant safety, and compliance with correctional standards. Key improvements include the elimination of unsafe restraint practices, updated suicide prevention protocols, strengthened supervision, improved compliance reviews, and targeted mental health and suicide awareness training.

In conclusion the ongoing reforms at Milwaukee County Jail (MCJ) reflect a strong commitment to improving correctional safety, accountability, and care. With continued funding and sustained collaboration between jail leadership, county stakeholders, and CRC, Milwaukee County is well-positioned for long-term success.

Creative Corrections LLC extends its sincere appreciation to the Milwaukee County Board of Supervisors for the opportunity to support this important initiative, and to the Milwaukee County Sheriff's Office for their cooperation and partnership throughout this process.

7. Compliance Review Appendix

7.1. CAP Actionable Concerns Compliance Table

Actionable Area of Concern	Final Report Section/Page	Summary of CAP Response	Resolution Status
Security – Restraint Benches Routine use of restraint benches for suicide-watch occupants in booking and special units (dangerous practice).	Security (Sec. 5.1, p.5–6)	Practice discontinued; intake procedures revised to ensure suicidal individuals are evaluated and moved to suicide-watch cells within 1 hour. MCJ is working with county officials to **remove bench restraints and add holding cells**, pending funding. *No instances of bench restraints were observed during the follow-up visit*.	Partially Compliant
Security – Post Orders Lack of detailed post orders for each officer post (unclear duties).	Security (Sec. 5.1, p.6)	Comprehensive **post orders developed and implemented** for all housing units (including Specialized and Mental Health units). They clearly define duties by post, shift, and emergency response procedures. Staff have reviewed and acknowledged these post orders.	Fully Compliant
Security – Tool Control Deficient tool security by maintenance staff (no risk categorization or inventory tracking by officers).	Security (Sec. 5.1, p.6–7)	An **enhanced tool control policy** is underway. MCJ created a tool accountability protocol (roll-call training with officer sign-offs) and identified a secure tool storage area. A digital tracking system (Jail	Partially Compliant

Actionable Area of Concern	Final Report Section/Page	Summary of CAP Response	Resolution Status
		Management System dropdown) is being implemented with go-live on May 12, 2025. *Full resolution awaits assembly of specialized toolkits by County Maintenance*.	
Security – Door Security During Maintenance Pod doors left unsecured during repairs; restraints unaccounted for (security lapse).	Security (Sec. 5.1, p.7–8)	**Inspection and training measures implemented**: MCJ set up structured inspections of restraints and trained officers to secure pod doors and control restraint equipment. Follow-up tours found no unsecured doors and verified restraint inventories. Staff received directives and training on door security protocols.	Fully Compliant
Security – Armory Management Armory inspection revealed missing inventory records and outdated protective gear (safety risk).	Security (Sec. 5.1, p.8)	**Armory inventory system established**: Daily equipment issuance and regular supervisory inspections are in place, with sign-in sheets for trained staff . All less-lethal munitions are inventoried and expired gear removed. *However, new protective gear and munitions need County funding*, so the item remains only partially resolved.	Partially Compliant
Security – Inmate Counting Inmate count policy unclear on frequency and handling out-of-unit inmates (risk of miscounts).	Security (Sec. 5.1, p.8–9)	**Count procedures updated**: MCJ added an extra midnight count (12:00 AM) and updated policies/post orders to clarify count frequency and out-count verification. Intake staff now verify all out-of-unit inmates during counts by contacting their locations. These measures ensure accurate, accountable inmate counts.	Fully Compliant

Actionable Area of Concern	Final Report Section/Page	Summary of CAP Response	Resolution Status
Security – Key Control (Key Watcher) No electronic key management system in use (risk of key loss/unauthorized access).	Security (Sec. 5.1, p.9)	**Key Watcher electronic system in progress**: MCJ is organizing key rings and removing obsolete keys in preparation for full Key Watcher deployment in May 2025. One Key Watcher unit is already installed in the supervisor's office. Staff training on key control will coincide with system go-live. *Interim audits showed no key control issues*.	Partially Compliant
Security – Compliance Reviews No ongoing internal compliance review program for security practices (no self-monitoring).	Security (Sec. 5.1, p.9)	**Compliance review program initiated**: MCJ began conducting internal compliance reviews (e.g. auditing food service logs, suicide watch documentation, use-of-force reports) and received sample perpetual audit tools from Creative Corrections. MCJ plans to expand these audits to all security areas as part of a continuous improvement model.	Fully Compliant
Security – Housing Unit Supervision Lack of supervisor presence in specialized housing units during day/evening shifts (safety risk).	Security (Sec. 5.1, p.9–10)	**Dedicated supervisors assigned**: MCJ assigned first-line supervisors to the specialized housing units on day and evening shifts. Schedules ensure coverage (one supervisor 8:30–16:30, another 11:30–19:30, with staggered days off). All shift supervisors now conduct regular rounds and respond to calls in those units.	Fully Compliant
Security – Suicide Watch Transfer Delayed transfer of suicidal occupants to proper watch cells (inconsistent procedures).	Security (Sec. 5.1, p.10–11)	**Expedited suicide-watch placement**: New procedures require individuals on suicide watch to be moved to an approved suicide-watch cell within 1 hour of mental health	Fully Compliant

Actionable Area of Concern	Final Report Section/Page	Summary of CAP Response	Resolution Status
		notification. A color-coded card system now flags such individuals, and booking prioritizes their processing. Staff must alert supervisors if any delay occurs. *No bench restraints were observed under the new process*.	
Security – Calculated Use of Force (CUOF) Policy CUOF policy lacks guidance for all team members (incl. medical/mental health) on roles and steps.	Security (Sec. 5.1, p.11)	**CUOF procedures clarified and trained**: MCJ, with Creative Corrections input, updated its Calculated Use of Force protocols, detailing role assignments, approval steps, de-escalation tactics, and after-action review processes. In March 2025, supervisory staff received targeted CUOF training and reviewed past incidents for compliance. *These improvements led to a 46% reduction in use-of-force incidents*.	Fully Compliant
Security – Suicide Watch Observation One-on-one suicide watch observation procedures not ensuring clear, unobstructed view of occupants.	Security (Sec. 5.1, p.12)	**Physical improvements to watch cells**: MCJ replaced scratched plexiglass in several suicide-watch cell doors to restore clear visibility. Lighting is being enhanced and electrical fixtures (outlets, switches) removed or relocated to prevent tampering. *Substantial progress made; full completion requires additional funding for remaining cell upgrades*.	Partially Compliant
Security – Leadership Rounds MCSO leadership not conducting weekly rounds in housing units.	Security (Sec. 5.1, p.12)	**Weekly leadership rounds implemented**: Jail administrators and command staff now tour all housing units weekly. Housing unit logs and	Fully Compliant

Actionable Area of Concern	Final Report Section/Page	Summary of CAP Response	Resolution Status
		staff interviews confirmed these rounds occur consistently, with leadership engaging staff and occupants during visits. This practice has been institutionalized.	
Training – Probationary Staff Newly hired staff lack training in handling mental health crises and suicidal behavior.	Training (Sec. 5.2, p.13)	**Enhanced academy training**: MCSO's training academy updated its lesson plans to include comprehensive content on mental health crises, suicide risk recognition, de-escalation, and intervention for probationary officers. All new officers now receive this specialized training as part of their required curriculum.	Fully Compliant
Training – Existing Staff Veteran officers need targeted suicide prevention and mental health awareness training with practical examples.	Training (Sec. 5.2, p.13)	**Annual refresher training added**: A tailored lesson plan focusing on suicide prevention and managing mentally ill occupants was developed by Creative Corrections and approved by Wellpath psychology staff. This training is scheduled for all active (non-probationary) staff starting May 19, 2025, and will be incorporated into annual training going forward.	Fully Compliant
Training – Communication & Resources Inadequate communication to occupants: lack of multilingual signage and suicide prevention information in the jail.	Training (Sec. 5.2, p.14)	**Improved inmate communication**: Bilingual English/Spanish signage has been posted in housing units, explaining how to request mental health services and assistance. Intake/orientation materials (videos and handbooks) are now provided in both English and Spanish, and a	Fully Compliant

Actionable Area of Concern	Final Report Section/Page	Summary of CAP Response	Resolution Status
		telephonic interpreter line is used for non-English speakers. Suicide prevention resource information is readily available to all occupants.	
Training – Supervisor CUOF Training Supervisors lack training on Calculated Use of Force procedures.	Training (Sec. 5.2, p.14)	**Mandatory CUOF training for supervisors**: All correctional supervisors received specialized training on proper procedures before, during, and after calculated uses of force (conducted April 16, 2025). Training rosters and a detailed lesson plan were provided, covering planning, de-escalation, medical/mental health involvement, and post-incident debriefing. This training is now conducted annually for all supervisors.	Fully Compliant
Safety – Program Oversight Safety program lacks oversight by a qualified safety professional (non-compliance with NFPA/OSHA standards).	Safety (Sec. 5.3, p.14)	**Safety officer training**: The Captain overseeing safety has engaged in professional safety training. He attended a county Risk Management meeting (Mar 10, 2025) and enrolled in an OSHA jail-safety training program, completing 5 of 10 modules as of April 2025. This demonstrates active progress toward obtaining qualified safety oversight, and the enrollment/completion was verified.	Fully Compliant
Food Service – Knife Security No formal knife inventory system (knives not consistently tracked or accounted for).	Food Service (Sec. 5.4, p.15)	**Knife inventory system implemented**: A daily tool/knife inspection and log system is now in place in Food Service. MCJ provided completed daily inventory forms for review.	Fully Compliant

Actionable Area of Concern	Final Report Section/Page	Summary of CAP Response	Resolution Status
		During the April 2025 on-site visit, Creative Corrections physically verified that knives and kitchen tools are being properly logged in/out and secured.	
Food Service – Posted Menus Inmates are not provided written menus of meals (limiting transparency and communication).	Food Service (Sec. 5.4, p.15–16)	**Plan for posting menus**: MCJ intends to post daily menus in housing units and on inmate tablets to improve transparency. However, as of April 28, 2025, this has **not yet been implemented** due to ongoing renovations at the Community Reintegration Center kitchen (which prepares meals). Menu posting will commence once the renovations are complete and operations normalize.	Partially Compliant
Food Service – Religious Diet Area Unsanitary conditions in religious-diet meal prep area (ceiling tiles and vents dirty).	Food Service (Sec. 5.4, p.16)	**Sanitation issues corrected**: Work orders were completed to replace the dirty ceiling tiles and clean the dust-laden A/C vent above the religious diet prep area. A follow-up inspection during the site visit found the area **clean and sanitary**, meeting food safety standards.	Fully Compliant
Food Service – Trash Can Lids Kitchen garbage containers lacked lids (potential contamination/pest issue).	Food Service (Sec. 5.4, p.16)	**Trash receptacles outfitted with lids**: MCJ provided photographic evidence that all kitchen trash cans now have proper fitted lids. Additionally, staff (and inmate kitchen workers) were trained on sanitation standards, with sign-in sheets confirming this training. These steps prevent contamination and pest attraction.	Fully Compliant

Actionable Area of Concern	Final Report Section/Page	Summary of CAP Response	Resolution Status
Food Service – Cooler Safety Releases Walk-in coolers #2 and #3 had no internal safety release (risk of entrapment).	Food Service (Sec. 5.4, p.16–17)	**Entrapment hazard eliminated**: The chains previously used to secure Coolers #2 and #3 (which prevented opening from inside) were removed. During the follow-up visit, inspectors confirmed that individuals can now exit these walk-ins freely and **no safety hazard remains**. (Installation of internal release handles is effectively accomplished by removing the external locking mechanism.)	Fully Compliant
Food Service – Non-Slip Shoes Inmate workers not provided with non-slip shoes for kitchen (risk of slips/falls).	Food Service (Sec. 5.4, p.17)	**Non-slip footwear provided**: The Food Service Administrator obtained non-slip shoe covers for all staff and inmate workers in the kitchen. During the site visit, both staff and inmate kitchen workers were observed wearing these slip-resistant shoe covers. This measure has reduced the risk of kitchen slips and related injuries.	Fully Compliant
Food Service – Menu Change Notification Food service not informing security of menu changes (could cause unrest if inmates uninformed).	Food Service (Sec. 5.4, p.17)	**Notification procedure in place**: The Food Service Administrator (Trinity Services) now sends email notifications to correctional supervisors any time there is a menu change. This fulfills the contract requirement and ensures supervisors can inform inmates of changes in advance, maintaining order. Documentation of these communications was provided in the CAP evidence.	Fully Compliant

Actionable Area of Concern	Final Report Section/Page	Summary of CAP Response	Resolution Status
Food Service – Delivery Security Inmates present in garage during supply deliveries (security risk for escape or contraband).	Food Service (Sec. 5.4, p.17–18)	**Secured delivery protocol implemented**: New procedures mandate that **no inmates are in the rear loading dock/garage area during deliveries**. Inmates are removed before trucks unload, and the garage door is closed and secured before inmates return to move supplies. A follow-up observation of a milk delivery confirmed compliance with this protocol.	Fully Compliant
MCJ Maintenance – Suicide-Watch Cell Visibility Scratched cell-door glass in suicide-watch cells impedes observation of occupants.	MCJ Maintenance (Sec. 5.5, p.18)	**Plexiglass replacements begun**: MCJ replaced most scratched plexiglass panels in suicide-watch cell doors (e.g. in the Mental Health Unit), restoring clear visibility. Cells were observed to be clean, well-lit, and suitable for 1:1 monitoring after these fixes. *Full completion requires additional funding to replace all remaining panels*.	Partially Compliant
MCJ Maintenance – Light Switches Light switches located inside suicide-watch cells (allowing inmates to control lighting).	MCJ Maintenance (Sec. 5.5, p.18–19)	**Planned infrastructure change**: MCJ developed a proposal to relocate all suicide-cell light switches to outside the cells. A quote for the work was submitted to the County's Capital Improvement Committee (as of March 28, 2025). *This project is awaiting approval and funding; switches have not yet been moved*, so the safety risk is acknowledged but not fully eliminated at this time.	Partially Compliant
MCJ Maintenance – Graffiti Removal Cells defaced with extensive	MCJ Maintenance (Sec. 5.5, p.19)	**Graffiti abatement efforts ongoing**: Maintenance staff have been actively removing graffiti in	Partially Compliant

Actionable Area of Concern	Final Report Section/Page	Summary of CAP Response	Resolution Status
graffiti (creates distressing environment).		affected housing units (e.g. Unit 4D) during the follow-up period. Documentation shows a "pod rehabilitation" initiative for graffiti cleanup in multiple units. To prevent future damage, MCJ switched from pencils to easily washable ink pens for inmates. *Continued monitoring is recommended to ensure this issue remains under control*.	
A&O Handbook – Visitation Procedures Inmate handbook not updated with new visiting procedures.	A&O Handbook (Sec. 5.6, p.19)	**Handbook revised**: The inmate (A&O) handbook undergoes an annual review, and the latest edition now includes the updated visitation procedures. The follow-up confirmed that the new visiting rules are documented in the handbook provided to inmates.	Fully Compliant
Medical – TB Screening Non-compliance with tuberculosis screening guidelines (at-risk inmates missing chest X-rays or annual tests).	Medical (Sec. 5.7, p.20)	**Intensive audit and monitoring**: The Infection Control Nurse is conducting 100% chart audits to enforce TB screening per policy. Between January and April 2025, compliance improved to 83%, and average time to chest X-ray for HIV+ inmates dropped to ~14.8 days. *Audits will continue until a sustained 60-day full compliance is achieved*.	Partially Compliant
Medical – Intake Drug Screening Pregnant inmates who tested positive for pregnancy at intake were not given subsequent drug tests.	Medical (Sec. 5.7, p.20)	**Clarification of procedure**: It was determined that "drug screening" at intake refers to verbal screening, not an automatic lab test. Wellpath confirmed no policy change was needed, but staff were re-educated on this definition. Medical booking staff have now	Fully Compliant

Actionable Area of Concern	Final Report Section/Page	Summary of CAP Response	Resolution Status
		been trained to ensure understanding that any indications of substance use in pregnant inmates trigger proper follow-up. *With this clarification and training, the gap was resolved*.	
Medical – Emergency Drill Follow-up Emergency medical drills lacked formal corrective action plans for identified weaknesses.	Medical (Sec. 5.7, p.20–21)	**Drill process improved**: The Health Services Administrator updated the emergency drill critique form to include a **Corrective Actions Follow-up** section with sign-off for completion. Evidence was provided that all corrective actions from quarterly drills in 2024 were retrospectively completed and documented. Going forward, every drill will have documented follow-up to ensure weaknesses are addressed.	Fully Compliant
Medical – Health Assessment Review Physician/Medical Director not consistently reviewing health assessments with positive findings (per policy).	Medical (Sec. 5.7, p.21)	**Policy updated for compliance**: Wellpath's policy was reviewed and revised (as of Jan 30, 2025) to require documentation by the "responsible healthcare provider" (not only a physician) for any health assessment with positive findings. At MCJ, nurse practitioners conduct initial health assessments and are licensed to independently perform these duties. The policy change aligned the practice with Wisconsin standards, resolving the compliance issue.	Fully Compliant
Medical – Commissary List & Oversight Commissary offerings list	Medical (Sec. 5.7, p.21–22)	**Medical input integrated**: Although the private commissary vendor is outside Wellpath's	Fully Compliant

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outdated; Medical Director/HSA not involved in approving items (per policy).		direct control, the Medical Director and Health Services Administrator now provide recommendations to jail leadership on health-related commissary items (e.g. allowable over-the-counter meds). MCSO leadership incorporates this clinical input when updating commissary lists. Thus, the intent of involving medical leadership in commissary choices is being met.	
Medical – Leadership Rounds Medical leadership (HSA, DON) not making weekly rounds in housing units to address inmate health concerns proactively.	Medical (Sec. 5.7, p.22)	**Weekly HSA/DON rounds instituted**: A weekly rounding schedule for the Health Services Administrator and Director of Nursing was established. During an administrative meeting on April 15, 2025, it was reported that these medical leadership rounds are occurring routinely. The increased presence has led to fewer inmate grievances, indicating improved communication and issue resolution on the spot.	Fully Compliant
Medical – Bulk Stock Medications Nurses administering medications from bulk stock bottles (meds not labeled by pharmacy).	Medical (Sec. 5.7, p.22–23)	**Practice under review**: MCJ is reassessing the practice of using bulk stock meds. The HSA has been in discussions with the pharmacy vendor to transition to blister-pack medications (which are safer and labeled). However, **formal guidance from the state nursing board is still pending** and the policy has not yet been revised. Until a decision is reached and policy updated, the	Partially Compliant

Actionable Area of Concern	Final Report Section/Page	Summary of CAP Response	Resolution Status
		original issue is only partially addressed.	
Medical – Sharps/Needle Counts Inaccuracies in sharps and needle count logs (pharmacy, clinic, booking, med carts).	Medical (Sec. 5.7, p.23)	**Inventory verification and ongoing audits**: A physical inventory on March 23, 2025, of all bulk and unit-level sharps/needles found **no missing items**, confirming 100% accuracy in physical counts. However, documentation logs for sub-stock carts were only about 80% complete in April (improving from 14% in March). MCJ has instituted weekly audits of 10% of log entries and will continue until **60 consecutive days of perfect documentation** are achieved.	Partially Compliant
Medical – Language Access Inadequate communication for non-English or special-needs inmates (interpreter use not documented; Spanish forms not used).	Medical (Sec. 5.7, p.24)	**Improved LEP communication tracking**: MCJ added a dedicated field in the Electronic Health Record to record interpreter usage, achieving 100% documentation compliance for intake screenings of limited-English and hearing-impaired inmates. For other clinical encounters, compliance improved from 14% (Mar 2025) to 100% in Apr 2025 with staff training and EHR updates. *Facility-wide sustained compliance is not yet proven, so audits and training continue*.	Partially Compliant
Medical – TTY Device TTY telephone device for deaf inmates was not medically certified (limiting its usability).	Medical (Sec. 5.7, p.24)	**Certified communication device implemented**: MCJ adopted the Voyce Global platform, a medically-approved communication aid for the hearing impaired. This system	Fully Compliant

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		meets healthcare communication requirements, ensuring deaf or hard-of-hearing inmates have access to certified devices for communicating their medical needs.	
Medical – CQI Program Scope Continuous Quality Improvement program focuses on tasks, not outcome-based studies (no root-cause analysis of issues).	Medical (Sec. 5.7, p.24–25)	**Outcome-driven CQI adopted**: MCJ transitioned its CQI (Continuous Quality Improvement) program to an **outcome-focused model**. They have integrated new tools such as a CQI calendar for long-term planning, improved performance tracking in annual reviews, and templates like Plan-Do-Study-Act (PDSA) worksheets and action plans (with guidance from HHS and IHI) . These materials demonstrate a robust framework now in place for data-driven quality improvement, meeting the CAP's requirements.	Fully Compliant
Medical – Booking Nurse Notification Booking nurses not consistently notifying mental health staff before placing someone on suicide watch.	Medical (Sec. 5.7, p.25)	**Procedure reinforced with training**: Booking nurses have been trained to **always notify Psychology Services prior to initiating a suicide watch**. A protocol now requires that if mental health staff are on-site, nurses defer the suicide watch decision to them. Since implementing this training and protocol, inappropriate or unnecessary suicide-watch placements have dropped, indicating more proper use of mental health evaluations.	Fully Compliant
Mental Health – 24hr Watch Policy Wellpath	Mental Health (Sec. 5.8, p.25)	**Policy made flexible**: Wellpath revised its suicide watch policy	Fully Compliant

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policy mandating minimum 24-hour suicide watch for everyone, regardless of actual risk (overly rigid).		(HCD-100-B05) on Dec 2, 2024, eliminating the blanket 24-hour minimum watch rule. The updated policy allows clinical staff to use professional judgment to discontinue suicide watch when appropriate. This change empowers clinicians to tailor suicide watch duration to the individual's needs, addressing the concern.	
Mental Health – Incident Reviews Operational reviews after serious incidents (suicide attempts) were not detailed or root-cause focused.	Mental Health (Sec. 5.8, p.25–26)	**Comprehensive review process implemented**: Wellpath Psychology now conducts **standardized, multidisciplinary reviews** of all serious suicide attempts or self-harm incidents. Using a Creative Corrections-provided template, these operational reviews analyze the incident timeline, missed warning signs, risk factors, and prevention efficacy. This structured, in-depth review process ensures lessons are learned and safety practices improved after each event.	Fully Compliant
Mental Health – Training Compliance Contracted mental health staff (Wellpath) had not completed required annual suicide prevention training.	Mental Health (Sec. 5.8, p.26)	**100% training completion achieved**: All Wellpath contract psychological staff at MCJ have now completed their mandatory annual suicide prevention training. Additionally, Wellpath supervisors implemented a tracking system to monitor ongoing compliance and ensure that all contractors remain up-to-date on required training. This addresses the training lapse and maintains future compliance.	Fully Compliant

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Mental Health – Group Treatment Access Lack of open-ended, open-door mental health treatment or support groups for inmates.	Mental Health (Sec. 5.8, p.26)	**Psycho-educational groups introduced**: MCJ Psychology Services, in collaboration with Creative Corrections, launched a series of **open-ended psychoeducational classes** for inmates ahead of the May 2025 target date. These ongoing classes cover wellness topics, coping skills, and mental health awareness, allowing inmates to join or leave as needed. This flexible group format is now in place to support the inmate population.	Fully Compliant
Mental Health – Medication Tracking Inadequate tracking and follow-up for inmates who miss mental health medication doses.	Mental Health (Sec. 5.8, p.26)	**Multi-tier medication adherence system**: A robust tracking procedure ensures continuity of psychiatric care. If an inmate misses 3 doses of a psychotropic medication, the administering nurse notifies psychiatric staff for follow-up. Mental health clinicians also review their caseloads' medication records regularly and flag non-adherence in daily staff meetings. These steps ensure timely intervention when doses are missed.	Fully Compliant
Mental Health – 24/7 Coverage Facility lacks around-the-clock mental health staffing (no comprehensive plan for nights/weekends).	Mental Health (Sec. 5.8, p.27)	**Staffing plan initiated**: MCJ restructured positions by converting one full-time psychologist position into two part-time positions to provide greater coverage (aiming for nights and weekends). The two part-time roles were posted and recruitment is ongoing. *As the new positions are not yet filled, 24/7 coverage is not fully*	Partially Compliant

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		realized; the plan's success is pending hiring and onboarding of these clinicians.	
Communication w/ External – Transfer to CRC MCJ should coordinate with Community Reintegration Center (CRC) to move 70 female inmates to the CRC Annex (to relieve crowding at MCJ).	Communication w/ External (Sec. 5.9, p.27)	**Opened dialogue with CRC**: MCSO leadership initiated communication with the CRC Superintendent to discuss transferring 70 female inmates to the CRC annex. While no transfer has occurred yet, the CRC agreed to reconsider the request in July 2025. *Thus far, this item remains in progress (contingent on CRC approval)*.	Partially Compliant
Communication w/ External – Classification for CRC Work with CRC to enhance the classification system for inmates transferred from MCJ to CRC.	Communication w/ External (Sec. 5.9, p.27–28)	**Collaboration initiated**: MCJ has reached out to the CRC Superintendent to jointly improve the inmate classification process for transfers. This is intended to ensure smoother transitions and appropriate placement for MCJ inmates sent to CRC. Discussions are ongoing; *CRC is reviewing MCJ's proposals, but no final plan has been adopted yet*.	Partially Compliant
Communication w/ External – Female Classification System Create a classification system specifically for female inmates consistent with MCJ practices.	Communication w/ External (Sec. 5.9, p.28)	**Developing gender-specific classification**: MCJ and CRC leadership are actively working on a female-specific classification system. They participated together in the Equivant Corrections Conference in June 2025 to develop strategies for a gender-responsive classification aligned with current jail standards. This cooperative effort is well underway; *however, the new*	Partially Compliant

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		system is still in development and not yet implemented. **Joint maintenance planning**: MCJ established regular communications with County Maintenance. A collaborative action plan is being formulated, and some maintenance projects have already been completed (e.g. repairs in units MHU and 4D, creation of organized key rings for security). *Despite progress, several maintenance issues remain outstanding; continued partnership and project completion are needed for full resolution*.	
Communication w/ External – Maintenance Support Coordinate with County Maintenance leadership to address facility maintenance issues in the jail.	Communication w/ External (Sec. 5.9, p.28)		Partially Compliant

Note: "Fully Compliant" indicates the issue has been addressed to the satisfaction of the corrective action plan, with appropriate evidence provided. "Partially Compliant" indicates that while significant actions have been taken, additional steps (often requiring external support, funding, or sustained effort) are still needed to achieve full compliance. "Pending" items are included under "Partially Compliant" since all concerns have seen at least initial action in the final report.

7.2. Narrative Compliance Summary

The Milwaukee County Jail (MCJ) has made substantial progress in addressing the 52 actionable items identified in the Corrective Action Plan (CAP). As illustrated in the compliance status chart below, approximately **71%** of the concerns have been **fully resolved**, while the remaining **29%** are **partially compliant** and actively being addressed.

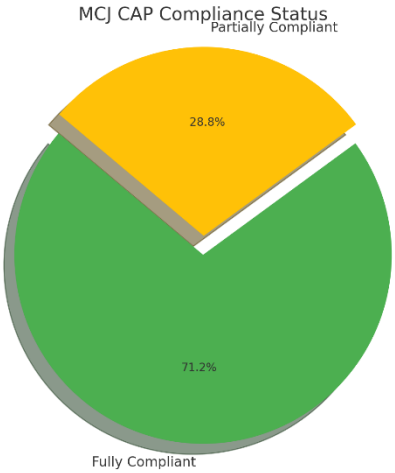

Figure: Percentage of Fully vs. Partially Compliant CAP Items

These findings demonstrate MCJ's significant commitment to corrective action, safety, and policy improvement. Areas rated as partially compliant are not due to inaction, but rather to ongoing processes such as capital improvements, interagency coordination, or extended monitoring to confirm sustained compliance. With continued effort and appropriate support from Milwaukee County leadership, MCJ is well-positioned to achieve full compliance across all identified areas.